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ORIGINAL ARTICLE

Nurses Involvement in the Management of Family Violence Victims in Primary Care Settings in Ondo State, Nigeria: A Qualitative Study

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Keywords

Nurses' involvement;

Management;

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Nigeria

ABSTRACT

Background: Nurses in primary healthcare settings are strategic for appropriate responses to family violence victims in Nigeria. The study described nurses' involvement in identifying and managing victims of family violence.

Methods: The interpretive descriptive qualitative approach was adopted for the study. Participants were purposively selected and in-depth interviews were conducted among 12 nurses working at primary health care settings with a developed interview guide. The interviews were analyzed via qualitative content analysis.

Results: Findings showed that nurses identified victims of physical violence via signs of physical injury. Nurses had difficulty identifying other forms of violence that may not have physical signs and not disclosed by victims. Nurses' management strategies were wound care for physical injuries sustained, counselling and mediation. Risk assessment, safety planning measures were not instituted as well as effective management and specialized care services for victims.

Conclusion: This study showed there were gaps in identifying family violence cases and their management by nurses. Hence, the implication for further education and training of nurses, and advocacy for policy guidelines for effective management of family violence victims.

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INTRODUCTION

Family violence is a major public health problem with consequences on all spheres of life, including family functioning and peaceful cohabitation in families.[1–3] Family violence has grown in incidence and prevalence across social settings, with families in low- and middle-income countries at a great disadvantage with one in three women as victim of a form of family violence.[4,5] Often, the victim of family violence seek help in healthcare facilities to manage injuries sustained during violence episodes without disclosing the cause of the injury. Healthcare providers, most especially community health nurses, are uniquely positioned to facilitate disclosure of violence and provide appropriate care, support and referral to other specialized services as required.[6] Studies have shown that women who have experienced violence are more likely to seek health care than

non-abused women because of the long-term consequences of family violence on the physical, mental and reproductive health of such women.[7,8]

Individuals exposed to violence require comprehensive and gender-sensitive healthcare services that address the physical and mental health consequences of such traumatic events. [8] Within the healthcare team, nurses are numerical in strength and strategic in interrogating sensitive issues like family violence during health facility visits. [9-11] Furthermore, Community Health Nurses (CHN) have the unique opportunity of working with individuals and families in their homes, schools, workplaces and other locations within the community. [12] The contexts in which community health nurses operate create variations in what services are suitable for family violence prevention, identification, screening, treatment and interventions. [13] The variations in contexts also position community health nurses in negotiating with ease, the trust of their clients in disclosing violent experiences and how to assess the situation. It also gives nurses insight to assess and understand the interpersonal relationships and patterns of family functioning with the possibility of identifying violence before it starts or escalates.

Nurses perform roles such as identification, care for victims' physical health needs, safety attention, referrals and providing support and advice for family violence victims. [9] Nurses working at primary healthcare facilities may be knowledgeable about the concept of family violence in relation to heterosexual relationships but not skillful in practice for identification and management of victims of family violence.[13-16] Nurses working in settings where the victims are constrained by cultural expectations and norms around disclosing family issues are faced with the challenge of how to support the victims. [14] This make nurses perceive themselves to be insufficiently prepared to provide care for victims of family violence. Studies have also shown that nurses do not have adequate knowledge, appropriate skill and experience to care for women exposed to family violence for assessment and probable interventions to control the public health dilemma. [17, 20]

Nurses' involvement in family violence must be approached with caution and context-relevant evidence because family violence is complex and must be approached through a culturally relevant lens that is guided by the professional ethics of nursing.[21-23] There are chances of over-involvement, which essentially could be dysfunctional with negative consequences. However, the prevailing practice has been a superficial involvement of nurses in identifying and managing family violence victims during clients/patients visits to healthcare facilities. Against this backdrop, this study gathered contextual evidence on nurses' involvement in the identification and management of family violence in order to plan appropriate interventions that could improve nurses' capacity to effectively identify victims of family violence and appropriately intervene within the Nigerian context.

METHODOLOGY

Study Design

The interpretive descriptive qualitative approach was used for this study. The interpretive description is a qualitative method that draws upon the philosophical structure of applied disciplinary

knowledge for its interior logic and design decisions. [24,25] This qualitative method permits an understanding of the phenomenon under study and the generation of knowledge that can inform and improve nursing practice. The interpretive descriptive is appropriate for this study because of its capability to generate a reliable and meaningful nursing-based body of knowledge that allows for the evolution of qualitative practical application to the scope of nursing. [25] The interpretive descriptive design focuses on the in-depth analysis of a phenomenon toward the development of knowledge for evidence-based practice. [26-28] This study used a face-to-face, one-on-one individual interview with concurrent data collection and analysis done iteratively as recommended by the design employed by this study. [25,28] This allows participants' voices to guide the interview process and inform analysis as the findings unfold. [29]

Study Setting

The study was conducted in three randomly selected (Ifedore, Owo and Ileoluji/Okeigbo) Local Government Areas across Ondo State, southwest Nigeria in May 2019. The selected LGAs Ifedore had 28 health centers and 38 nurses, Owo had 38 health centers and 26 nurses and Ile-oluji/Okeigbo had six health centers and 13 nurses. Ondo State is one of the six states in the southwest geopolitical zone of Nigeria. The state consists majorly of the Yoruba tribe, but with the presence of various Yoruba sub-tribes specific to the state. There are areas of congruence in culture and beliefs among the sub-tribes with some superficial differences that exist. The state has the capacity to provide healthcare services at three levels: primary, secondary and tertiary. The primary health centers attached to the communities where nurses work was the focus of the study. The primary health centers are responsible for providing primary level healthcare services; health promotion and illness prevention services, treatment of minor ailments among the different age-groups within the community. These healthcare services were provided majorly by nurses and other supporting staff.

The nurses work in the context of patriarchal arrangements where the males are naturally the provider, the landowners and take most decisions in homes and households. The females occupy the home care and supporting role. A general belief that issues relating to the family are kept 'within' and non-family members are not involved. The family structure within this community is mainly the traditional family living as nuclear households alongside extended family members, although there are changes to this type of living arrangement due to the acceptance of western culture preferring individualism. The patriarchal society where these nurses practice accepts the polygyny marital arrangement.

These nurses practice in the context where couples are expected to remain together irrespective of their experiences in the relationship. There is an emphasis on tolerance and endurance for the woman (wife) to remain in the marital relationship to care for the offspring of such relationships, while the man (husband) can escape from such relationships to find solace with another woman (outside wives) when not satisfied with his wife [32] without condemnation by society.

Participants and Sampling Approach

The participants in this study consisted of registered nurses working with the selected

primary health centres situated within selected communities. The inclusion criteria for participants were registered nurses with or without other professional qualifications, had worked in the facility within the selected communities for not less than one year and had contact with victims of family violence in their years of practicing as nurses. The purposeful sampling was embraced to ensure information-rich cases.[30] Recruitment started with the identification of primary health centres where nurses work within the communities. Nurse participants were recruited through the offices of the primary healthcare coordinator and nurse managers in the selected Local Government Areas. The research team had a briefing with nurses in each local government area to provide information about the study and participation was voluntary. Twelve nurses participated in the interviews.

Data Collection

The primary data source in this inquiry was face-to-face semi-structured interviews conducted at the health care settings at the request of participants. The interviews were conducted in English Language the official language in Nigeria. An interview guide was developed and pre-tested among six nurses in three selected healthcare settings in Ile-Ife to simplify and remove vague questions. The interview guide was prepared based on literature and designed to capture data that fit the objectives. The interview guide had eight major questions (Table 1). The face-to-face interview sessions captured nurses' experiences about their care for victims of family violence seen at the healthcare setting. Their experiences included their methods of detection and intervention strategies. The concluding part of the session allowed nurses to recommend actions that will improve their services and strategies that may work among the people in the community through the health system.

The principal researcher led all interviews with the participants. The participants completed a demographic survey before the start of each interview session after explaining the processes and core of the study to the nurses. The conversations were tape-recorded with the approval of the participants. The longest interview lasted for 65minutes:10 seconds and the least lasted 43minutes: 20 seconds.

Ethical Consideration

Ethical approval (OSHREC/15/11/2018/071) for the study was obtained from the Review Board of the Ondo State Primary Healthcare Development Board in Akure. Permission to conduct the study was taken from primary health coordinators and nurse managers. Informed consent was taken from respondents and participation was voluntary.

Data Analysis

The audio recordings of the interviews were transcribed verbatim, and all identifying information of the participants were removed. The analysis began with the revision of written transcriptions while listening to the audio recordings to ensure the accuracy of the transcripts by three of the authors. The transcripts were read, re-read and re-listened to the tapes while simultaneously reading the text for familiarization. All the transcripts were deposited and analysed using Atlas ti qualitative software Version 8. This was followed by a line-by-line analysis of themes reflecting the interaction of

nurses with victims of family violence. The analysis was guided by the thematic approach and quotes were used to provide more perspectives and retain participants' views on each theme and subthemes that emerged from the data.

The research team identified dominant themes through the categorization of phrases and terms most frequently mentioned to bring out key concepts relating to family violence and its management. The data gathered was entirely for this study. All recordings of the interviews were labelled using numbers and dates, stored on a personal computer protected by a password and a backup copy on an external drive owned by the first author. Verification of data integrity was ensured through the principles of credibility, confirmability and dependability.[31] Credibility was ensured by presenting the research proposal, and interview guides to nursing and sociology experts in the field of study for content validation, which includes the appropriateness, clarity and level of the congruence of the content and the set objectives. Adjustments were made based on the comments retrieved from the experts to incorporate their suggestions. Member checking was used for confirmability, this was done by the interviewer checking with the participants after each session with the summary of the notes taken for them to make corrections as indicated and subsequently the inferences derived from the participant responses. Dependability was ensured by conducting the interviews in English, the official language in Nigeria. The interviews were audio-recorded to avoid misinterpretation. A further literature review was done to establish a connection between the research findings of this study with other evidence-based scientific findings.

The researchers' reflexivity is essential to maintain a balance in understanding the reality of inquiry. Four of the authors are registered nurses in Nigeria with a specific specialty in community health nursing and family violence. They are also practicing nurses and university lecturers. The fifth author is a sociologist by academic qualification and research focus. All the authors are from the Yoruba ethnic group, and engage in conducting quantitative, qualitative and mixed-methods research with published articles in reputable journals and not less than fifteen years of experience.

RESULTS

Table 2 represented the socio-demographic characteristics of participants. Twelve nurses were interviewed aged between 24 and 57 years. Their median age was 35.5 (15.5) years. Their duration of practice as nurses ranged from 3 to 32 years with a median of 10 (14) years. All the participants were females, married with additional professional qualifications, such as registered midwife and public health nursing certificates.

The themes identified were nurses' understanding of family violence, usage of health facilities by victims of family violence, experiences with the detection of family violence, intervention approaches for managing family violence and recommendations provided by the nurses to improve their practice.

Table 1: Interview guide for semi-structured interviews

1. What do you understand by the term "family violence"?
2. What are the forms of family violence known to you? Probe for types of violent acts in families within the community as reported where she works
3. What are the modes of identification of family violence and how do you intervene?
4. From your explanations, what do you think are the common causes of violence among families in this community? Probe for other factors responsible for the family violence occurrence within this community.
5. Share some of your experiences in which you have successfully intervened to resolve violence within a family. Probe for male clients too.
6. Based on your profession, what services are available within this health facility for clients going through family violence?
7. What do you think are the roles of nurses in the identification and management of family violence?
8. Based on your experience what are the methods or strategies adopted by nurses to identify and manage family violence within this community?

Table 2: Socio-demographic characteristics of study participants

Participants	Age (years)	Highest level of education	Duration of practice (years)	Professional qualification	Designation
P1	43	BNSc	12	RN, RM	Assistant Chief Nursing Officer
P2	34	BNSc	10	RN, RM	Senior Nursing Officer
P3	29	RN, RM	5	RN, RM	Nursing Officer I
P4	33	RN, RM	5	RN, RM	Nursing Officer I
P5	37	RN	10	RN	Senior Nursing Officer
P6	30	RN	10	RN	Nursing Officer
P7	37	BNSc	5	RN, RM, RPHN.	Nursing Officer I
P8	51	BNSc	26	RN, RM, RPHN.	Chief Nursing Officer
P9	24	RM	3	RM	Nursing Officer II
P10	34	RN, RM	10	RN, RM	Senior Nursing Officer
P11	54	BNSc	28	RN, RM, RPHN.	Chief Nursing Officer
P12	57	BNSc	32	RN, RM, RPHN.	Deputy Director of Nursing

**BNSc- Bachelor of Nursing Science, *RN- Registered Nurse, *RM- Registered Midwife*
**RPHN- Registered Public Health Nurse*

Understanding of Family Violence by the Nurses

The nurses interviewed ascertained that family violence was a common occurrence in the communities. From their responses, family violence was viewed as conflict and maltreatment occurring in the family mostly between couples. They thought that such conflicts often arose from misunderstanding and lack of fulfilment of assigned societal gender roles. On the forms of family violence, they reported that family violence occurred in the forms of physical, psychological, economical and sexual violence. Controlling behaviour was also mentioned as a form of family violence. Furthermore, rape came up as the most mentioned sexual violence among the nurses. This is not commonly reported among couples but among young girls within the community and the perpetrator may be close or extended family or community members. Participants' definition of the concept of family violence could be best represented by two of the participants' responses:

"Family violence is a form of conflict that happens between husband and wife in a family relationship. Most often, with the man beating the wife but I have also seen cases of women beating their partners." (P10)

"Family violence is when couples fight or maltreat each other due to argument or misunderstanding" (P3)

Utilization of the Health Facility by Victims of Family Violence

The victims utilized the health facilities to receive care mostly for obvious injuries sustained from physical or sexual violence. The injuries varied from bruises and deep lacerations to any part of the body to eardrum rupture and eye injuries. Miscarriages and other antepartum bleeding episodes were presenting complaints from some women victims of family violence that the nurses had interacted with.

"Yes, they come. The presentation is usually either deep cuts or injuries in any part of the body that cannot be handled by them at home. The presenting partner (wife or husband) always points an accusing finger at the other partner. Sometimes they tell the story such as being attacked with knives, sharp objects or forceful blows by their partner. Although, men may be discreet about telling the nurse. The wife too may not tell the nurse because she feels like it is a disgrace to her family and to herself that the man is always beating her up but the man will come straight saying don't mind her." (P1)

"I could recollect the case of a pregnant woman beaten by her husband, the couple came to the facility because the woman started bleeding per vagina, and we referred her to a higher level of health care for proper management." (P12).

The nurses also shared that these victims mostly women will not come to the healthcare setting if there were no visible injuries or if the injuries were manageable at home. The psychological effects of violence itself were not concerns for seeking help at the healthcare facilities. There was less emphasis on help seeking for emotional violence because injuries from this type of violence cannot be seen. Two of the participants also stated that men were also victims of family violence but mostly not of physical violence that could make them come to the facility with injuries but mostly of emotional violence as witnessed in the facility and community.

Issues relating to sexual violence were also common in some facilities but such sexual violence cases were not from couples. The victims of sexual violence utilizing the health facility were unmarried girls with their perpetrators being male strangers. Disputes associated with sex among couples were not usually disclosed except for a few victims that might perceive that there might be a resolution from the nurse in this regard. When sex becomes the cause of violence in a marital relationship, it was not perceived as an issue to seek help, hence, such might not be reported.

"Emotional violence or psychological violence is mostly reported by men. This is observed when some men accused their wives of using sharp words against them which often affect their ego. Some women have also talked about not being comfortable with the way men talk to them by using insults, curses and other forms of humiliation". (P4)

"Another form of violence that is often reported here is forced sexual intercourse, I mean rape which is common among young girls. Issues relating to sexual violence is not commonly reported among couples around here. I am sure you know that even if it exists, they are not likely going to report it because of the societal belief that such issues should not be discussed with external people". (P2)

Experiences about the Detection of Family Violence

The nurses also reiterated that victims did not express the cause of the injuries that often brought them into the facility as violence within the home despite inquiring about the cause of the injury and how it occurred. However, when the clients decided to disclose, injuries were expressed to be sustained from physical violence acts such as slaps, beatings, punches and the use of sharp weapons. The nurses stated that there was no recommended guideline for the identification of violence in their facilities. Hence, nurses identified victims of family violence visiting the facility from the couple's conversations or other non-verbal clues observed when the perpetrator and victim presented themselves together at the facility. Other approaches of identification were the cues from clients' signs and symptoms, recurrence of the same injuries at the same body parts and the use of specific or direct questions while taking the history of the present complaints of the clients. The kind disposition, calm and welcoming approach of the nurse is also important to the client for disclosure. It also influences the disclosure or non-disclosure of violence experience by the client.

"We identify the victims of family violence from the way they respond to questions, and sometimes if the person has been coming from time to time for treatment, the nurse may see the same injuries, the same swelling then the nurse may suspect family violence and further conversations may allow the woman talk to us" (P7)

"Aha! Whenever the couple come together, you will quickly know that the injury sustained is caused by fight because they will be angry with each other. When you ask questions their responses are suspicious and the perpetrator may express that he will not pay for the treatment". (P2)

Intervention Approaches for Managing Family Violence

The nurses stated that there was no standard protocol to follow for managing family violence in the health facilities visited for this study. The strategies for management of identified victims of family violence depended on the extent of the injury, frequency of occurrence and the disposition of the victim for support and help. All the nurses interviewed had been involved in the management of victims at a time or the other. The management of victims ranged from the regular wound dressing, suturing of deep lacerations and referral of complex physical or obstetrical health issues occurring from any form of family violence to higher levels of health care after the preliminary first aid treatment. Counselling the victim alone and sometimes with the perpetrator was the strategic approach used by the nurses after the injuries and other physical health issues had been attended to. The sexual violence victims, mostly unmarried girls were managed with contraceptives within the stipulated days of the occurrence of the incident and pre-exposure prophylaxis (PEP) for the human immunodeficiency virus and acquired immunodeficiency syndrome. A senior nurse, however, emphasized that junior nurses usually avoid the sexual violence victims by referring them to the senior nurses to evade the police. This is because they perceived that in severe cases, the police might be involved and the nurse might be required to visit the police station to file a report

Table 3: Summary of study findings

Key questions	Responses
Who seeks care for management of symptoms related to family violence at healthcare facilities?	Mostly married women Rarely married men Sometimes unmarried young girls
What are the common symptoms they present at the facility?	***Married women*** Visible physical injuries e.g. deep lacerations, eye injuries, contusions Intrapartum bleeding Miscarriages ***Married men*** Psychological trauma **Young girls** Injuries from rape experience
What do the nurses do to manage cases of violence reported?	Mainly counselling Management of physical injuries Contraceptive counselling Post-exposure prophylaxis (PEP)
What nurses are not doing	Screening of patients for the experience of violence Reporting cases of violence Referrals for follow-up and support with appropriate professionals and institutions Attending to safety issues

of their findings and testify where necessary. These, the junior nurses perceived to be cumbersome to accomplish without the necessary skill and legal framework of doing so. Nurses were asked to share their experiences of their involvement in the management of family violence victims that disclosed violence at the clinic. Most of the nurses claimed, they use counselling, with the proviso that the couple had the right to make informed decisions regarding their relationships. The counselling might be for the woman victim alone or with the husband perpetrator or vice versa on issues established to be the cause of the violence. Counselling is tailored toward addressing the cause of the violence, which may differ from one patient to the other. Some of the key quotes from participants' responses are stated below:

"The only thing we use to do is to counsel them about the identified causes of the violence and things relating to healthy relationships. Sometimes the husband or perpetrator is included in the counselling. Sometimes, it could be violence against the men too, not just the woman alone". (P2)

The participants also admitted that they did not know other things to do to support or intervene with the victims. They also mentioned that they involved children in most interventions because they were also traumatized when the violence happens with their parents.

Recommendations provided by the Nurses to improve Practice

Nurses gave some recommendations for managing family violence. They suggested intervention in the form of policy support from the government

that backs up healthcare providers to support victims of family violence beyond counselling and treatment of injuries. There is a need for mandatory reporting policies for nurses and other healthcare providers to involve law enforcement agents. Furthermore, there should be advocacy groups among nurses to manage the reporting and management of family violence. Other recommendations, as stated by participants were enactment and enforcement of strict penalties for perpetrators of family violence, and multi-sector interventions involving the law enforcement agents, non-governmental organizations, and religious institutions. The summary of study findings is shown in Table 3.

DISCUSSION

This study provides contextualised evidence on family violence and nurses involvement in providing support for victims seeking help from selected primary health care facilities in Ondo State, Nigeria. The study adopted qualitative methods in interviewing the reality of family violence as understood among nurses and what measures they adopt in providing the needed care and support at the facilities where they work. Findings from this research has shown that family violence victims use the health system for the management of their injuries and other health issues associated with family violence. This is in congruence with other studies that emphasized the frequent use of healthcare services by abused women.[32,33] This pattern is expected as most of the women that are violated are victims of physical and emotional violence, both with huge implications on physical and mental well-being. The patronage of health facilities by these victims could be dominated by the immediate need for relief and beyond the desire for relief, such victims also leverage on their pains in seeking help for other conditions. [32] The findings in this study supports such motive, while it was difficult to lay claim to stigma and fear as a possible rationale for mentioning other health conditions to nurses when help is sought, stigma and fear cannot be ruled out in the study settings. Nurses in this study reported that some of the victims arrived at their health facilities with blunt and open injuries sustained from different acts of physical violence. These were markers of physical violence and abuse, which could be difficult to hide, but may possibly be explained as accidents when consulting or interacting with nurses during facility visits. Existing literature has documented similar findings and showed that the injuries sustained by victims of physical violence ranged from musculoskeletal injuries to fractures. [34] The escalation of intimate partner violence was associated with intentional physical injury resulting in fractures[34] thus, endangering the lives of victims the more with probably associated morbidity. The nurses expressed that their line of management span through the administration of medicines, dressing of wounds and counselling as documented in a study conducted among nurses in Brazil. [35] These forms of management have also been documented as clinical (administration of medicines and wound dressing) and non-clinical (counselling) forms of management among nurses. [36] The dangers in focusing on clinical procedures more than cultural elements are the possible loss of context and relationships, which are vital to trust-building and disclosure of violent experiences. This is the worst in a cultural setting where conflict arising within families is not the subject of discussion outside the

home among ‘strangers’ (health care workers). Hence, nurses approach victims through the biomedical lens, which restricts their attention to clinical procedures.

The findings of this study also showed that nurses were involved in the care of victims who are mostly women, whether they disclose family violence or not. The disclosure of family violence as the cause of injuries sustained is not a common phenomenon, probably due to the secrecy associated with unpleasant issues occurring within the family. [37] Other contributory factors for non-disclosure of family violence may be the acceptance of violence in relationships as a way of correcting the victim, [38] the stigma imagined by the victim and ineffective post-disclosure interventions. [39] The attitude of healthcare providers, sharing the victims’ prejudice and cultural norms associated with violence in relationships with consequential influence on their professional attitude toward clients has also been found to influence a client to disclose violence occurrence. [16]

Mandatory screening has been prominent in literature though problematic, [40] either by lack of time, the burden of the screening tool to be used or the inability of the victim to spontaneously disclose violence occurrence when asked. The findings from this study showed there was routine screening nor protocol for screening and identification of victims of family violence that were reported at the health facilities. There were also no mandatory reporting policies within the health facilities despite the health facility recommendations for routine screening to identify victims of family violence. [41] In the same light, the study found that nurses only identified victims of violence through the presenting complaints of mostly injuries. The screening of women with physical injuries by healthcare providers has been recommended for easy identification of victims of family violence. [42]

This study found that nurses provided care majorly for victims’ physical injuries in isolation of other standard management strategies, probably due to non-disclosure by the victims, lack of knowledge from the part of nurses and lack of protocol for comprehensive assessment of victims in the primary healthcare facilities. The identification and management of victims of violence in Nigeria is with multiple complexities; ranging from the lack of protocols for identification, lack of laws for universal screening, mandatory reporting to further management of victims after disclosure. This is complicated with the lack of health system policies in this regard, the societal belief of secrecy about issues arising in the family between spouses and the patriarchal accepting society. This may be probably from the cultural belief of enduring the unpleasant occurrences in marital relationships, the view of such unpleasant occurrences as a family affair shielded away from ‘strangers’ and the acceptance of all forms of punishment for spouses to ‘curb their excesses’. These promote the reoccurrence of violence within family relationships with particular reference to intimate partner violence.

The roles nurses played in the management of family violence include: the provision of nursing care which include physical and psychological care in the form of counselling. These roles were documented in a previous study [35] as clinical and non-clinical elements of nursing care. The findings of this study only emphasized the physical care and

some psychological care only which were similar to the findings from a Sri Lanka study among nurses that only provided physical care without fulfilling the roles of nurses for identification, providing support, making referrals and attending safety issues for the victims and children as identified by the study.[17]

The management of family violence is not taken seriously outside family settings in the cultural context of the study setting because of the belief that whatever happens stays within the family. Thus, victims may not express the source of injuries as family violence within family relationships. More saddening is the fact that nurses displayed inadequate knowledge of the identification and management skills for victims of family violence. Nurses from the study setting expressed willingness to improve knowledge and build skills for managing family violence.

Strengths and Limitations

This study is one of the few studies conducted to document and get a baseline of nurses' involvement with victims of family violence in Nigeria, where spousal homicide is on the increase. This is with the view to developing interventions that will meet the peculiarities of the study setting. The face-to-face or one-on-one interviews conducted with the nurses at the health centres within the communities provided insights into how nurses identified and responded to victims of family violence at the first level of the healthcare system. The findings were limited to the first level of health care in the Nigerian context. Hence, requiring further inquiry among nurses in the second and third levels of health care. Furthermore, the lack of a screening tool for identification of victims of family violence is a huge gap in the study setting. Hence, there is need for tools that will objectively help to identify victims of family violence.

Implications for Practice

This study has shown that victims of family violence seek help from the healthcare system for treating injuries. Nurses can intervene appropriately to prevent and control further occurrence of family violence with adequate knowledge and skills. This will allow the nurse to identify and further assess the victim and family members while collaborating with other community resources to intervene. The health center can also serve as a place of succour for victims of violence while the healthcare providers plan other safety measures with the victims. This study has also revealed that there is a need for appropriate screening measures for the identification of victims of family violence with suitable authorized reporting frameworks. The findings from the study also situated the provision of support and referral mechanisms as required with other professionals in the context of the appropriate health system policy framework for reporting with concerns for the safety of victims.

Conclusion

Our findings revealed gaps in the nursing management of victims and other family members that witnessed family violence in the home. There were also gaps in policy formulation and implementation of healthcare responses to the victims of family violence. However, additional education and training for nurses should improve their response and management of direct and indirect victims of family violence while

curriculum modification is required for student nurses programs. There is also need to develop appropriate and contextual protocols to aid nursing practice in this regard. Nurses require appropriate skills to be able to provide adequate health care response as required.

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REFERENCES

1. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 2019; 56(6): 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

2. Steele H. Commentary: Money can't buy you love, but lack of love costs families and society plenty – a comment on Bachmann et al. J Child Psychol Psychiatry Allied Discip. 2019; 60(12): 1351-1352. https://doi.org/10.1111/jcpp.13111

3. Cooper DK, Erolin KS, Wieling E, Durtschi J, Aguilar E, Diaspro-Higuera MO et al Family violence, PTSD, and parent-child interactions: Dyadic data analysis with Mexican families. Child Youth Care Forum. 2020; (0123456789). https://doi.org/10.1007/s10566-020-09564-3

4. Sardinha IL, Ctor H, Ná Jera CE. Attitudes towards domestic violence in 49 low- and middle-income countries: A gendered analysis of prevalence and country-level correlates. 2018; Available from: https://doi.org/10.1371/journal.pone.0206101

5. Spangaro J, Toole-Anstey C, Macphail CL, Rambaldini-Gooding DC, Keevers L, Garcia-Moreno C. The impact of interventions to reduce risk and incidence of intimate partner violence and sexual violence in conflict and post-conflict states and other humanitarian crises in low- and middle-income countries: A systematic review. 2020; Available from: http://creativecommons.org/licenses/by/4.0/.TheCreativeCommonsPublicDomainDedicationwaiver https://doi.org/10.1186/s13031-021-00417-x

6. Guruge S, Illesinghe V, Gunawardena N. Healthcare provider responses and preparedness towards caring for females who have experienced intimate partner violence in Sri Lanka. OUSL Journal. 2021 Dec 30; 16(2): 65. https://doi.org/10.4038/ouslj.v16i2.7507

7. Ansara DL, Hindin MJ. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. Soc Sci Med. 2010; 70(7): 1011-1018. https://doi.org/10.1016/j.socscimed.2009.12.009

8. Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. Am J Lifestyle Med. 2011; 5(5):428-439. https://doi.org/10.1177/1559827611410265

9. Djikanović B, Lo Fo WS, Jansen HAFM, Koso S, Simić S, Otašević S et al. Help-seeking behaviour of Serbian women who experienced intimate partner violence. Fam Pract. 2012; 29(2): 189-195. https://doi.org/10.1093/fampra/cmr061

10. Koziol-Mclain J, Garrett N, Fanslow J, Hassall I, Dobbs T, Henare-Toka TA et al. A

randomized controlled trial of a brief emergency department intimate partner violence screening intervention. Ann Emerg Med. 2010; 56(4): 413-423. https://doi.org/10.1016/j.annemergmed.2010.05.001

11. Hooker L, Taft A. Screening for intimate partner violence in health care settings is a contested arena. Aust Nurs Midwifery J. 2013; 21(5): 22. Available from: https://www.proquest.com/openview/bddd457f4f537e5ba78f5db53c9c86fc/1?pq-origsite=gscholar&cbl=33490

12. Smiley RA, Lauer P, Bienemy C, Berg JG, Shireman E, Reneau KA et al. The 2017 National Nursing Workforce Survey. J Nurs Regul. 2018; 9(3): S1-S88 https://doi.org/10.1016/S2155-8256(18)30131-5

13. Hitchcock J. Nurses: A force for change. Journal of Neonatal Nursing. 2015; 21(6): https://doi.org/10.1016/j.jnn.2015.05.003

14. World Health Organization. Enhancing the role of community health nursing for universal health coverage. 2017. Available from: http://apps.who.int/iris/bitstream/10665/255047/1/9789241511896-eng.pdf?ua=1

15. Jack SM, Ford-Gilboe M, Wathen CN, Davidov DM, McNaughton DB, Coben JH et al. Development of a nurse home visitation intervention for intimate partner violence. BMC Health Serv Res. 2012; 12(1): 50. https://doi.org/10.1186/1472-6963-12-50

16. Alsafy NN, Alhendal ES, Alhawaj SH, El-Shazly MK, Kamel MI. Knowledge of primary care nurses regarding domestic violence. Alexandria J Med. 2011; 47(2): 173-180. https://doi.org/10.1016/j.ajme.2011.02.002

17. Guruge S. Nurses' role in caring for women experiencing intimate partner violence in the Sri Lankan context. ISRN Nurs. 2012; 2012: 1-8. https://doi.org/10.5402/2012/486273

18. 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 Nurs. 2012; 11(1): 1. https://doi.org/10.1186/1472-6955-11-1

19. Lawoko S, Seruwagi GK, Marunga I, Mutto M, Ochola E. Healthcare providers' perceptions on screening for intimate partner violence in healthcare: A qualitative study of four health centres in Uganda. Open J Prev Med. 2013; 03(01): 1-11. https://doi.org/10.4236/ojpm.2013.31001

20. Zeleke H, Mengistu D, Alem G. 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; 04(03): -10. https://doi.org/10.4172/2167-1168.1000250

21. Turner M. Involvement or over-involvement? Using grounded theory to explore the complexities of nurse-patient relationships. Eur J Oncol Nurs. 1999; 3(3):153-160. https://doi.org/10.1016/S1462-3889(99)80737-6

22. May C. Affective neutrality and involvement in nurse-patient relationships: Perceptions of appropriate behaviour among nurses in acute medical and surgical wards. J Adv Nurs. 1991; 16(5): 552-558. https://doi.org/10.1111/j.1365-2648.1991.tb01690.x

23. Skår R. Knowledge use in nursing practice: The importance of practical understanding and personal involvement. Nurse Educ Today. 2010; 30(2): 132-136. https://doi.org/10.1016/j.nedt.2009.06.012

24. Thorne S. Toward methodological emancipation in applied health research. Qual Health Res. 2011; 21(4): 443-453. https://doi.org/10.1177/1049732310392595

25. Teodoro IP, Rebouças VD, Thorne SE, Souza NK, Brito LS, Alencar AM. Interpretive description: A viable methodological approach for nursing research. Escola Anna Nery. 2018; 22(3): 1-8. https://doi.org/10.1590/2177-9465-EAN-2017-0287

26. Hunt MR. Strengths and challenges in the use of interpretive description: Reflections arising from a study of the moral experience of health professionals in humanitarian work. Qual

Health Res. 2009; 19(9): 1284-1292. https://doi.org/10.1177/1049732309344612

27. Kalengayi N, Kyungu F, Kalengayi N, Hurtig A, Ahlm C, Ahlberg BM. "It is a challenge to do it the right way": An interpretive description of caregivers' experiences in caring for migrant patients in Northern Sweden. BMC Health Serv Res. 2012; 12(443). https://doi.org/10.1186/1472-6963-12-433

28. Thorne S, Kirkham SR, O'Flynn-Magee K. The analytic challenge in interpretive description. Int J Qual Methods. 2004; 3(1):1-11. https://doi.org/10.1177/160940690400300101

29. Woodruff K, Clark L, Joy E, Summers SA, Metos JM, Clark Nl. An interpretive description of women's experience in coordinated, multidisciplinary treatment for an eating disorder. Glob Qual Nurs Res. 2020; 7: 1-10. https://doi.org/10.1177/2333393620913271

30. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and Policy in Mental Health and Mental Health Services Research. 2015 Sep; 42(5):533-544. https://doi.org/10.1007/s10488-013-0528-y

31. Holloway I, Galvin K. Qualitative research in nursing and healthcare. John Wiley & Sons; 2016.

32. Hooker L, Versteegh L, Lindgren H, Taft A. Differences in help-seeking behaviours and perceived helpfulness of services between abused and non-abused women: A cross-sectional survey of Australian postpartum women. Heal Soc Care Community. 2019; 1-11. https://doi.org/10.1111/hsc.12927

33. Vyas S. Violence against women in Tanzania and its association with health-care utilisation and out-of-pocket payments: An analysis of the 2015 Tanzania Demographic and Health Survey. East African Heal Res J. 2019; 3(2):125-133. https://doi.org/10.1080/03056249308703992

34. Petrisor BA, Drew B, Rajaratnam K, Williams D, Wong I, Kwok D, et al. Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: A multinational prevalence study. Lancet. 2013; 382(9895): 866-876. https://doi.org/10.1016/S0140-6736(13)61205-2

35. Gaúcha De ER, Ferreira CL, De SM, Padoin M, Becker VL, Landerdahl MC et al. Care for women victims of violence: Empowering nurses in the pursuit of gender equity. Rev Gaúcha Enferm. 2015; 36(spe):77-84. https://doi.org/10.1590/1983-1447.2015.esp.57162

36. Saletti-Cuesta L, Aizenberg L, Ricci-Cabello I. Opinions and experiences of primary healthcare providers regarding violence against women: A systematic review of qualitative studies. J Fam Violence. 2018; 33(6): 405-420. https://doi.org/10.1007/s10896-018-9971-6

37. 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 Fam Pract. 2017; 59(2): 67-71. https://doi.org/10.1080/20786190.2016.1272245

38. Easteal P, Young L, Carline A. domestic violence, property and family law in Australia. Int J Law, Policy Fam. 2018; 32(2):204-229. https://doi.org/10.1093/lawfam/eby005

39. Yeung H, Chowdhury N, Malpass A, Feder GS. Responding to domestic violence in general practice: A qualitative study on perceptions and experiences. Int J Family Med. 2012; 2012: 1-7. https://doi.org/10.1155/2012/960523

40. Paulman PM, Taylor RB, Paulman AA, Nasir LS. Family Medicine: Principles and practice. In: Family Medicine: Principles and Practice; 2016: 1-1863. https://doi.org/10.1007/978-3-319-04414-9

41. Awwad JT, Ghazeeri G, Nassar AH, Fakih A. Intimate partner violence in a Lebanese population attending gynecologic care: A cultural perspective. Journal of Interpersonal

Violence 1 –18 © The Author(s) 2014 Reprints and permissions: sagepub.com/journals. J Interpers Violence. 2014; (September). https://doi.org/10.1177/0886260513520507

42. Wong YHJ, Choi WMA, Fong YTD, Wong KSJ, ChuLeung L, ChakWah K. Patterns, aetiology and risk factors of intimate partner violence-related injuries to head, neck and face in Chinese women. BMC Women's Health. 2014; 14(6): http://www.biomedcentral.com/1472-6874/14/6