ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF MIDWIFERY

HEALTH PROVIDER'S READINESS IN MANAGING INTIMATE PARTNER VIOLENCE IN PUBLIC HEALTH INSTITUTIONS AT HAWASSA CITY, SIDAMA REGION, ETHIOPIA, 2021.

BY: LIDIYA TESHOME (BSc.)

A THESIS SUBMITTED TO ADDISA ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY IN PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN MATERNITY AND REPRODUCTIVE HEALTH NURSING

JUNE, 2021

ADDIS ABABA, ETHIOPIA.

ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEPARTMENT OF MIDWIFERY

HEALTH PROVIDER'S READINESS IN MANAGING INTIMATE PARTNER VIOLENCE IN PUBLIC HEALTH INSTITUTIONS AT HAWASSA CITY, SIDAMA REGION, ETHIOPIA, 2021.

BY: LIDIYA TESHOME (BSc.)

ADVISORS: MR. LEUL DERIBE (ASSISTANT PROFESSOR)
S/R HAWENI ADUGNA (MSc)

A THESIS SUBMITTED TO ADDISA ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF NURSING AND MIDWIFERY IN PARTIAL FULLFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS IN MATERNITY AND REPRODUCTIVE HEALTH NURSING

JUNE, 2021

ADDIS ABABA, ETHIOPIA.

APPROVAL BY THE BOARD OF EXAMINATION

This thesis by health provider's readiness in managing intimate partner violence in public health institutions at Hawassa city, sidama region, Ethiopia, 2021 is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in maternity and reproductive health nursing.

EXAMINER

MR. BERHANU WORDOFA	ASSISTANT PROFESSOR	_____	_____
NAME	RANK	SIGNITURE	DATE

RESEARCH ADVISORS:

Mr. LEUL DERIBE	ASSISTANT PROFESSOR	_____	_____
NAME	RANK	SIGNITURE	DATE

S/R HAWENI ADUGNA	MSc	_____	_____
NAME	RANK	SIGNITURE	DATE

DEPARTMENT HEAD

S/R HAWENI ADUGNA	MSc	_____	_____
NAME	RANK	SIGNITURE	DATE

STATEMENT OF DECLARATION

By my signature below, I honestly declared that this research thesis on health provider's readiness in managing intimate partner violence in public health institutions at Hawassa city, Sidama region, Ethiopia, is my own work and all the sources that I have used indicated and acknowledged by means of complete references. Also, this work has not been submitted before for any other degree in any other institutions.

Name: Lidiya Teshome (BSc) Signature: _____ Date

RESEARCH ADVISORS

MR. LEUL DERIBE	ASSISTANT PROFESSOR	_____	_____
NAME	RANK	SIGNATURE	DATE
S/R HAWENI ADUGNA	MSC	_____	_____
NAME	RANK	SIGNITURE	DATE

ACKNOWLEDGEMENT

For all, I am eternally grateful to my Almighty God. I'd like to express my gratitude to Addis Ababa University Colleague of Health Science, School of Nursing, and Midwife for the opportunity they provided me to study on my thesis. My gratitude also extends to my sponsor, Hawassa College of Health Sciences.

Next, my heartfelt gratitude goes to my advisors, Mr. Leul Deribe (Assistant Professor) and s/r Haweni Adugna (MSc), for their invaluable assistance, advice, and feedback in the writing of this thesis.

Also, I would like to express my warm regards to the respondents who gave me the opportunity to spend their time. Finally, I want to express my gratitude to my wonderful friends and colleagues for their assistance and technical support in this thesis writing.

ACRONYMS AND ABBREVIATIONS

ACOG	American College of Obstetricians and Gynecologists
ANC	Antenatal care
DV	Domestic violence
EFY	Ethiopian Fiscal Year
GP	General Practitioners
HC	Health center
HO	Health officer
IPV	Intimate partner violence
KM	Kilometer
MCH	Maternal and child health
OPD	Outpatient department
PC	Primary care
PHC	Primary health care
PI	Principal Investigator
PREMIS	Physician readiness to manage intimate partner violence survey tool
SNNPR	Southern Nations, Nationalities and People Region
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
USA	United States of America
VIF	Variance inflation factor
WHO	World health organization

TABLE OF CONTENT

LIST OF TABLES

LIST FIGURE

ABSTRACT

Introduction: Intimate partner violence is prevalent worldwide public health problem and major human and legal rights abuse of all women, which requires complex and multifaceted interventions. Health facilities are situated to provide management for IPV. Thus, Nurses and midwives are front lines responsible for consolidating essential health care services for IPV victims. There is no detail, however, on whether or not health providers are prepared to identify and manage IPV.

Objective: The aim of this study was to assess health provider's readiness in managing IPV in public health institutions at Hawassa city, Sidama, Ethiopia, 2021.

Method: A cross-sectional study was performed at an institution. An anonymous self-administered questionnaire was distributed across 424 respondents selected by simple random sampling. Categorical variables were reported by frequency with percentage. Mean and standard deviation were used to report perceived readiness score. The factors influencing providers' perceived readiness were assessed using linear regression analysis. The strength of association between independent and dependent variables was assessed by using unstandardized β with 95% CI. In all statistical tests used, statistical difference considered significant when P-value was less than 0.05.

Results: The mean score for provider's readiness in managing IPV was 26.18±6.69. Not having received IPV training (P = 0.013: 95% CI of β: -3.746, -0.449), providers with higher age (P = 0.017: 95% CI of β: 0.032, 0.321), perceived knowledge on IPV management (P <0.001: 95% CI of β: 0.203, 0.383), absence of protocol in the institution dealing with IPV management (P = 0.049: 95% CI of β: -2.706, -0.008) and attitude of providers toward IPV (P = 0.027: 95% CI of β: 0.013, 0.213) were factors that affect providers perceived readiness in managing IPV.

Conclusion: Providers had limited perceived readiness to manage IPV and certain factors were affected their perceived readiness.

Recommendations: Interventions on provision of training, develop protocols and improvement in perceived knowledge should be needed to increase provider's perceived readiness in managing IPV.

Keywords: Intimate partner violence, provider's perceived readiness. Provider's readiness.

1. INTRODUCTION

1.1. Background

Violence against women characterizes by deliberative and repetitive physical, sexual, psychological, or economic abuse. It is prevalent worldwide public health problem and major human and legal rights abuse of all women(1, 2). Even though, the universal declaration of human rights indorse recognition of all people regardless of age, sex, race, color, language, and religion women's still continued to suffer from violence (3). Violence can occur in different forms and settings with the workplace, school, and community. Yet, violence at home by an intimate partner is the most prevalent form (4).

Intimate partner violence (IPV) refers to any conduct that causes physical, sexual, or psychological harm in an intimate relationship, such as physical assault, sexual harassment, psychological abuse, and controlling behavior(5). Among all violent behavior in IPV psychological violence leaves long-lasting adverse effects and serious health problems to the victims(6, 7).

Globally one in every 3 or 35% of women has experienced physical and/or sexual or both intimate partner violence in their lifetime and the prevalence is high in developing countries (8). Women of the developed country less affected by IPV with a range of 5% and 40% for developed and developing country respectively(9).

The lifetime prevalence of IPV in Saharan Africa is 37% which puts the region as severely affected regions in the world (10, 11). majority of (15% to 71%) sexual and physically intimate partners abused victims develop gynecological, central nervous system, and stress-related problems (3).

In Ethiopia, IPV is common in both urban and rural areas and it is often tenable by family silence, cultural norms, fear, and shame (12). About 30.2% ever married woman in Ethiopia experience one types of IPV in their lifetime and the situation is similar during pregnancy about 33.5 % - 41.6% of pregnant woman experience IPV(3, 13).

Thus IPV requires complex, multifaceted, and culturally specific interventions provided by trained health-care providers (14). It can be managed in different health care settings at an emergency unit, ANC unit, or psychiatric unit (15). Despite early identification and intervention

of IPV reduce farther physical, sexual, and mental injuries, health systems were not sufficiently addressed and reluctant to pay comprehensive response to it (16).

Health care providers are uninformed about appropriate interventions and really received training to manage intimate partner violence (17). Specifically, providers in primary health care (PHC) are not prepared to detect and intervene in IPV, consequently, the abusers continue experience secondary victimization and suffering (18). Hence, in order to offer effective care and management for intimate partner victims in health facilities, it is necessary to assess the health provider's readiness for proper intervention and management. To this end, this study aims to assess health provider's readiness in managing intimate partner violence in public health institutions of Hawassa city.

1.2. Statement of problems

Intimate partner violence occurs without exclusion in all countries irrespective of cultural, economic, and religious background. Woman and children are predominately affected by IPV Moreover, globally about 40–70 % of female homicide committed by intimate spousal therefore especially women need a range of health services(19, 20).

Since IPV more affect woman's it may occur at any stages of woman life including during pregnancy which result miscarriage, premature labor or delivery, low birth weight and higher levels of depression to the mother, correspondingly substance abuse, delay in seeking prenatal care, insufficient weight gain during pregnancy and low levels of breastfeeding are Indirect health consciences (16, 21). As well as, unintended pregnancy and unsafe abortion are other major public health consequences of IPV that result in serious complications or death to the women (22, 23). Furthermore, children who are born from mothers who experiencing IPV are face a higher risk of poor growth and development which increases under-five mortality and an increased risk of experiences IPV against women later in their life (8).

Therefore, medical treatment and support are essential to reduce the serious adverse medical and social consequences of IPV (15). To prevent farther violent injuries health sectors have crucial role by providing effective care delivers which require appropriate health providers preparedness and training (24). Regularly IPV victims call on PHC which is exclusively situated to respond to violence and an entry to the health care system with the first point of contact for health providers who give care and facilitate access to father support (25).

Nurses and midwives are front lines responsible for providing essential health care services for IPV victims (6). Thus, they should have adequate readiness with knowledge, attitudes, and skills about medical care for injuries, referral systems, information about legal rights, and legal or social service resources in the community (26). However, majority of health care professionals are unclear about their role in the responses of IPV and detect it as difficult to recognize a victims experiences of disclosure (27).

Factually in the worldwide setting, the quality of care for women who were experienced violence were poor. Physicians and other medical staff are rarely provided with training (28). Moreover, few health care providers consider that addressing IPV is not a part of their role(29). A minority

of women are identified at health facilities settings due to inadequate essential skill of providers, even though the majority of them disclose themselves to health providers. This suggests that providers are not prepared to manage IPV (26). Lack of knowledge, skill, and resource in addition with lack of treating are difficulties that pay to low health care provider's readiness in managing IPV (30). However, in order to identify and treat women who have been exposed to IPV, providers must have adequate knowledge and skill (31).

A lack of provider readiness in managing IPV lead to ineffective responses to IPV disclosure or ineffective referrals for services which preventing victims of violence from receiving the care and assistance they need. (29). Consequently if the victims do not receive proper treatment and management, they will continue suffering from physical, psychological, sexual, and reproductive health problems (32). In order to provide full diagnosis and curative care for IPV patients, health care providers in low and middle-income countries typically need additional and repetitive treating. (33). Despite the fact that IPV victims need a multifaceted approach and that the health system is primarily intended to provide promoted and preventive care, the majority of victims to non-former organizations such as religious leaders, relatives, and friends. Furthermore, health-care facilities have a poor response rate to the problem (26).

In Ethiopia despite most women have at least one ANC visit during their pregnancy no one is screened for IPV since IPV screening is not include in ANC service despite the fact that it is a good opportunity to address IPV(34). As a result, very few individuals seek medical care for their injuries following an abusive event (28). The majority of studies about IPV conducted in Ethiopia focused on its prevalence, associated factors, and consequences, with only a few studies attempt to address the identification and treatment of IPV. Particularly in the study area there is no information about IPV management and much less is known about health providers' readiness to identify and manage IPV. Therefore, the aim of this study was to assess health provider's perceived readiness in managing IPV in selected public health institutions at Hawassa city. Because feeling prepared was found to be the prerequisite for ability to identify and manage IPV.

1.3. Significant of the study

Appropriate identification and provision of medical or psychological care for IPV victims in health facilities reduce further physical and psychological suffering of victims. Therefore the goal of this study was to assess health providers' readiness in managing IPV. This study provides information which can be utilized in health institutions included in the study to fill the gaps in IPV management and intervene on the barriers that delay providers from proper readiness to assist the quality of care provision for IPV victims.

The finding can also be utilized by the health department of Hawassa city administration, health institutions not included in this study and other government and non-government organizations concerned in this area to develop action plan and intervention based on the result.

Moreover, the findings of this study can be used at the national level to develop a policy which include IPV screening and management at ANC services. Lastly, the information of this study can be utilized by other researchers concerned to do further research on this area.

2. LITERATURE REVIEW

2.1. Introduction

Health care provider's readiness in managing IPV implies preparation of the providers to identify the case , provide first line support which is non-judgmental, deliver medical care including referral and follow up (35). Provider's knowledge and positive attitudes are crucial for proper management and preventing further victimization of IPV(36). Moreover Confidentiality, empathy and security are the principal considerations that used to intervene and response to IPV mainly to address psychological impacts of the problem (37). On the other hand health care providers must have near to entry level of competency to deal with sensitive issue that IPV encompass with capable to provide essential care that are supported with appropriate skills(38).

The study conduct in the Mid-Atlantic region of the United States implies knowledge, attitude, and skillfulness of providers are the indicators that used to measure health care provider readiness in the management of IPV. Knowledge includes both Actual and perceived knowledge(39). Correspondingly, Health care provides readiness is achieved through proper attitudes, having good knowledge, experience, and a supportive working environment (40). Knowledge and skill can be built up by in-service training, evidence-based guidance, and provider capacity building(15). According to the novel educational program, training improve provides IPV-related knowledge, attitudes, beliefs, and behaviors(41). Moreover, facilitating clinical skill treating for providers is the best way to identify and manage IPV rather than depending merely on theoretical knowledge of health care providers moreover treating enhances their confidence and competencies(33).

Furthermore, A study done in Spain to evaluate realist evaluation used to assess health-care response to IPV prove that self-efficacy, perceived readiness, woman-centered care, motivated professionals, and accrued experience are pillars that used to develop adequate health care and providers responses to IPV(42). A qualitative meta-analysis agree with personal commitment, encouragement, which measured by non-judgmental and active listening skill, strong team approach and supported by well-organized health system are requirements which determine health providers readiness to responded IPV (26).

2.2. Health provider's readiness to manage intimate partner violence

Since IPV has intense health impact health care professionals should be absolutely ready to manage health related IPV problems however, A Pilot Study done in United States Observe that majority of health care providers are not prepared to manage IPV(43). The other study in USA on diverse health care providers Suggest that all most all provider are not feeling well prepared to identify and respond to IPV as a result of they have low knowledge about IPV(29).

According to one study in china on health provider's attitude on IPV Suggest that majority of health care provider's belief that dealing with IPV is not part of their professional responsibilities rather providing medical treatment and they are reluctant to support the victims(44). Similarly a study conducted in Thailand agree only very few number of health care providers ready to give appropriate support including referral for IPV victims (45).

A qualitative study in Zimbabwe examine all midwifes lack skills or competence to identify victimized women during antenatal and postnatal care and they hadn't specific training therefore they aren't feel ready to identify and manage IPV(46). Correspondingly According to Tanzania study, majority of nurses and midwife lack knowledge , hadn't positive attitudes, due to this near to half of them had inadequate preparedness to provide capable IPV care and services for the victims those who need health service (6).

Similarly Nigerian study on Physician's Readiness on IPV management indicate physician had positive attitude towards IPV victims but they had insufficient knowledge on IPV management and only some of them access pre and post qualification training and had low in-service training on DV/IPV this put them on low prepared to manage IPV in their clinical setting (28).

Limited study conduct in Ethiopia ,Study done in east Gojjam show nurses are not prepared to give care for IPV victims due to majority of nurse participate in the study hadn't knowledge, had negative attitude to IPV victims and most of them lack skill to give appropriate care for woman who exposed to IPV (31).

2.3. Barriers related with health provider readiness in managing IPV

2.3.1. Health provides related barriers

Health care providers particularly those in primary health care (PHC) the only point of contact for the majority of IPV victims hence, they are expected to have a sound understanding and knowledge for appropriate identification of IPV. however, a number of barriers that avert individual health care providers from responding to IPV(47, 48). Lack of preparation, non-accountability, negative attitudes toward IPV victims are barriers that delay their readiness health providers in managing IPV [38]. Lack of attention and empathy with a personal history of violence push provides to negative attitude (49).

Socio demographic characteristics of providers affect their perceived readiness in responding to IPV. A study conducted in Netherlands show that age and clinical experience are factors for managing and identification of IPV (50). On the other hand a study conducted in Ethiopia evaluated male providers more ready to provide care for IPV victims(31). According to study done in US, Professional type was found to be predictor that determine health providers perceived readiness(29).

Study conduct in Italy display limited knowledge on the most common signs and symptoms of violence, lack of training, and cultural taboos inhibit the provider from the identification of violence (51). Similarly, a study conduct in Egypt describes being distressed to discuss violence, lack of skills to communicate with the victims and lack of awareness about negative health consequences of IPV are provider-related factors that prohibiting intervention on IPV(52). A descriptive study done in Kenya confirms that Personal limitations and inadequacy due to lack of skills, Interference by the victims, and Fear about the legal aspects of the problem are the factors that delay health providers from managing IPV(53).

The lowest attention to basic communication, lack of counseling skills, and absence of legal protection for providers facilitate higher preparedness gaps to IPV management(54). According to study done in Nigerian Perceived preparedness regarding to the management of IPV victims was significantly affected by the level of perceived knowledge about the issue (28).

Low Health care provider skills, cultural beliefs, Low level of clinical working experience on IPV management, and lack of training are factors that affect their perceived readiness to manage

IPV(31, 55). However, a study done in Greek prove that IPV training mainly improve health care provides perceived knowledge and preparedness in managing IPV(56) .

Limited provider's skill such as being judgmental, reluctant to listen to women concern who experiencing IPV have a negative impact on readiness in the management of IPV (57). Low level of self-efficacy, sense of responsibility, and lack of intrinsic feelings, confidentiality dilemmas, and fear of risking patient-provider relationships are factors that limit response to IPV (58). Lack of Culture harmony between provider and patient delay provides to response in IPV management (59).

2.3.2. Health care system related barriers

Health system are organizations, resources and institutions which mainly situated to improve health and it have important role in the management of IPV(54). The health system particularly primary health care services has critical role in responding and preventing IPV(55). organizational support is significant to improve care of women exposed to violence (40). Indeed the health system often are not sufficiently addressing the problem of violence and donating to complete multi- sectorial response for IPV(2).

Lack of protocol or guideline that help management process in health institutions and limited facilitated IPV truanting for providers. Lack of organizational policies, programs, an on-site victim advocate and formalized connection to community based services are factors that influence health provider's readiness in the managing of IPV (28, 58). Moreover Lack of referral network due to disorganized services and limited access to services for IPV pay major obstacle in identification and management of IPV (57). In fact Screening or attempting to manage IPV case without prepared protocol put the victims at greater risk(60). Besides guidelines has positive influence on health care provider's willingness and ability to proper management of IPV (40).

According to evaluation of implementation that done in health providers Suggest that positive support help to increase knowledge and self-efficacy Consequently, this helps health providers to proper managing IPV (57). A qualitative Study conducted in Ethiopia state that lack of separate recording and registration, lack of specific referral systems or follow-up care and gap in providing timely medico legal reports for IPV victims are health system related difficulties to intervene on IPV(58). Correspondingly other stud conducted in Ethiopia show that the health system is low developed and poorly equipped to address and response to IPV(34).

2.4. Conceptual framework

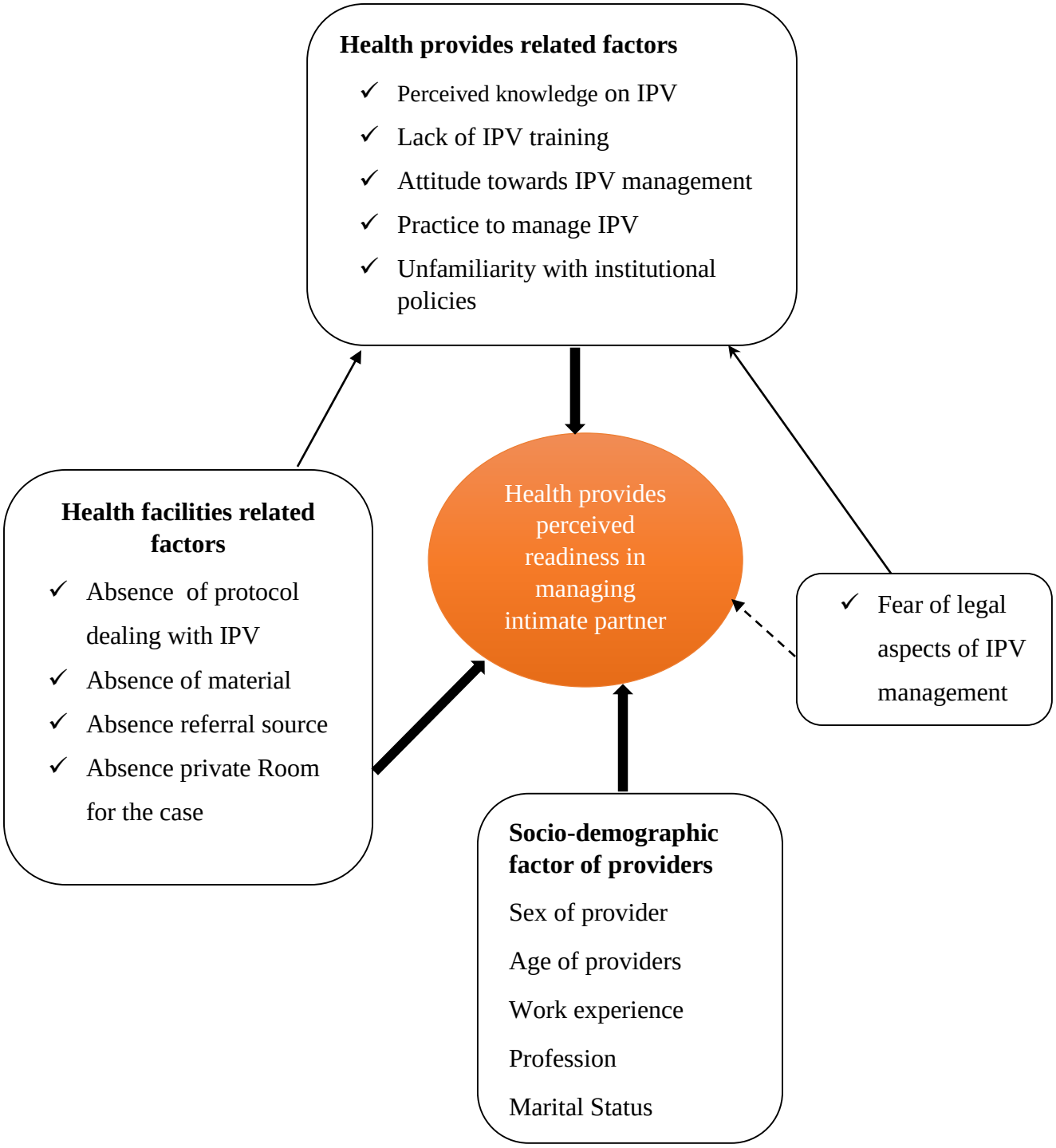

Figure 1 1: Conceptual framework developed by principal investigator adapted from different literatures (28, 34, 38, 50, 53, 55, 58) for health provider's readiness in managing intimate partner violence in public health institutions at Hawassa city, sidama region, Ethiopia.

3. OBJECTIVES

3.1. General objective

To assess health provider's readiness in managing intimate partner violence in selected public health institutions at Hawassa city, sidama region, Ethiopia, 2021.

3.2. Specific objectives

- ✓ To determine health provider's perceived readiness in managing intimate partner violence.
- ✓ To identify barriers that affect provider's perceived readiness in managing IPV.

4. METHODS

4.1. Study Area

The study was conducted in public health institutions at Hawassa city. Hawassa city is surrounded by shores of Lake Hawassa in the Great Rift Valley, and located 273 km far away from Addis Ababa the capital city of Ethiopia. The city serves as the capital of southern nations, nationalities and people region (SNNPR) and sidama region. Geographically it is located 130 kilometers east of Woliata Sodo, 75 kilometers north of Dilla, and 22 kilometers south of Shashemene. The city administration is divided into eight sub cities and 32 kebeles. According to Hawassa City Administration Health department 2013 EFY population profile, the total population of Hawassa city is 394,057. Regarding to the health infrastructure, there were 3 governmental hospitals and 10 health centers.

4.2. Study Period

This study was conducted from February 08 to March 08/2021

4.3. Study Design

Institutional based cross-sectional study was conducted

4.4. Description of the populations

4.4.1. Source population

The source population was all heath care providers that provided direct care for women in public health institutions at Hawassa city.

4.4.2. Study population

The study population was selected heath care providers that provided direct care for women at selected public health institutions of Hawassa city.

4.5. Eligibility criteria

4.5.1. Inclusive criteria

The inclusion criteria to the study were

- ✓ General practitioner, Nurses, midwives and health officers who were willing to participate in the study
- ✓ Those who were provided consent and available at the time of data collection.

4.5.2. Exclusion criteria

- ✓ Health care providers in study group who had less than six-month experience.

4.6. Sampling method

4.6.1. Sample size calculation

Sample size was calculated using single population mean formula, with the following Assumption

n= Maximum sample size

Z= Level of significance of 95%

σ^2 = Sample variance (standard deviation)

d= Margin of error, which was 5%

There was no similar study done to determine variance or standard deviation. It was determined by conducting pilot study on 10% of source population which was 60 of 596 total source population

$$n = \frac{(Z\,\alpha/2)^2 \,.\, \sigma^2}{d^2}$$

$$n = \frac{(1.96)^2.(0.5)^2}{(0.05)^2} \qquad = 385$$

With Adding 10 % for non-response rate the required sample size was 424.

4.6.2. Sampling Methods

The list of health facilities took from Hawassa city administration health department then, one hospital and five health centers were selected by simple random sampling, using lottery method to conduct the study. The selected facilities were Adare general hospital, Allamura, Chefekotijebessa, Adare, Millennium, and Tula health centers. The sample size was proportionally allocated for the selected health facilities. A total of 596 health providers (GP, HO, Midwives, and Nurses) were currently working in the above-listed hospital and health centers. Lastly, the study participants were selected from the available professionals by simple random sampling, using lottery method (figure 2).

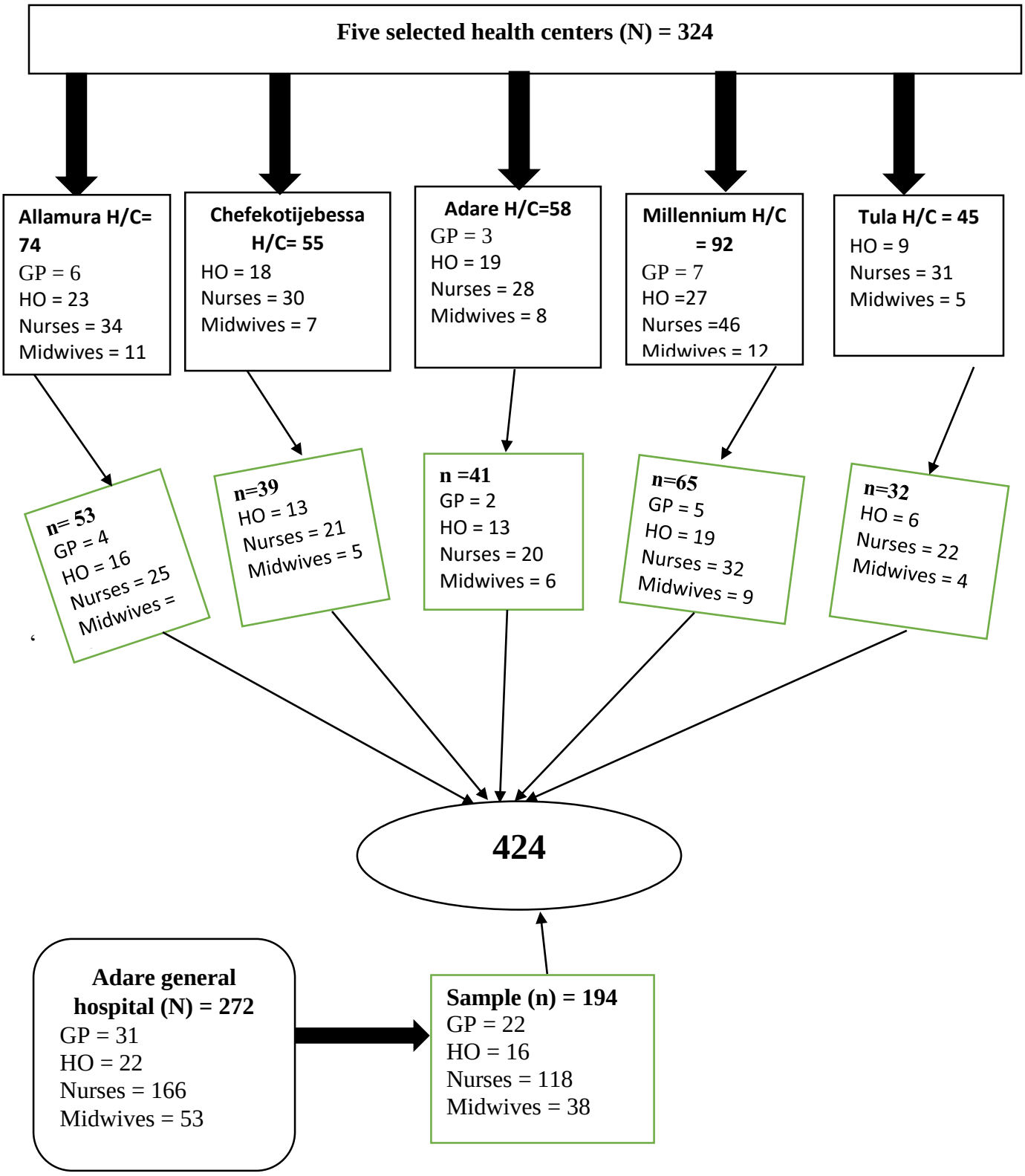

Figure 2: Schematic presentation of sampling procedure to assess health provides readiness in managing IPV in public health institution at Hawassa city, sidam region, Ethiopia, 2021.(n=424)

4.7. Study variable

4.7.1. Dependent variable

- ✓ Perceived provider's readiness in managing IPV

4.7.2. Independent variable

Health provider's related factors

- ✓ Perceived knowledge to IPV
- ✓ Attitude towards IPV
- ✓ Lack training on IPV
- ✓ Fear of legal aspects of IPV management
- ✓ Unfamiliarity with institutional policies

Health system related

- ✓ Lack of protocol or guideline
- ✓ Lack of referral network
- ✓ lack of private space

4.8. Operational definition

Intimate partner violence: - Physical &/or sexual &/or psychological violence that committed by boyfriends, cohabitant, and husbands.

Woman: - A victims of IPV who affected by physical or sexual or psychological violence**.**

Barriers: - Anything which had a negative influence on provider's readiness in managing IPV.

Perceived knowledge: - Feeling of providers about how knowledgeable provider sense about IPV. Measured with 4 point scale the higher scores indicated the more perceived knowledge of providers.

Perceived readiness: - Health care providers feeling regarding to their readiness to manage IPV. Perceived readiness of provider's were measured by mean score of nine items.

Attitude: - Belief and /or opinion of provider's toward IPV management, it was measured by 4 point Likert scale with the highest score indicate the more positive attitude.

Practice: - Skills of providers in managing IPV measured by 11 items focused on the current providing care practices and the clinic environment. The higher scores indicated the more environmental support for IPV management and greater perceived readiness of providers in managing IPV.

4.9. Data Collection

An anonymous self-administered questionnaire was distributed to participants who met the inclusion criteria. The questionnaire was adopted from Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS) tool(61).

The PREMIS tool had different section. The perceived readiness section contains nine items that determine how well respondents feel as they were prepared to manage IPV. It was assessed using a Likert scale of seven points ranging from "not prepared" to "very well prepare". All scores were summed and the mean score was calculated to determine provider's perceived readiness in managing IPV.

Perceived knowledge section determine how much respondents feel as they know about IPV. The response was based on a 7-point Likert scale with a total of 12 items ranging from "nothing know" to "very much know". All scores were summed to predict the outcome variable. For the descriptive presentation "very little" and "a little" responses of the Likert scale were recoded as " little " , "a moderate amount " and "a fair amount" responses were recoded as "moderate amount " and "quite a bit " and " very much " responses were recoded as "very much". At the end four responses were available know "nothing", "little", "moderate amount" and "very much".

Attitude was constructed from a total of 13 items, reflecting positive attitudes towards in managing IPV along a 4 point Likert scale. Scoring was graded from score "1" given to "strongly disagree" responses, to score "4" given to "strongly agree" responses, with higher score reflecting more positive attitude. For the descriptive presentation of frequencies, "Agree" and "Strongly agree" responses of the Likert scale were recoded as "Agree" while "Disagree" and "Strongly disagree" responses were recoded as "Disagree". All scores were summed to predict the outcome variable.

Practice section is made from a total of 11 items and the last two items contain 15 items inside it with a 5 point Likert scale ranging from "1" for "Never" to "5" for "Always". Which showed their practice in managing IPV. All scores were summed to predict the outcome variable.

The PREMIS tool showed evidence of high internal consistency and reliability with Cronbach's alpha > 0.65. Internal consistency of perceived knowledge, perceived preparedness, and attitude were reported to be Cronbach's α=0.963, α=0.959 &α > 0.65, respectively(61).

On the other hand, the tool had good construct validity (r=0.859) and reliability (α >0.70) for health students (62). Furthermore, this tool is valid to assess pharmacies readiness to IPV care with internal consistency of Cronbach's alpha=0.97, stability (Cronbach's alpha=0.73) and constrict validity r=0.889(63). Previously, the tool was used to assess health care providers such as (physicians, nurses, and midwives' preparedness to manage IPV in different countries including Ethiopia (6, 28, 31) .

4.10. Data Quality Control

The data was collected by six BSc nurses who were working in out of selected health institutions. The entire data collection process was closely monitored by the principal investigator and two supervisors (both BSc nurses). Two days of training on the data collection tool and each section of the questioner were provided to ensure that both data collectors and supervisors had the correct understanding in the data collection procedure. Then the data collectors practiced how to collect and complete the data collection format during training time. Data quality was assured through continuous supervision and designing proper data collection tool. All collected data examined for completeness and consistency during the data management, storage and analysis. Furthermore, the conducted pilot study was used to adjust the data collection tool.

4.11. Data Analysis

The collected data was coded and cleaned, then the coded data were entered into Epi-data version 4.6.2 to look for outliers, missing value, and inconsistency, then the data was exported into SPSS version 25.0 for analysis. Descriptive statistics like frequency, percentage, mean and standard deviation was used to summarize the socio demographic characteristics. Continues variables such us Perceived knowledge, attitude, and practical section were summarized by figure and table after adding items in each section.

All linear regression assumptions were confirmed. The scatter plot was used to verify the linearity between the dependent and independent variables, histogram /Q-Q plot was used to check the multivariate normality. The scatter plot was used to assess for homoscedasticity (constant variance), which showed that the residuals were similar around the regression line. The Variance Inflation Factor (VIF) was used to determine multicollinearity, and it showed that there

is no multicollinearity on the final model because the value for each variables were less than 5. Scatter plot was used to check for the presence or absence of outliers. The finding indicated that all assumption were fitted.

Simple linear regression was done to select candidate variables for multivariable linear regression. All variables having P-value ≤ 0.25 during the simple linear regression analysis and deemed important variable by the researcher were considered as candidates variables for the multivariable linear regression. After the multivariable linear regression analysis, variables having p-values <0.05 was considered as having a statistically significant association with dependent variable. The strength of association between independent and dependent variables was assessed by using unstandardized β with 95% CI.

4.12. Ethical consideration

Ethical clearance letter was obtained from Research Ethics Committee of Addis Ababa University, College of Health Science, department of Nursing and Midwifery. Official letters of cooperation gotten from Hawassa city administration health department. Permissions for data collection was obtained from each health facilities. Before the questionnaire was administered clear information on the nature and importance of the study was offered to the participants and oral consents was obtained. Participants were assured as voluntary participation in the study. Confidentiality, anonymity and freedom to withdraw from the study at any time was permitted.

4.13. Dissemination of results

The finding of this study was submitted to Addis Ababa University, College of Health Science, school of nursing and midwifery as fulfillment of master of degree in maternity and reproductive health nursing. Also this finding was disseminated to Hawassa city administration health departments in soft copy. Furthermore, after we get permission from city administration health departments we will attempted to publish in a journal for wider dissemination of information.

5. RESULTS

5.1. Socio-demographic characteristics of the study participant

A total of 424 health care providers took part in this study, with a 100% response rate. The majority of the respondents 238(56.1%) were females, more than half 221(52.1%) were protestant faith adherents, and 218 (51.4%) were married /living together. The respondent's average age was 31.12 years (with a standard deviation (SD) of 5.45) and 204 (48.1%) of them were between the ages of 20 and 29.

In terms of work-related demographics, nurses made up the bulk of the participants in this study, with 238 (56.1%), followed by health officers with 83(19.6%). In terms of educational attainment, 366 (86.3%) of respondents had a bachelor's degree, 200 (47.2%) had 6–10 years of clinical work experience, and 146 (34.4%) were currently working at maternal and child health unit (MCH). When asked if they had undergone any IPV training, only 64 (15.1%) of those polled said they had. (Table 1).

Table 1: socio-demographic characteristics of respondents in selected public health institutions at Hawassa city, Sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variables	**Category**	**Frequency**	**Percentage**
Sex of respondent	Male	186	43.9
	Female	238	56.1
Age (completed years)	20 – 29	204	48.1
	30 – 39	196	46.2
	≥ 40	24	5.7
Religion of the respondent	Protestant	221	52.1
	Orthodox	153	36.1
	Muslim	28	6.6
	Catholic	19	4.5
	Others	3	0.7
Marital Status	Single	196	46.2
	Married and living together	218	51.4
	Divorced/separated	10	2.4
Profession	General practitioners	33	7.8
	Health officers	83	19.6
	Midwives	70	16.5
	Nurses	238	56.1
Educational level	Master	36	8.5
	Bachelor	366	86.3
	Diploma	22	5.2
Work Experience	1 – 5 years	174	41.0
	6 – 10 years	200	47.2
	11 – 15 years	32	7.5
	>15	18	4.5
Current Practical area	OPD	143	33.7
	MCH	146	34.4
	Emergency	135	31.4

Table 1: Socio-demographic characteristics of respondents in public health institutions at Hawassa city, Sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424) Continued

Received IPV training	Yes	64	15.1
	No	360	84.9

5.2. Perceived knowledge of the respondents in managing IPV

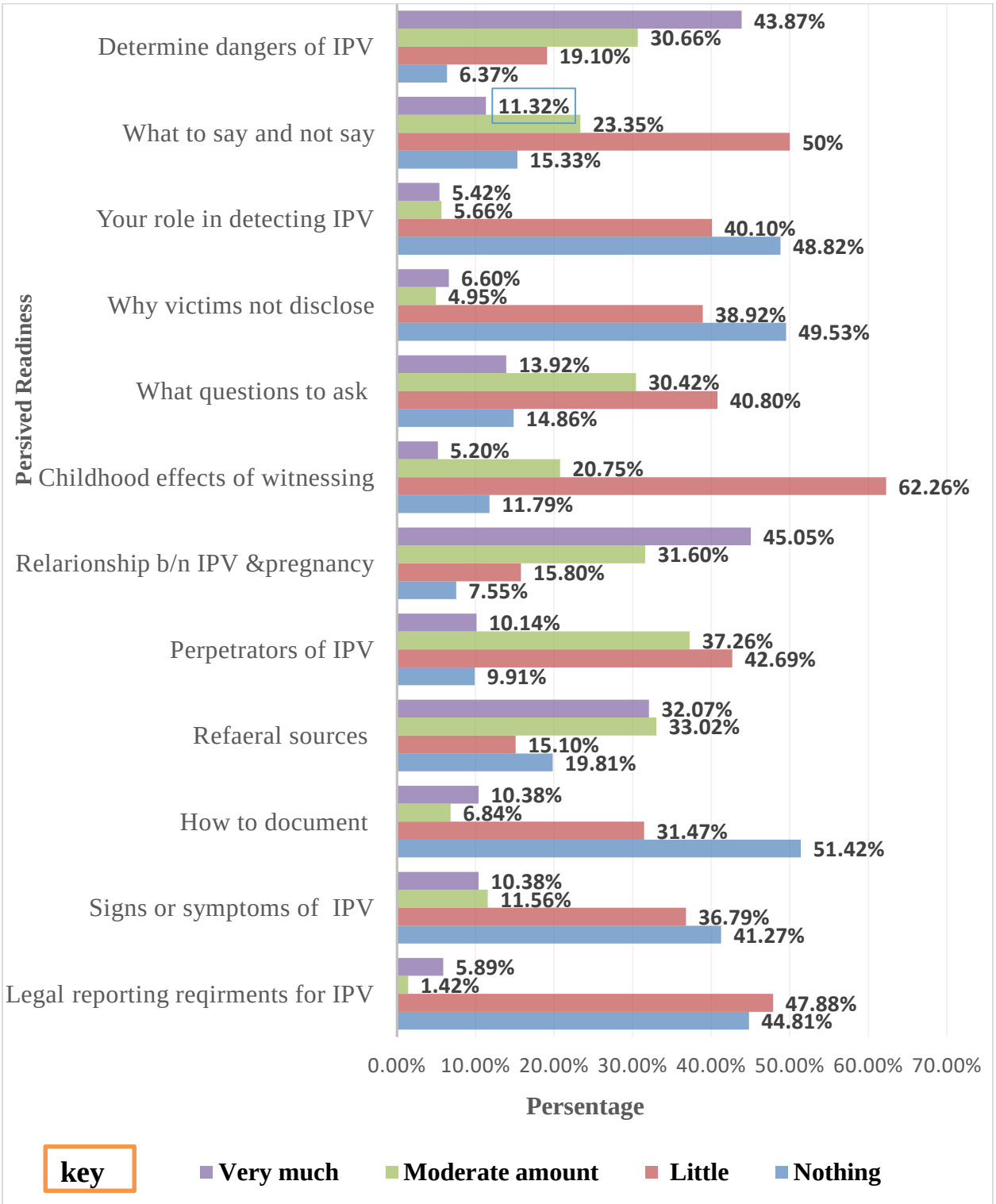

Figure 3: perceived knowledge of respondents for IPV management in health institution at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

The perceived knowledge part assesses how much respondents believe as they know about the listed IPV management activities. 12 items from a 7-point Likert scale were recoded as know "nothing," "little," "moderate amount," and "very much" on a 4-point Likert scale.

Of the 424 respondents, 203 (47.88 %) had little knowledge of the legal reporting requirements for IPV, while 175 (41.3%) had no knowledge of the signs and symptoms of IPV. And 136 (32.07 %) had a moderate amount knowledge of referral sources for IPV victims. In turn, 191 people (45.05 %) were very knowledgeable about the relationship between IPV and pregnancy. finally 207 (48.8%) of respondents had no idea about what their role was in detecting IPV (figure 3).

5.3. Attitudes of the respondents in managing IPV

The statements expressing positive attitudes toward managing IPV were used to measure the attitude. The responses were recoded as disagree and agree for descriptive purposes. A higher score indicates a more upbeat attitude.

Around 362 respondents (85.4%) agreed that it is their duty to ask about intimate partner abuse (IPV). 324 (76.4%) of the participants said they were not comfortable discussing the topic of IPV. The majority of respondents 311(73.3%) said they were unaware of the state's legal requirements for reporting IPV. Only 162 (38.2%) of respondents accepted that their workplace allows them to respond to IPV. The majority of 279 respondents (65.8%) denied that sufficient private space was available to provide care for IPV victims. Around 320 (75.5%) of respondents disagreed that women always have good reasons to remain in abusive relationships (table 2).

Table 2: Attitude of respondents towards managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variable	Disagree		Agree	
	Frequency	%	Frequency	%
Health providers have responsibility to ask about IPV	62	14.6	362	85.4
I feel comfortable to discuss about IPV	324	76.4	100	23.6
I am able to gather necessary information to identify IPV	310	73.1	114	26.9
I can match therapeutic information to an IPV patient	104	24.5	320	75.5
I can make appropriate referral to service	89	21.0	334	79.0
IPV victims have the right to make their own decision	100	23.6	324	76.4
I am aware of legal requirements for reporting of IPV	311	73.7	113	26.7
My work place encourages to respond to IPV	262	61.8	162	38.2
There is private space to provide care for IPV victims	279	65.8	145	34.2
Victims of IPV can leave the r/s if they want	90	21.2	334	78.8
victims often have valid reason for reaming in the violent r/s	320	75.5	104	24.5
If IPV patient refuse to discuss about violence providers should treat only injury	118	27.8	306	72.2
If IPV victims remain in the r/s after repeated episode, they mustn't accept responsibility for violence	289	68.2	135	31.8

5.4. Practice of respondents in managing IPV

The practice of the respondents was measured using 15 items, structured in a way that they always conduct the tasks.

In this report, 150 (35.4%) of respondents were almost always asked about IPV when they saw a patient with injury, and 127 (30.0%) were almost always asked about IPV when they saw a patient with depression. The majority of respondents 130 (30.7%) still correctly registered patient statements.

In terms of using a body map to record patient injuries, 145 respondents (34.2%) said they had never used a body map to record a patient's injury. Similarly, 185 (43.6%) never photographed the victim's injuries for inclusion in the document. Approximately 127 (30.0%) of respondents almost always provided victims with validating or supportive statements, and 147 (34.7 %) of respondents almost always provided referral and/or resource details for the victims (table 3).

Table 3: practice of respondents in managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variables	Never	Seldom	Some time	Nearly Always	Always
	No (%)	No (%)	No (%)	No (%)	No (%)
Asked about IPV when they see patient with injury	27(6.4)	17(4.0)	105(24.8)	150(35.4)	125(29.5)
patient with chronic pelvic pain	55(13.0)	35(8.3)	104(24.5)	135(31.8)	95(22.4)
patient with irritable bowel	101(23.8)	31(7.3)	78(18.4)	142(33.5)	72(17.0)
patient with headache	54(12.7)	17(4.0)	145(34.2)	100(23.6)	108(25.5)
patient with depression	41(9.7)	25(5.9)	120(28.3)	127(30.0)	111(26.2)
patient with eating disorder	120(28.3)	40(9.4)	126(29.7)	90(21.2)	48(11.3)
Documented patient statement	130(24.3)	36(8.5)	39(9.2)	116(27.4)	130(30.7)
used body map to document patient injuries	145(34.2)	36(8.5)	77(18.5)	99(23.3)	67(15.8)
Photographed victim's injuries to include in chart	185(43.6)	46(10.8)	49(11.6)	77(18.2)	67(15.8)
Notified appropriate authorities when mandated	102(24.1)	50(11.8)	64(15.1)	94(22.2)	114(26.90
Conducted a safety assessment for victim	97(22.9)	36(8.5)	89(21.0)	111(26.2)	91(21.5)
Helped an IPV victim to develop a safety plan	73(17.2)	41(9.7)	74(17.5)	146(34.4)	90(21.2)
Offered validating statements	67(15.8)	26(6.1)	107(25.2)	127(30.0)	97(22.9)
Provided basic information about IPV	68(16.0)	20(4.7)	101(23.8)	126(29.7)	107(25.7)
Provided referral and/or resource information	63(14.9)	27(6.4)	66(15.6)	147(34.7)	121(28.5)

5.5. Health provider's perceived readiness in managing IPV

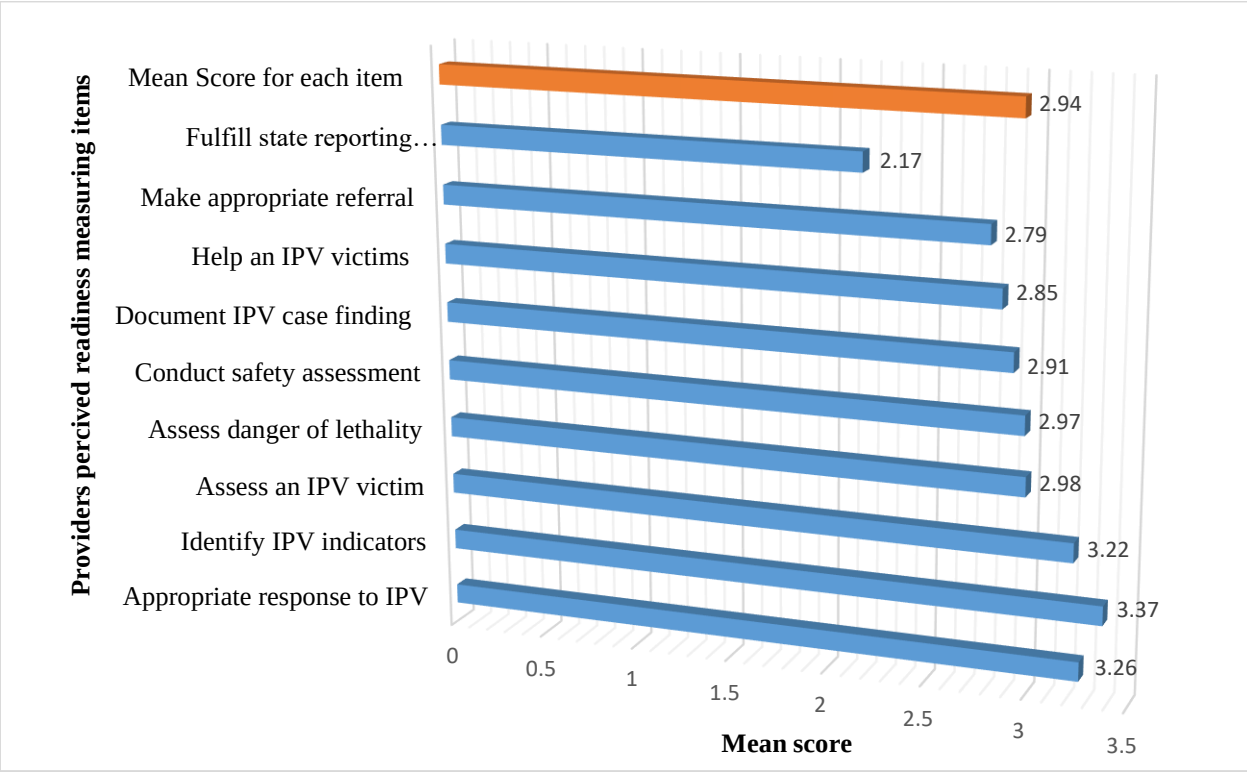

Figure 4: Perceived readiness of respondents in managing IPV in selected health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

On a 7-point Likert scale, provider's perceived readiness was measured using 9 items that reflected their readiness in managing IPV. Scores ranged from 1 to 7, with 1 denoting "not prepared" responses and 7 denoting "very well prepared" responses. The mean score was determined after adding all of the scores together. The range of potential scores is 9 to 63.

The mean score of perceived readiness in managing IPV was 26.18± 6.69 and 95%CI (0.393, 12.639) with a range of 11-47. Individual items mean score as showed below indicated, the mean score for appropriately respond to disclosures of IPV victims was 3.26. Correspondingly, Mean score for identify IPV indicators based on patient history and physical examination was 3.37. Whereas the mean score for document IPV history and physical examination findings in patient's chart was 2.91. The list mean score was measured for item fulfill state reporting requirements for IPV was 2.17. Furthermore the total mean score to each items was 2.94 (figure 4).

5.6. Barriers that affect respondents perceived readiness in managing IPV

Before proceeding with the regression analysis, the assumptions of linear regression were checked using different methods. Multivariate normality was checked by histogram/Q-Q plot, linearity by P-P/plot, homoscedasticity by sector plot, multicollinearity by VIF. Since the assumptions were met., linear regression analysis was done (figure 5).

5.6.1. Respondents socio-demographic related barriers for readiness in managing IPV

The bivariate analysis was done to show significance of each socio-demographic variable in affecting respondent perceived readiness in managing IPV. Any variable didn't show significant association with the outcome variable. However age, sex, clinical work experience, marital status and profession were candidate variables for the multiple regressions (table 4).

Table 4: Simple linear regression analysis for Sociodemographic barriers to provider's readiness in managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variable	**Categories**	**Unstandardized β**	**p-value**	**95%CI for β**
Sex	Male	0.132	0.841	(-1.158 , 1.422)
	Female	1		
Age		0.073	0.221	(-0.044 , 0.191)
Marital status	Single	1		
	Married /Cohabited	-0.066	0.920	(-1.364 , 1.232)
	Divorced	-1.245	0.567	(-5.520 , 3.030)
Profession	GP	-1.213	0.156	(-2.888 , 0.453)
	HO	0.800	0.379	(-0.987 , 2.589)
	Nurse	1		
	Midwives	-0.903	0.468	(-3.344 , 1.539)
Educational level	Masters	1		
	Bachelor	0.123	0.890	(-1.620 , 1.866)
	Diploma	1.636	0.319	(-1.589 , 4.862)
Clinical work experience	1 -5	1		
	6- 10	-0.249	0.721	(-1.617 , 1.120)
	11 – 15	0.389	0.764	(-2.151 , 2.928)
	>15	-0.688	0.679	(-3.956 , 2.581)
Current Practical area	OPD	1		
	MCH	0.606	0.443	(-0.945 , 2.157)
	Emergency	0.376	0.540	(-1.206 , 1.959)

5.6.2. Health providers related barriers for perceived readiness in managing IPV

In simple linear regression IPV training (p = 0.017), perceived knowledge of providers in managing IPV (P < 0.001) and attitude (P=0.002) showed statistical significance with provider's perceived readiness in managing IPV (table 5).

Table 5: Simple linear regression analysis for health providers related barriers to provider's readiness in managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424).

Variables	Categories	Unstandardized β	p-value	95%CI for β
Receiving IPV training	Yes	1		
	No	-2.165	0.017	(-3.940 , -.0.389)
Attitude		0.161	0.002	(0.057 , 0.264)
Practice		0.110	0.240	(0.167 , 0.253)
perceived knowledge		0.349	< 0.001	(0.259 , 0.439)
Report if legally mandate	Yes	0.911	0.316	(-0.534 , 2.356)
	No	1		
Familiarity with institutional	Yes	1		
policies for IPV management?	No	0.987	0.240	(-0.662 , 2.636)

5.6.3. Health facilities related barriers for perceived readiness in managing IPV

Likewise, bivariate analysis was conducted to assess significance association between health facilities related barriers and outcome variable. Availability of protocol for dealing with IPV at practical area (P=0.027) showed statistical significance with provider's perceived readiness in managing IPV. Familiarity with institution's policies regarding management of IPV victims (P= 0.240) didn't show association with the outcome variable However, it is candidate variables for the multiple regressions since P- value <0.25 (table 6).

Table 6: Simple linear regression analysis for institutions related barriers to perceived readiness in managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variable	**Categories**	**Unstandardized β**	**p-value**	**95%CI of β**
Availability of Protocol for dealing IPV?	Yes	1		
	No	-1.979	0.007	**(**-3.406 , -0.552)
Availability of Camera	Yes	1		
	No	1.437	0.430	(-2.141, 5.016)
Presence of Referral source	Yes	1		
	No	-0.559	0.417	**(**-1.911 , 0.794)
Have adequate Knowledge of referral	Yes	1		
	No	0.027	0.968	(-1.333 , 1.388)
Presence of Private space	Yes	1		
	No	-0.297	0.665	(-1.646 , 1.052)

5.8. Factors associated with provider's perceived readiness in managing IPV

Multiple linear regression analysis was done to determine the effect of independent variables on provider's perceived readiness in managing IPV. Those variables with P-value <0.25 and deemed important by the researcher were entered into the final regression model analysis.

Accordingly eleven variables entered into multiple linear regression. Sex, marital status, profession, clinical work experience, practice and familiarity with institution's policies regarding management of IPV victims were no longer sustained in multiple linear regression analysis. Age of respondent, IPV training, perceived knowledge, protocol, and attitude were found to be significant factors for perceived provider's readiness in managing IPV.

According to this particular study the age of provider's was found to be significantly associated with the outcome variable. By controlling the effect of other factors, the perceived readiness score of health providers in managing IPV increased by 0.176 for every ten years of age (P = 0.017: 95 % CI: 0.032, 0.321).

When all other variables in the model were kept constant, IPV training had a significant association with the dependent variable. The perceived readiness score of providers who did not receive IPV training fell by 2.098 (P = 0.013: 95 % CI: -3.746, -0.449).

This study results showed that availability of protocol for dealing with IPV management in the institutions was significantly associated with dependent variable. Absence of protocol for dealing with IPV management in the institutions decrease provider's perceived readiness score by 1.357 (P = 0.049: 95% CI of β: -2.706, -0.008). By controlling the effects of other variables in the model.

There was, however, a positive association between perceived knowledge and provider perceived readiness to manage IPV. Providers who feel as they know about IPV management had increased perceived readiness score by 0.293 (P 0.001: 95% CI: 0.203, 0.383) while all other variables in the model were kept constant. Similarly, provider attitude had a significant association with the outcome variable. By controlling the effect of other variables in the model, provider attitude decreases perceived readiness score by 0.113 (P = 0.027: 95 %CI: 0.013, 0.213) (table 7).

Table 7: Multiple linear regression analysis for factors in managing IPV in selected public health institutions at Hawassa city, sidama region, Ethiopia, from February 8 – March 8, 2021. (n= 424)

Variable	**Category**	**Unstandardized Coefficients ß**	**P-value**	**95%CI of β**
Sex	Male	1		
	Female	0.064	0.917	(-1.141 , 1.269)
Age		0.176	**0.017**	(0.032 , 0.321)
Marital status	Single	1		
	Married/cohabited	-0.526	0.428	(-1.829 , 0.777)
	Divorce	-0.665	0.669	(-4.953 , 3.182)
Profession	GP	-1.296	0.274	(-3.622 , 1.029)
	HO	-0.839	0.309	(-2.460 , 0.781)
	Midwives	0.407	0.634	(-1.274 , 2.088)
Clinical work	1 -5	1		
experience	6- 10	-0.695	0.356	(-2.174 , 0.784)
	11 – 15	0.005	0.997	(-2.536 , 2.547)
	>15	-1.982	0.325	(-5. 935 , 1.972)
Received IPV training	Yes	1		
	No	-2.098	**0.013**	(-3.746 , -0.449)
Availability of	Yes	1		
protocol for dealing IPV	No	-1.357	**0.049**	(-2.706 , -0.008)
Familiarity with	Yes	0.711	0.362	(-0.820 , 2.242)
institutional policies	No	1		
Perceived knowledge		0.293	< **0.001**	(0.203 , 0.383)
Attitude		0.113	**0.027**	(0.013 , 0.213)
Practice		0.084	0.061	(0.049 , 0.226)

6. DISCUSSION

This study attempts to assess health provider's perceived readiness in managing IPV in public health institutions at Hawassa city, Sidama region, Ethiopia. Perceived readiness in managing IPV represented provider's believed as how much prepared to identify the case, provide first line support, delivered medical care including referral and follow up. Indeed, readiness can be thought of as a motivator to made positive changes. (29). Therefore, assessing provider's readiness in managing IPV could be an effective first step in ensuring an adequate response to IPV at the health facility level by assisting victims of violence in obtaining the care and assistance they needed.

The current study looked at the mean perceived readiness score for managing IPV, which was based on nine items. The total mean and standard deviation of perceived readiness to manage IPV were 26.18 $\pm$ 6.69, respectively. In fact, single items measures had lower mean scores on average, which may contributed to a low overall mean perceived readiness score. The item Identify IPV indictors based on patient history and physical examination had a higher mean score than the other items. Fulfill state reporting requirements for IPV, on the other hand, received a lower mean score. This highlights the fact that, while providers can provide medical treatment for victims' injuries, they were still unprepared to respond to IPV. The mean score to each items was 2.94 which was low as compared to previous studies in Saudi Arabia and the United States, which scored 3.10 and 4.98 respectively (15, 29). This might be due to a disparity in health-care attention gave to violence. Promoting an IPV screening program was basic evidence for this, and it provided an opportunity to boost health-care provider's perceptions of their ability to manage IPV in addition to early identification and managements of victims of IPV.

According to the current findings, there was a statistically significant association between provider's perceived readiness in managing IPV and their age (P= 0.017), with the mean perceived readiness score in managing IPV increasing as provider's ages increased. This might be linked to a change in attitude and work experiences. These associations could be explained by when a provider's maturity and years of experience grow, they gain a better understanding of IPV and more positive attitudes toward it. Also, as their work experience grows, opportunities for IPV-related training could arise, which allowed them to better ready for managing IPV. This finding was in line with the findings of a Nigerian report ($p < 0.001$) (64). Likewise, Tanzanian

study founded that providers with longer work experience were more likely to had opportunity for IPV in-service training (6). This might be because early on, providers lacked some basic knowledge about IPV management, and as they get older, this knowledge gap can close with experience and training.

This study findings highlighted that the majority of health professionals had not received IPV related in-service training, with just 15.1% receiving it. However, WHO emphasizes the importance of health-care professionals being trained on how to respond and recognized psychological and physical health indicators associated with violence, as well as how to ask about violence when victims are present (35). Correspondingly, studies had shown that training was important for enhancing a provider's readiness to deal with and manage IPV (26). The focuses of training were knowing when and how to ask about violence, having conversations about violence with victims who reveal it, providing first-line psychological help, encouraging IPV victims to engage in safety-promoting activities, and identification and reporting of the violence with improved documentation as well as referring victims (65). This content was definitely linked to items that used to measure perceived readiness of provider's in managing IPV, which has a positive impact on proper identification and response to IPV. A study conducted in Greek confirmed that training has a substantial effect on provider's perceived preparedness in managing IPV (56).

Moreover, the results of this study revealed the association between training and perceived readiness in managing IPV ($P = 0.013$). Not receiving in service IPV training reduced provider's perceived readiness score in managing IPV. The findings highlight that in-service IPV training was the predominant means of preparing health care providers to assist victims of IPV. This finding aligns well with previous studies that has linked training to improved IPV identification in a health setting. Training was associated with greater perceived preparation score and more active identification of IPV ($p <0 .001$)(29). Likewise, providers who lack IPV training had the low level of preparedness for managing IPV (30).

Furthermore the findings suggested training needs that appear relevant to all providers and providing training for healthcare providers in how they should respond to IPV should be a central component of interventions that help them to feel well and ready to manage IPV. This is concurrent with a study conducted in Australia, training made students feel more knowledgeable

and prepared to IPV management (p=0.05) (64). Tanzanian study agreed with lack of IPV training experience affected perceived preparedness for IPV care provision (P=0.001) (6). A study done in Ethiopia, stated that nurses who had training were more ready to give proper care for IPV victims (P = 0.014) (31). This might be due to provider's received little or no class room training on how to identify, manage, and refer patients who were being abused by an intimate partner.

This study result revealed, majority of health provider's reported that their institution did not have an IPV management protocol. The protocol, however, guides providers in how to identify victim subject to IPV, what type of question ask to identify IPV, what to do if victims do not disclose, providing physical care, how to create safety plan, how to provide psychological support and how to record IPV-related issues(66). This protocol help providers to build confidence and improve their perceived readiness in managing IPV. Furthermore, this study findings showed that protocol in place to guild provider's on IPV management had statistically significance with providers readiness in managing IPV (P value =0.049). Which implies absence of protocol which dealing about IPV management in facilities condensed perceived providers readiness in managing IPV, without protocols the standard operating procedure for a victim was not effective. This finding concurrent with a study conducted in US (P = 0.001) and Systematic Review(29, 49). This might be due to Standardized protocols were important to guide service delivery and support the delivery of safe, good quality, respectful and effective health care that was consistent across locations. The existence of a protocol that guild the management procedure might also be critical for provider's readiness in managing IPV.

The findings indicated provider's perceived knowledge was associated with their perceived readiness (P<0.001). Which suggested that perceived readiness of the providers regarding the management of IPV victims was significantly predicted by the level of their perceived knowledge of the issue. The majority of respondents in this study scored low on items that assessed their perceived knowledge on identification and management of IPV. Particularly, respondents reported that they had little knowledge about what question to ask to identify IPV. Furthermore, they reported that they were unaware of their role in detecting IPV. This infers that provider's feeling about IPV knowelge predominantly affected their percived readiness of IPV managing. This finding was agreed with study done in Sweden, having obtained knowledge by

themselves increase provider's perceived readiness score in managing IPV ($p < 0.001$) (40). Correspondingly, Nigerian study supported the finding, perceived preparedness for IPV management significantly affected by the level of perceived knowledge ($P<0.001$)(28). This might be due to perceived knowledge is the initial and prerequisite requirements for perceived readiness in managing IPV.

Likewise, respondent's attitude were significantly associated with their perceived readiness in managing IPV (P 0.027). This study highlighted providers were not feel comfortable to discuss about IPV. This might be due to either lack of knowledge about IPV or fear of legal aspects of the issue. These suggested that the reason why providers are not dealing about IPV, as they had low confidence and encouragement, the way they perceive readiness in managing IPV could be affected. This finding was in line with previous studies (9, 15). This might be due to awareness of one's own attitudes plays an important role in one's perceptions. Also personal discomfort with the issue may be influenced provider's perception on managing IPV which may overcome by providing training.

7. STRENGTH AND LIMITATION OF THE STUDY

7.1. Strength of the study

- The findings of this study opens the way for farther analytical studies to identify determinants of provider's perceived readiness in managing IPV.
- The study incorporate different professionals, general practitioners, health officers, nurse, and midwives which can help to make appropriate inference.

7.2. Limitations of the study

- Hard to establish a cause and effect relationship since it is a cross sectional study design

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

Intimate partner violence (IPV) is a public health problem that disproportionately affects women's health and well-being, and the effects of IPV have been well reported throughout the literature. The findings of this study revealed that providers had limited perceived readiness to manage IPV. Which was problematic, because feeling prepared was found to be associated with the ability to identify women exposed to IPV.

Provider’s age, not taking IPV training, absence of protocol in facilities dealing with IPV management, Perceived knowledge and attitude of health provider towards IPV management were a significant predictors variables which had a substantial impact on a health care provider's perceived readiness in managing IPV.

8.2. Recommendations

Based on the findings of this study the following recommendations are forwarded for concerned bodies.

For Ministry of health

- Health planer and policy makers needs to develop and implemented formal, written protocol detailing the specific procedures for identifying and managing IPV cases.

For health facilities

- These findings identify the focus of health provider's training to address their readiness in managing IPV so, health facilities should facilitate and open training access to their providers.

For health professionals

- They need to be motivated and interested for successful implementation of IPV protocol accordingly in diligent manner in order to help the victims.
- They also need to be familiar to institution's policies regarding management of IPV victims.

For researchers

- National studies are recommended to examine provider's readiness in managing IPV.
- Further exploratory studies need to account to explore barriers that avert provider readiness, since this study was unable to cover those specific factors for different reasons.

For non-governmental organizations

- Non-Governmental organizations those working on maternal and child health are supposed to participate in providing IPV related training for provider's in collaboration with the Ministry of Health.

9. REFERENCES

1. Krahé B. Violence against women. Current opinion in psychology. 2018;19:6-10.

2. Semahegn A, Mengistie B. Domestic violence against women and associated factors iEthiopia; systematic review. Reproductive health. 2015;12(1):78.

3. Chernet AG, Cherie KT. Prevalence of intimate partner violence against women and associated factors in Ethiopia. BMC women's health. 2020;20(1):22.

4. Berhanie E GD, Berihu H, Gerezgiher A, Kidane G. Intimate partner violence during pregnancy and adverse birth outcomes: a case-control study. Reproductive health. 2019;16(1):22.

5. Onigbogi MO, Odeyemi KA, Onigbogi OO. Prevalence and Factors Associated with Intimate Partner Violence among Married Women in an Urban Community in Lagos State, Nigeria. African journal of reproductive health. 2015;19(1):91-100.

6. Ambikile JS, Leshabari S, Ohnishi M. Knowledge, attitude, and preparedness toward IPV care provision among nurses and midwives in Tanzania. Human resources for health. 2020;18(1):1-7.

7. Simona S, Muchindu M, Ntalasha H. Intimate Partner Violence (IPV) in Zambia: Socio-demographic Determinants and Association with Use of Maternal Health Care. Int'l J Soc Sci Stud. 2018;6:42.

8. Coll CV, Ewerling F, García-Moreno C, Hellwig F, Barros AJ. Intimate partner violence in 46 low-income and middle-income countries: an appraisal of the most vulnerable groups of women using national health surveys. BMJ global health. 2020;5(1).

9. Jones KM, Taouk LH, Castleberry NM, Carter MM, Schulkin J. IPV screening and readiness to respond to IPV in ob-gyn settings: a patient-physician study. Advances in public health. 2018.

10. Ogum Alangea D A-LA, Sikweyiya Y, Chirwa ED, Coker-Appiah D, Jewkes R, et al. Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: Baseline findings from a cluster randomised controlled trial. PloS one. 2018;13(7):e0200874.

11. Peirone AE. Intimate Partner Violence in sub-Saharan Africa: Characteristics, Patterns, and Multi-Level Influences. 2019.

12. Kasaye HK, Bobo FT, Yilma MT, Woldie M. Poor nutrition for under-five children from poor households in Ethiopia: Evidence from 2016 Demographic and Health Survey. Plos one. 2019;14(12):e0225996.

13. Adhena G, Oljira L, Dessie Y, Hidru HD. Magnitude of Intimate Partner Violence and Associated Factors among Pregnant Women in Ethiopia. Advances in Public Health. 2020.
14. Recommendations W. On antenatal Care for a Positive Pregnancy Experience. Geneva: World Health Organization. 2016.
15. Alhalal E. Nurses' knowledge, attitudes and preparedness to manage women with intimate partner violence. International nursing review. 2020.
16. Alebel A, Kibret GD, Wagnew F, Tesema C, Ferede A, Petrucka P, et al. Intimate partner violence and associated factors among pregnant women in Ethiopia: a systematic review and meta-analysis. Reproductive health. 2018;15(1):1-12.
17. Yang M, Yang F, Su Y, Yen C. Nurses' Preparedness to Care for Women Exposed to Intimate Partner Violence in Rural Communities in Taiwan. European Psychiatry. 2015;30(S1):1-.
18. McLennan JD, MacMillan HL. Routine primary care screening for intimate partner violence and other adverse psychosocial exposures: what's the evidence? BMC family practice. 2016;17(1):1-4.
19. Shepard LB. Addressing violence against women and girls in sexual and reproductive health services: A review of knowledge assets. UNFPA, nd Web; 2016.
20. Mohammed BH, Johnston JM, Harwell JI, Yi H, Tsang KW-k, Haidar JA. Intimate partner violence and utilization of maternal health care services in Addis Ababa, Ethiopia. BMC health services research. 2017;17(1):1-10.
21. Berhanie E, Gebregziabher D, Berihu H, Gerezgiher A, Kidane G. Intimate partner violence during pregnancy and adverse birth outcomes: a case-control study. Reproductive health. 2019;16(1):22.
22. Afiaz A, Biswas RK, Shamma R, Ananna N. Intimate partner violence (IPV) with miscarriages, stillbirths and abortions: Identifying vulnerable households for women in Bangladesh. PloS one. 2020;15(7):e0236670.
23. Semahegn A, Torpey K, Manu A, Assefa N, Tesfaye G, Ankomah A. Are interventions focused on gender-norms effective in preventing domestic violence against women in low and lower-middle income countries? A systematic review and meta-analysis. Reproductive health. 2019;16(1):93.

24. Grossman DC, Choucair B. Violence and the US health care sector: burden and response. Health Affairs. 2019;38(10):1638-45.
25. Goicolea I, Mosquera P, Briones-Vozmediano E, Otero-García L, García-Quinto M, Vives-Cases C. Primary health care attributes and responses to intimate partner violence in Spain. Gaceta sanitaria. 2017;31:187-93.
26. Hegarty K, McKibbin G, Hameed M, Koziol-McLain J, Feder G, Tarzia L, et al. Health practitioners' readiness to address domestic violence and abuse: A qualitative meta-synthesis. PLoS one. 2020;15(6):e0234067.
27. Eustace J, Baird K, Saito AS, Creedy DK. Midwives' experiences of routine enquiry for intimate partner violence in pregnancy. Women and birth. 2016;29(6):503-10.
28. Olaleye Atinuke O, Jagun Omodele O, Ajose Adeola A, Sokeye Elizabeth O. Management of Intimate Partner Violence: Physician's Readiness in Southwestern Nigeria (Management of Intimate Partner Violence). J Women's Health Care. 2015;4(269):2167-0420.1000.
29. Renner LM, Wang Q, Logeais ME, Clark CJ. Health Care Providers' Readiness to Identify and Respond to Intimate Partner Violence. Journal of interpersonal violence. 2019:0886260519867705.
30. Alvarez C, Debnam K, Clough A, Alexander K, Glass NE. Responding to intimate partner violence: Healthcare providers' current practices and views on integrating a safety decision aid into primary care settings. Research in nursing & health. 2018;41(2):145-55.
31. Alem G, Zeleke H, Mengistu D. Assessment of Nurses' Preparedness and Identify Barriers to Care Women Exposed to Intimate Partner Violence in East Gojjam Zone, Ethiopia, 2014. J Nurs Care. 2015;4(250):2167-1168.1000250.
32. Scott E. A brief guide to intimate partner violence and abuse. July 2015. 2015.
33. Nyame S, Howard LM, Feder G, Trevillion K. A survey of mental health professionals' knowledge, attitudes and preparedness to respond to domestic violence. Journal of Mental Health. 2013;22(6):536-43.
34. Gashaw BT, Schei B, Solbraekke KN, Magnus JH. Ethiopian Health Care Workers' Insights into and Responses to Intimate Partner Violence in Pregnancy—A Qualitative Study. International journal of environmental research and public health. 2020;17(10):3745.
35. García-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-McLain J, Colombini M, Feder G. The health-systems response to violence against women. The Lancet. 2015;385(9977):1567-79.

36. Alhalal E. The effects of an intimate partner violence educational intervention on nurses: A quasi-experimental study. Nurse education in practice. 2020;47:102854.
37. Stewart DE, Vigod S, Riazantseva E. New developments in intimate partner violence and management of its mental health sequelae. Current psychiatry reports. 2016;18(1):4.
38. Walton PhD D, Maria L, Aerts DPT F, Burkhart DPT H, Terry DPT T. Intimate Partner Violence Screening and Implications for Health Care Providers. Online Journal of Health Ethics. 2015;11(1):5.
39. Fedina L, Lee J, de Tablan D. MSW Graduates' Readiness to Respond to Intimate Partner Violence. Journal of Social Work Education. 2018;54(1):33-48.
40. Sundborg EM, Saleh-Stattin N, Wändell P, Törnkvist L. Nurses' preparedness to care for women exposed to Intimate Partner Violence: a quantitative study in primary health care. BMC nursing. 2012;11(1):1.
41. Investigators E. Novel educational program improves readiness to manage intimate partner violence within the fracture clinic: A pretest–posttest study. CMAJ open. 2018;6(4):E628.
42. Goicolea I, Hurtig A-K, San Sebastian M, Marchal B, Vives-Cases C. Using realist evaluation to assess primary healthcare teams' responses to intimate partner violence in Spain. Gaceta sanitaria. 2015;29(6):431-6.
43. Clark CJ, Renner LM, Logeais ME. Intimate partner violence screening and referral practices in an outpatient care setting. Journal of interpersonal violence. 2020;35(23-24):5877-88.
44. Rajan H, Kiss L, Devries K, Zimmerman C. Health worker attitudes to intimate partner violence on the Tibetan Plateau: A qualitative assessment of cultural and material factors behind non-interventionist attitudes. Global Journal of Health Education & Promotion. 2016;17(2):17-41.
45. Thongkaew P. Health Care Professionals' Roles and Experiences of Identifying and Responding to Intimate Partner Violence among Pregnant Women in Thailand: University of Sheffield; 2020.
46. Shamu S, Abrahams N, Temmerman M, Zarowsky C. Opportunities and obstacles to screening pregnant women for intimate partner violence during antenatal care in Zimbabwe. Culture, health & sexuality. 2013;15(5):511-24.

47. Ayodapo AO, Sekoni OO, Asuzu MC. Pattern of intimate partner violence disclosure among pregnant women attending ante-natal clinic in Oyo East Local Government, Nigeria. South African Family Practice. 2017;59(2):67-71.
48. Dichter ME, Wagner C, Goldberg EB, Iverson KM. Intimate partner violence detection and care in the Veterans Health Administration: patient and provider perspectives. Women's health issues. 2015;25(5):555-60.
49. Alvarez C, Fedock G, Grace KT, Campbell J. Provider screening and counseling for intimate partner violence: a systematic review of practices and influencing factors. Trauma, Violence, & Abuse. 2017;18(5):479-95.
50. Ruijne RE, Kamperman AM, Trevillion K, Garofalo C, Jongejan FE, Bogaerts S, et al. Mental health professionals' knowledge, skills and attitudes on domestic violence and abuse in the Netherlands: cross-sectional study. BJPsych open. 2019;5(2).
51. Procentese F, Di Napoli I, Tuccillo F, Chiurazzi A, Arcidiacono C. Healthcare professionals' perceptions and concerns towards domestic violence during pregnancy in Southern Italy. International journal of environmental research and public health. 2019;16(17):3087.
52. Aziz MM, El-Gazzar AF. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. Sexual & reproductive healthcare : official journal of the Swedish Association of Midwives. 2019;20:93-9.
53. Githui SN. Assessment of barriers associated with screening pregnant women for intimate partner violence from nurses perspective at Pumwani Maternity Hospital, Nairobi: University of Nairobi; 2015.
54. Briones-Vozmediano E, Maquibar A, Vives-Cases C, Öhman A, Hurtig A-K, Goicolea I. Health-sector responses to intimate partner violence: fitting the response into the biomedical health system or adapting the system to meet the response? Journal of interpersonal violence. 2018;33(10):1653-78.
55. Goicolea I, Marchal B, Hurtig A-K, Vives-Cases C, Briones-Vozmediano E, San Sebastián M. Why do certain primary health care teams respond better to intimate partner violence than others?. A multiple case study. Gaceta sanitaria. 2019;33:169-76.
56. Papadakaki M, Petridou E, Kogevinas M, Lionis C. Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. BMC medical education. 2013;13(1):46.

57. Ambuel B, Hamberger LK, Guse CE, Melzer-Lange M, Phelan MB, Kistner A. Healthcare can change from within: sustained improvement in the healthcare response to intimate partner violence. Journal of Family Violence. 2013;28(8):833-47.
58. Meskele M, Khuzwayo N, Taylor M. Healthcare worker experience and the challenges in screening for intimate partner violence among women who use antiretroviral therapy and other health services in Wolaita Zone, ethiopia: a phenomenological study. Journal of Multidisciplinary Healthcare. 2020;13:1047.
59. Colombini M, Alkaiyat A, Shaheen A, Garcia Moreno C, Feder G, Bacchus L. Exploring health system readiness for adopting interventions to address intimate partner violence: a case study from the occupied Palestinian Territory. Health policy and planning. 2020;35(3):245-56.
60. Daire AP, Carlson RG, Barden SM, Jacobson L. An intimate partner violence (IPV) protocol readiness model. The Family Journal. 2014;22(2):170-8.
61. Short LM, Alpert E, Harris Jr JM, Surprenant ZJ. A tool for measuring physician readiness to manage intimate partner violence. American journal of preventive medicine. 2006;30(2):173-80. e19.
62. Connor PD, Nouer SS, Mackey STN, Tipton NG, Lloyd AK. Psychometric properties of an intimate partner violence tool for health care students. Journal of interpersonal violence. 2011;26(5):1012-35.
63. Barnard M, West-Strum D, Yang Y, Holmes E. Evaluation of a tool to measure pharmacists' readiness to manage intimate partner violence. Pharmacy. 2018;6(3):66.
64. John I, Lawoko S, Svanström L, Mohammed A. Health care providers' readiness to screen for intimate partner violence in Northern Nigeria. Violence and victims. 2010;25(5):689-704.
65. Kalra N, Di Tanna GL, García-Moreno C. Training healthcare providers to respond to intimate partner violence against women. The Cochrane database of systematic reviews. 2017;2017(2).
66. Organization WH. Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. 2020.

10. APPENDIX

Appendix-I Information sheet

Research project: Health provider's readiness in managing IPV in public health institutions at Hawassa city, sidama region, Ethiopia, 2021.

Principal investigator: Lidiya Teshome (BSc)

Introduction: My name is Lidiya Teshome. I am postgraduate student on maternity and reproductive health nursing at Addis Ababa University, collage of health science and school of nursing and midwifery. Currently I am conducting a research on health provider's readiness and barriers in managing IPV in selected public health institutions at Hawassa city. Data collection in this study involve self-administer questionnaire.

Purpose of the study: This study mainly try to assess health provider's readiness in managing IPV and identify major barriers that delay provides from managing IPV. This enable to effective health care for IPV victim in health institutions.

Study procedure: You are kindly invited to take part in our research because we believe you can provide the necessary information for the research. In this study there is an anonymous questioners which completes within 20 – 30 minute. If you are willing to participate in this study, you need to understand and sign the consent form before give any information. All the responses will be kept anonymous and confidential and not access by anyone except research team.

Risk and/or Discomfort: This study will not possess any risk in the participants however it may take a bit of time this might be make uncomfortable.

Benefits: At the moment this study is no beneficial for the participant but I hope in the future it will defiantly have benefits because it identify the barriers which delay provides in managing IPV that help to implement on those barriers to achieve effective health care response for IPV.

Incentives: Since the study invite voluntary participation there is no payment for study participant.

Confidentiality and Anonymity: The information that collected for this study will be kept confidential. No other use will be made without study participant written permission.

Right to Refuse or withdraw

Participation in this study is volunteer so, you have the full right to refuse from participating in this study or you can choose not to respond some or all of the questions if you do not wish to participate, This condition not affect you at all. You have also the full right to withdraw from this study at any time you wish to.

Persons to contact for further information: If you have any question you can contact the principal investigator in the following address:

Lidiya Teshome

Mobile: +251 926 37 74 41.

E-mail: teshlidu20@gmail.com.

Thank you in advance for your cooperation.

Appendix II: Consent form

I_____ (Code name of participant) give written consent to participate in this research titled health provider's readiness in managing IPV in public health institutions at Hawassa city, sidama region, Ethiopia, 2021. I have read and understand the information letter and had a chance to ask questions. I am fully aware of my rights as a participant and voluntarly gave consent to participate in ths study.

If you agree to take part in this study, I appreciate your honesty, and after having this consent form read to you, please put a sign below to show your willingness to participate (No need of writing your name).

Signature _____ Date _____

Appendix: III questionnaire

Appendix table 1: Scio demographic characteristics of health providers in public health institutions at Hawassa city, Sidama region, Ethiopia.

S.no	Questions	Response	Skip
101	Sex	1. Male 2. Female	
102	Age in years	_____	
103	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic	
104	Marital status	1. Single 2. Merid/cohabited 3. Divorced/separated	
105	Profession	1. GP 2. HO 3. Midwife 4. Nurse	
106	Level of education	1. Mastreat 2. Bachelor 3. Diploma	
107	Experience in years	_____	
108	Practice area	1. OPD 2. MCH 3. Emergency	
109	Have you ever received training on IPV management?	1. Yes 2. No	

Appendix table 2: perceived readiness to manage intimate partner violence among health providers in public health institutions at Hawassa city, Sidama region, Ethiopia.

1 = Not prepared 2 = Minimally 3 = Slightly 4 = moderately 5 = fairly well 6 = Well 7 = Quite well prepared Please circle the number which best describes how prepared you feel to perform the following								
S.no	Questions	1	2	3	4	5	6	7
201	Appropriately respond to disclosures of abuse							
202	Identify IPV indicators based on patient history and physical examination							
203	Assess an IPV victim's readiness to change							
204	Assess danger of lethality							
205	Conduct a safety assessment for IPV victim							
206	Help an IPV victim create a safety plan							
207	Document IPV history and physical examination findings in patient's chart							
208	Make appropriate referrals for IPV							
209	Fulfill state reporting requirements for IPV							

Appendix table 3: perceived knowledge to manage intimate partner violence among health providers in public health institutions at Hawassa city, sidama region, Ethiopia.

1 = Nothing 2 = Very Little 3 = A little 4 = A moderate amount 5 = A fair amount 6 = Quite a bit 7 = Very Much Please circle the number which best describes How much do you feel you now know about								
s.no	Questions	1	2	3	4	5	6	7
301	Your legal reporting requirements for IPV							
302	Signs or symptoms of IPV							
303	How to document IPV in patient's chart							
304	Referral sources for IPV victims							
305	Perpetrators of IPV							
306	Relationship between IPV and pregnancy							
307	Recognizing the childhood effects of witnessing IPV							
308	What questions to ask to identify IPV							
309	Why a victim might not disclose IPV							
310	Your role in detecting IPV							
311	What to say and not say in IPV situations with a patient							
312	Determining danger for a patient experiencing IPV							

Appendix table 4: Providers Attitudes towards IPV in public health institutions at Hawassa city, sidama region, Ethiopia.

For each of the following statements, please indicate your response on the scale from "Strongly Disagree" to "Strongly Agree"

s.no	Questions	Strongly Disagree	Disagree	Agree	Strongly Agree
401	Health care providers have responsibility to ask patients about IPV.				
402	I feel comfortable discussing IPV with my patients.				
403	Victims of abuse have the right to make their own decisions about whether hospital staff should intervene.				
404	I am aware of legal requirements in this state regarding reporting of suspected cases of IPV				
405	My workplace encourages me to respond to IPV.				
406	There is adequate private space for me to provide care for victims of IPV.				
407	I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g. bruises, fractures, depression etc…)				
408	I can match therapeutic interventions to an IPV patient's readiness to change.				
409	I can make appropriate referrals to services for IPV victims.				
410	Victims of abuse could leave the relationship if they wanted to.				
411	Victims of abuse often have valid reasons for				

	remaining in the abusive relationship.				
412	If a patient refuses to discuss the abuse, staff can only treat the patient's injuries.				
413	If victims of abuse remain in the relationship after repeated episodes of violence, they must accept Responsibility for the violence.				

Appendix table 5: Providers Practice (skill) in managing IPV in public health institutions at Hawassa city, sidama region, Ethiopia.

s.no	Question	Response	Skip
501	How many new diagnoses of IPV or patient disclose in the last 6 months?	_____	
502	Is there a protocol for dealing with IPV at your clinic/practice?	1. Yes and widely used 2. Yes and used to some extent used 3. Yes but not used 4. No	
503	Are you familiar with your institution's policies regarding screening and management of IPV victims?	1. Yes 2. No	
504	Is a camera available by institution at your work site for photographing IPV victims' injuries?	1. Yes 2. No	
505	Do you practice in a state where it is legally mandated to report IPV cases?	1. Yes 2. No	
506	Are IPV patient education or resource materials (posters, brochures, etc.) available at your practice site?	1. Yes, well-displayed, and accessed by patients 2. Yes, well-displayed, but not accessed by patients 3. Yes, but not well-displayed 4. No	
508	Do you feel you have adequate IPV referral resources for patients at your work site (including mental health	1. Yes 2. No	

	referral)		
509	Do you feel you have adequate knowledge of referral resources for patients	1. Yes 2. No	

510. How often you asked about the possibility of IPV when seeing patients with the following

	Conditions	Never	Seldom	Sometimes	Nearly Always	Always	N/A
A	Injuries						
B	Chronic pelvic pain						
C	Irritable bowel syndrome						
D	Headaches						
E	Depression/anxiety						
F	Eating disorders						

511	For every IPV victim you have identified in the past 6 months, how often have you						
		Never	Seldom	Some times	Nearly Always	Always	N/A
A	Documented patient's statements IPV in chart						
B	Used a body map to document patient injuries						
C	Photographed victim's injuries to include in chart						
D	Notified appropriate authorities when mandated						
E	Conducted a safety assessment for victim						

F	Helped an IPV victim develop a safety plan						
H	Offered validating or supportive statements						
I	Provided basic information about IPV						
J	Provided referral and/or resource information						