

Assessment of Nurses' Preparedness and Identify Barriers to Care Women Exposed to Intimate Partner Violence in East Gojjam Zone, Ethiopia, 2014

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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 regarding to IPV care in Ethiopia, high prevalence and impact on women health, these make it problematic.

Method: descriptive correlational quantitative study design was conducted to assess nurses' preparedness (knowledge, practice and attitude). Required sample size was 448 nurses. From 18 woreda, nine woreda were randomly selected through proportionate sampling method then the study sample was selected randomly. Odds ratio, 95% confidence intervals and 0.5% marginal error was used. Descriptive, bivariate and multivariate analysis was conducted.

Result: Just over 94% of all respondents had not received any training. More than the halves of nurses were not knowledgeable. Around 60% of nurses had negative attitude to IPV cases. In addition, almost 60% of nurses were not skilful. There was a significant association between being male to care to Women exposed to IPV. Males were around 8 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. Conclusion and recommendation: 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 skilful.

Keywords: Preparedness to care; Readiness to care; Intimate partner violence care

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, 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, gynaecological, 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].

Physical violence, mild emotional violence to severe emotional violence and high spousal control of women by their partners [17], high relationship between IPV and HIV as a risk factor [18]. 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 are crucial to reduce the impact [19,20]. Sufficient preparedness of nurses in the health institutions necessarily require in both knowledge and experience for identifying and caring women exposed to IPV properly [21].

Objectives

1. Assess the nurses knowledge, attitude and practice to Care Women Exposed to Intimate Partner Violence
2. Assess the associated factors with nurses preparedness to Care Women Exposed to Intimate Partner Violence

Methods and Materials

Study design

Descriptive correlational design was conducted in selected Governmental health institutions.

Sampling procedure

In Ethiopia, there are 11 region, Amhara is one of region which has sub classification that is zone. East Gojjam is one classification as zone. In East Gojjam there is also further other division which is woreda. There are 18 woredas (Motta, Hulet Ejjue Enesie, Enarge Enawga, Goncha Siso Enesie, Enebsie Sarmider, Enemy, 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, Enemy, 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 (Figure 1).

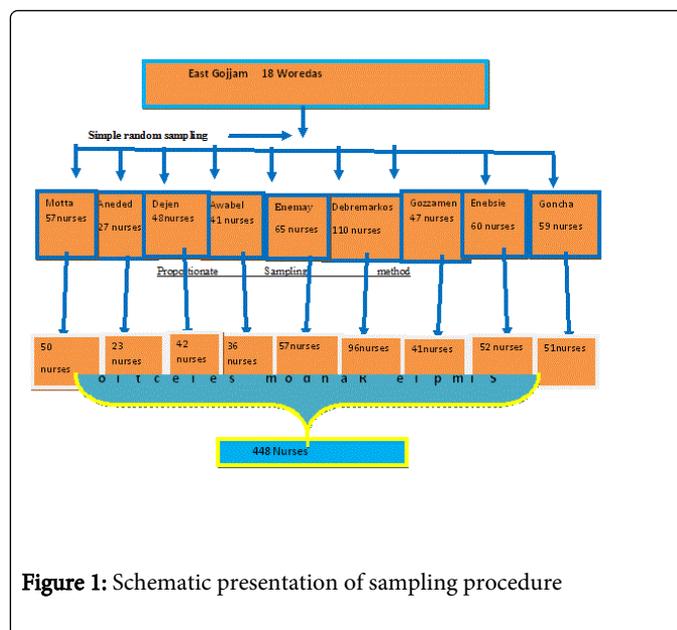


Figure 1: Schematic presentation of sampling procedure

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 and also because of the study population less than 10,000, adjustment or correction formulas was applied to this study. Required sample size was 448 nurses.

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.

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.

Instrument

A structured self-administered questionnaire was used to collect data from nurses. It was constructed from already studied research adopting and modifying [21] and PREMIS (Physician Readiness to Manage Intimate Partner Violence Survey) tool [22]. It consisted of four 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.

Data processing and analysis

The collected data was cleaned, coded and entered in Epi Data 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, bivariate 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.

Operational definitions

The following operational definitions were used for this study:

1. Knowledgeable: - Nurses who answered correctly to all knowledge questions above the median were considered as knowledgeable.
2. Not knowledgeable: - participants who answered correctly to all knowledge questions below the median were considered as not knowledgeable.
3. Negative attitude: - Nurses who agreed to all attitude questions below the median were considered as negative attitude.
4. Positive attitude: - Nurses who agreed to all attitude questions above the median were considered as positive attitude.
5. Skilful: - Nurses who worked to all practice questions above the median were considered as skilful.
6. Not skilful: - Nurses who worked to all practice questions below the median were considered as not skilful.

Ethical considerations

Ethical clearance obtained from Addis Ababa University, 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

Results

Nurses' socio-demographic characteristics about women exposed to IPV in East Gojjam

There is 91% respondent rate, from this 53.9% were female nurses. From the total participants 47.3% were within 30 to 39 years of age, and 31.6% worked in outpatient department /OPD/, 32.6% in Emergency and 20.3% in obstetrics/gynecology/. The majority of respondents were orthodox religion follower (79.7%). Sixty five percent 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 with other nurse (from 1 up to 5 nurses) in the same place/room but 81% of participants worked alone i.e. without physician (Table 1).

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 Women exposed to IPV you cared for	Never	85	20.8
	"none this year"	97	23.8
	"less than twenty"	193	47.3
	"twenty or over"	33	8.1
How many patients you saw per week	less than 20	41	10
	20 to 39	56	13.7
	40 to 59	46	11.3
	60 or more	265	65
Had you received previous training on caring for women exposed to IPV?	Yes	24	5.9
	No	384	94.1

nurses work with you / including you/	1-5	223	54.7
	6-10	138	33.8
	>11	47	11.5
Physicians work with you.	0	329	80.6
	1-5	76	18.6
	>5	3	0.7

Table 1: Nurses' socio-demographic characteristics about women exposed to IPV in East Gojjam governmental health care institution, 2014

Nurses' Knowledge about women exposed to IPV in East Gojjam

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 (Table 2).

242(59.3%) nurses replied that, women exposed to IPV got harm from their 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 (Table 2).

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 (Table 2).

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	0	0
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
Why Women exposed to IPV not leave their 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
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
	"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

Table 2: Assessment of nurses' knowledge towards women exposed to IPV in East Gojjam health care institution, 2014

Nurses' Attitude about women exposed to IPV in East Gojjam

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%) (Table 3).

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 the underlying cause of patient injuries (e.g., bruises, fractures, etc.)	Disagree	52
		agree	48
	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
		agree	51
	Women who choose to step out of traditional roles are a major cause of IPV.	Disagree	57.4
		agree	42.6

Table 3: Assessment of nurses' attitude towards care of women exposed to IPV in East Gojjam, governmental health care institution, 2014

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 (Table 3).

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 (Table 3).

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 counselling 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 (Table 4).

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
	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 when you identified women exposed to IPV	Provided information (phone numbers, pamphlet, other information)	57	14
	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

Table 4: Assessment of nurses' skill towards care of women exposed to IPV in East Gojjam health care institution, 2014, 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 (Table 5).

Variables	Never & seldom %	Sometimes & always %
4.4.1. How often in the past 6 months, have you asked about the possibility of IPV (women) when seeing the following sign?		
a) Injuries	12	88
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
4.4.2 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	12
f) Helped an Women exposed to IPV develop a safety plan	83.7	16.3
g) Contacted an IPV service provider	88	12

h) Provided referral and/or resource information	74.1	25.9
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Table 5: 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

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 (Table 5).

Knowledge, attitude and skill score of East Gojjam nurse to women exposed to IPV

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 skilful and negative attitude. Above the median was considered as knowledgeable, skilful 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 skilful (Table 6).

Variable		Frequency	Percent
Knowledge score	not knowledgeable	234	57.4
	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 skilful	242	59.3
	Skilful	166	40.7

Table 6: 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

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/ crude odd ratio/ 2.540(1.693, 3.810) and AOR / adjusted odds ratio/ 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 (Table 7).

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	1	0	1
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	0	1
How many Women exposed to IPV you did care	Never	78	7	0	1	0	1
	"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	22.993 (10.028, 52.720)	0	13.214 (6.485, 26.928)
	"20 or over"	11	22	0	22.286 (7.727, 64.272)	0	10.808 (4.08, 28.63)

Table 7: Identifying association through bivariate 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

Nurses' skill and attitude were significant with bivariate but knowledge of nurses was not significant. Through multiple regressions, skill and knowledge became significant. Nurses who were not skilful 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 (Table 8).

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	0	.008(0.004, .016)	0	.006(.003, .014)
	Skillful	12	154		1		1
Knowledge	Not knowledgeable	140	94	0.161	0.753(0.507, 1.119)	0.008	.349(.161, .757)
	Knowledgeable	92	82		1		1
Attitude	Negative attitude	139	89	0.06	0.684(0.461, 1.016)	0.614	1.208(.579, 2.519)
	Positive attitude	93	87	0.655	1		1

Table 8: Identifying association through bivariate and multivariate analysis between nurses' care of women exposed to IPV with nurses' preparedness (Knowledge, Attitude and Skill)

Discussion

Nurses' care for women exposed to IPV influenced with demographic factors. Male nurse was more likely to give care for women exposed to IPV than female nurse, in this study. The findings could not be echoing previous work indicating that women patients were more likely to discuss

IPV issues with female professionals [23]. In addition, study was indicating that female nurses were more prone for screening and giving care to women exposed to IPV [24]. 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 within 3 years [21].

A study, which conducted, reported care of IPV women increased as the level of experience (practice) increased. Inadequate preparation, for experience, emerged as a key factor to routine inquiry and k management to IPV women [25].

In this study, nurses who never did care for women exposed to IPV less likely to give care to them. Other study also supports 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 [25].

Knowledgeable Nurses were 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 [21].

A study showed that 16.7% nurses from 89 had given care to women exposed to IPV [26]. However, in this study, 40.7% of the nurses had given care at least once IPV case. It is due to IPV prevalence in Ethiopia [27] different from UK [28] and large participants in these studies.

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, have negative attitude and even not skilful to IPV. The knowledge and skill of nurses' affect the nursing care, which were given to women exposed to IPV. Quesi experiment revealed 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 [29].

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 [30].

Recommendations

- Expanding education opportunity about IPV for employed nurses at higher institutions like university is recommended.
- Even though, 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.

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