



Research Paper

Healthcare Providers' Readiness in Managing Intimate Partner Violence in Public Hospitals of Gurage Zone, Ethiopia, 2023; Mixed Study Design

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Abstract

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Intimate partner violence severely affects women's health, especially during pregnancy, causing problems such as miscarriage, maternal depression, and suicidal attempts. Victims also face challenges like substance abuse and inadequate prenatal care, necessitating crucial support from healthcare providers. This study aimed to assess the readiness of healthcare providers to manage intimate partner violence at public hospitals in the Gurage Zone, Ethiopia, in 2023. A cross-sectional study involving all 610 healthcare providers from selected hospitals was conducted, with data analyzed using SPSS version 25. Readiness scores were reported using the mean and standard deviation, while regression analyses identified factors influencing providers' readiness to manage intimate partner violence, with statistical significance set at a p -value of less than 0.05. Qualitative data were collected through in-depth interviews and analyzed thematically. A 99.2% response rate was achieved, with 605 healthcare providers participating. The mean perceived readiness score for managing intimate partner violence was 26.4 ± 7.5 (95% CI: 25.8, 27.0). Significant factors included receiving training on intimate partner violence ($P < 0.001$, 95% CI $\beta = 4.23, 7.21$), knowledge about intimate partner violence ($P < 0.001$, 95% CI $\beta = 0.13, 0.25$), availability of protocols ($P < 0.001$, 95% CI $\beta = 0.86, 5.49$), presence of a private room ($P < 0.001$, 95% CI $\beta = 1.88, 4.98$), and attitude towards intimate partner violence management ($P < 0.001$, 95% CI $\beta = 0.10, 0.38$). Healthcare providers demonstrated limited readiness in managing intimate partner violence, highlighting the need for training, protocol development, and improved perceived knowledge about intimate partner violence to enhance providers' readiness.

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1. Introduction

Violence against women, including intimate partner violence (IPV), represents a grave global public health issue and a profound human rights abuse. It is a deliberate and repeated physical, psychological, or economic abuse (Semahegn & Mengistie, 2015). Violence can occur in different forms and settings in the workplace, school, and community. Yet, violence at home by an intimate partner (IPV) is the most prevalent form (Berhanie et al., 2019). Despite international human rights declarations promoting equality, violence against women persists across all cultures and backgrounds (Chernet & Cherie, 2020). IPV encompasses physical aggression, sexual coercion, psychological abuse, and controlling behaviors inflicted by a current or former intimate partner (Alem et al., 2015; Ambikile et al., 2020a; Miller & McCaw, 2019; Smith, 2016). This abuse can lead to severe health consequences for women, including miscarriage, maternal depression, and suicidal attempts, with victims facing additional challenges such as substance abuse and inadequate prenatal care (Alem et al., 2015; Berhanie et al., 2019).

Globally, IPV affects about one in three women, with significant variation in prevalence across regions. Sub-Saharan Africa reports the highest rates, with over 66% of ever-partnered women experiencing IPV (Adhena et al., 2020; EPHI, 2019; Hatcher et al., 2019; Jakobsson et al., 2013; Tiruye et al., 2020). In Ethiopia, IPV prevalence ranges from 20% to 78% across different regions, affecting both urban and rural populations. About 30.2% of ever-married women experience IPV, and this rate increases during pregnancy, with 33.5% to 41.6% of pregnant women affected (Adhena et al., 2020; Chernet & Cherie, 2020).

Intimate partner violence affects women universally, regardless of cultural, economic, or religious background, with women and children being the primary victims. IPV results in severe

outcomes, including physical injury, psychological distress, and even death, with intimate partners committing a significant portion of female homicides (Mohammed et al., 2017; Shepard, 2016). In pregnant women, IPV can cause miscarriage, premature labor, and low birth weight, along with mental health issues such as depression and anxiety. This abuse also leads to substance abuse, inadequate prenatal care, and unsafe abortions, which further exacerbate health complications (Afiaz et al., 2020; Semahegn et al., 2019).

Children born to IPV-affected mothers face higher risks of poor growth and developmental issues, contributing to a cycle of violence (Coll et al., 2020). Consequently, IPV requires well-trained and prepared healthcare providers to offer effective and appropriate care. However, many providers lack the necessary knowledge, skills, and readiness to address IPV adequately, leading to insufficient responses and continued suffering for victims (Alhalal, 2020; McLennan & MacMillan, 2016). In Ethiopia, despite many women receiving their first antenatal care visit, IPV screening is not included, leading to underreported cases and inadequate medical intervention (Gashaw et al., 2020; Olaleye Atinuke et al., 2015).

Intimate Partner Violence is a significant global public health issue with severe physical, psychological, and social consequences, and its prevalence remains alarmingly high in Ethiopia (Teshome et al., 2023). Addressing this issue requires well-prepared healthcare providers who can effectively identify, support, and refer IPV survivors (Gashaw et al., 2020). However, the readiness of healthcare providers in terms of knowledge, attitudes, and practices remains underexplored in such areas. Despite national guidelines to address gender-based violence, policy implementation faces challenges due to limited training, resources, and institutional support (Yitbarek et al., 2019).

This study aims to fill a critical knowledge gap by assessing healthcare providers' readiness, contributing to improved survivor-centered care, evidence-based planning, and policy development, ultimately enhancing Ethiopia's efforts to address IPV and promote public health equity. It aims to assess healthcare providers' readiness to manage IPV in public hospitals within the Gurage Zone, South Nation, Nationalities, and People's Region (SNNPR), Ethiopia, as feeling prepared is considered a prerequisite for the ability to identify and manage IPV.

2. Methods and Materials

2.1. Study Setting

This study was conducted in the Gurage Zone, SNNPR, Ethiopia, focusing on five randomly selected public hospitals; namely Wolkite University Specialized Hospital, Butajira General Hospital, Gaucherie Primary Hospital, Bue Primary Hospital, and Agena Primary Hospital. The Gurage Zone is one of the administrative Zones in the SNNPR, with Wolkite as its capital. It is located 153 km southwest of Addis Ababa, the capital city of Ethiopia. According to the Ethiopian Central Statistical Agency's 2017 forecast, the Zone has a population of 1,635,311, including 842,065 women and 793,246 men (Shitu et al., 2021). The Gurage Zone consists of 16 districts and 5 town administrations, forming its administrative structure. Within the zone, there are seven hospitals, of which five are publicly owned and two are operated by non-governmental organizations. Additionally, the health system is supported by 72 health centers strategically distributed across the area, ensuring that healthcare services are accessible to the zone's total population. This network of facilities plays a critical role in meeting the healthcare needs of the community, offering both preventive and curative services (Shitu et al., 2021).

2.2. Study Period and Design

The study was conducted from March 22, 2023, to June 3, 2023. The research employed an institution-based cross-sectional mixed study design with a concurrent nature, combining both quantitative and qualitative approaches.

2.3. Population

Source Population for quantitative: The source population comprised all healthcare workers (nurses, midwives, general practitioners, public health officers) at the hospitals in the Gurage Zone.

Study Population for Quantitative: The study population included all healthcare workers present in the emergency unit, maternal and child health unit, inpatient department, outpatient department, family planning unit, mental health unit, and immunization unit during the study period.

Inclusion and Exclusion Criteria for Quantitative: Healthcare workers with at least six months of experience in the hospital were included, while those without this experience and data collectors were excluded. For the qualitative component, key informant healthcare providers were purposively selected.

Source population for Qualitative: Healthcare providers working in public hospitals in the Gurage Zone, SNNPR, Ethiopia which includes physicians, nurses, midwives, and health officers.

Study population for Qualitative: All healthcare workers present in the emergency unit, maternal and child health unit, inpatient department, outpatient department, family planning unit, mental health unit, and immunization unit during the study period.

2.4. Sample Size Determination

The sample size was calculated using a single population proportion formula with a proportion

of healthcare providers' preparedness for managing IPV 54% (Ambikile et al., 2020c), a precision of 5%, and a 95% confidence level. The formula used was:

$$n = \left[\left(Z \frac{\alpha}{2} \right)^2 \times P (1-P) \right] / d^2$$

$$n = [(1.96)^2 \times 0.54(1-0.54)] / (0.05)^2$$

$$n = 382$$

To account for a 10% non-response rate, the sample size was increased to 421.

Table 1: Sample size calculation by taking significant factors from previous study

Factor	Category	Ready to manage IPV		AOR	Sample size with 10% non-response rate	Reference
		Yes	No			
Receiving IPV training	Yes	167	29	2.14	22+10%=25	(Alem et al., 2015; Teshome et al., 2023)
	No	45	183			
Availability of protocols	Yes	100	83	10.6	42+10%=47	
	No	23	204			
Familiarity with institutional policies	Yes	76	30	22.4	28+10%=31	
	No	22	296			
Sex	Male	99	89	2.6	164+10%=181	
	Female	67	153			

The sample size with this objective was 181 after adding a 10% non-response rate.

Thus, our final sample size was 421. However, due to the total population being only 610 in selected hospitals, which is not enough to apply the sampling technique, the final sample size was adjusted to 610.

For the qualitative portion of the study, a total of 10 key informants were interviewed until data saturation was reached. These informants included a diverse group of professionals: one head of the nursing department, one head of the midwifery department, one focal person from the IPV center, three senior staff members from the IPV center, one psychiatric nurse, one medical director, one chief executive officer, and one senior physician. Interviews continued until no new significant insights emerged, ensuring a thorough understanding of the subject matter.

2.5. Sampling Techniques

Systematic random sampling was initially planned using a selection of five public hospitals from the Gurage zone. However, there were only 610 healthcare providers across the selected units, which proved insufficient for applying the

sampling technique. As a result, all 610 healthcare workers were included in the study.

For the qualitative study, a purposive sampling technique based on rich information was applied, and in-depth interviews with 10 key informants. These individuals are chosen for their expert knowledge, extensive experience, or specialized expertise, ensuring they offer valuable perspectives. Moreover, key informants also provide access to hidden information, such as personal experiences or behind-the-scenes insights, and their relevance to the research objectives ensures their input aligns with the study's goals. Their ability to provide in-depth answers on complex issues makes their contribution invaluable for enhancing the depth and reliability of the research findings.

2.6. Data Collection Tool and Measurement

An anonymous self-administered structured questionnaire was distributed to participants who met the inclusion criteria. This questionnaire was adapted from the Physician's Readiness to

Manage Intimate Partner Violence Survey (PREMIS) (Short et al., 2006). The PREMIS tool includes the following sections:

The PREMIS tool evaluates multiple aspects of IPV management through various sections. Perceived Readiness comprises nine items assessing respondents' preparedness on a seven-point Likert scale from "not prepared" to "very well prepared," with scores summed and averaged. Perceived Knowledge includes 12 items gauging respondents' knowledge of IPV, rated from "nothing" to "very much," and scores are aggregated. Attitudes toward IPV management are measured through 12 items on a four-point Likert scale from "strongly disagree" to "strongly agree," with higher scores indicating more positive attitudes, and scores are summed. The Practice section includes 11 items, plus an additional 15 items within the last two, rated on a five-point Likert scale from "never" to "always," to assess current IPV management practices, with scores summed to reflect practice levels.

The tool demonstrates high internal consistency, with Cronbach's alpha values of 0.963 for perceived knowledge, 0.959 for perceived preparedness, and over 0.65 for attitudes, indicating strong reliability (Short et al., 2006). It has also been validated in diverse settings, including Ethiopia (Alem et al., 2015; Ambikile et al., 2020c; Olaleye Atinuke et al., 2015).

For the qualitative component, in-depth interviews were conducted with key informants to explore barriers and enablers in IPV management, using a structured open-ended questionnaire adapted from relevant literature (Gashaw et al., 2019).

2.7. Data Collection Procedure

Data collection involved a structured approach for both quantitative and qualitative components. Two midwives from each hospital were trained

for three days by the investigators. This training focused on the administration of the self-administered structured questionnaires and emphasized understanding the questions, obtaining informed consent, ensuring confidentiality, and maintaining data quality. Supervision was provided to monitor the data collection process.

For the qualitative aspect, the investigators conducted in-depth interviews. These interviews were guided by a structured open-ended questionnaire, initially prepared in English, then translated into Amharic and interviews were held in Amharic at the department head offices in each hospital. All interviews were recorded and transcribed for analysis.

2.8. Study Variables

Independent variable: the main outcome variable for this study is the perceived readiness of healthcare providers to manage IPV.

Independent variables: variables included in this group were sex, age, religion, marital status, profession, education level, work experience, department, received IPV training, perceived knowledge about IPV, attitudes towards IPV management, concerns about legal aspects of IPV management, familiarity with institutional policies, availability of protocols, referral networks, and availability of private spaces for IPV management.

2.9. Term Definitions

Intimate Partner Violence (IPV) is defined as physical, sexual, or psychological violence by a partner, such as a boyfriend, cohabitant, or husband.

Perceived knowledge refers to how healthcare providers feel about their understanding of IPV, with "good knowledge" being a score greater than or equal to the median for IPV-related

knowledge questions, and "poor knowledge" being a score below the median.

Attitude represents the beliefs or opinions of providers on IPV management, with a "favorable attitude" being a score above the median for attitude-related questions, and an "unfavorable attitude" being a score below the median.

Practice refers to providers' skills in managing IPV, assessed by 11 items on their care practices and clinic environment.

Perceived readiness indicates how prepared providers feel to manage IPV, measured by the mean score of nine items.

2.10. Data Quality Control

The PREMIS tool was validated, and a pretest involving 5% of the total sample (31 participants) was conducted at Worabe Comprehensive Specialized Hospital. Adjustments were made based on the pretest results. Data collectors received three days of training to ensure accurate data collection, which included understanding the questionnaire, obtaining consent, maintaining confidentiality, and ensuring quality. Supervisors monitored the data collection process to ensure adherence to protocols.

For qualitative data, the structured open-ended questions were carefully translated into Amharic and then back into English to check for consistency. Interviews were recorded, and comprehensive notes were taken. Data analysis involved peer debriefing, member checking, and prolonged engagement with the data. All recorded interviews were transcribed and analyzed manually using content analysis in Microsoft Word.

2.11. Data Processing and Analysis

Data were entered into Epi-data version 4.6 and then exported to SPSS version 25 for analysis. Descriptive statistics, including frequency,

percentage, mean, and standard deviation, were used to summarize socio-demographic characteristics. Continuous variables related to perceived knowledge, attitude, and practice were presented using tables and graphs.

Regression analyses were conducted to identify significant associations. Linear regression assumptions, including linearity, multivariate normality, homoscedasticity, and multicollinearity, were verified. Variables with a $p\text{-value} \leq 0.25$ in simple regression were considered for multivariable analysis, with statistical significance set at $p \leq 0.05$. Unstandardized β and 95% confidence intervals assessed the strength of associations.

For qualitative data analysis, audio recordings were transcribed into text with a focus on accuracy to preserve the richness of the information. The transcriptions were reviewed alongside notes taken during data collection to identify and address any errors or inconsistencies, and the data were then organized thematically. A thorough familiarization with the data was undertaken to understand its context and to note initial impressions, patterns, and emerging themes.

Open coding was performed by labeling meaningful segments of text, followed by axial coding to group related codes into categories or sub-themes, and finally, selective coding to identify core themes. The coded segments were then used to develop main themes aligned with the research objectives, which were compared with quantitative findings to provide additional depth and identify alignments or contrasts.

The interpretation process involved analyzing the themes within the study's context and integrating the qualitative findings with quantitative data to construct a cohesive narrative. To ensure accuracy and robustness, validation techniques such as member checking or triangulation were

employed. The findings were presented in a narrative format, including participant quotes, and integrated with quantitative results to provide a comprehensive perspective. Throughout the process, reflexivity was practiced to reflect on potential biases and assumptions, maintaining the validity and trustworthiness of the analysis.

3. Results

3.1. Socio-Demographic Characteristics of the Study Participant

A total of 605 healthcare providers participated in this study, resulting in a response rate of

99.2%. Among them, 50.6% were male, 40.3% were Orthodox Christians, and 48.8% were married. The average age was 31.03 years, with 51.7% aged 30-39. Nurses were the largest group at 44.5%, followed by 30.6% midwives. Most respondents (79.2%) had a bachelor's degree, and 64.3% had 0.5–5 years of clinical experience. Only 14.0% had received training in IPV management (Table 2).

Table 2: Socio-demographic characteristics of respondents in public hospitals of the Gurage zone, SNNPR, Ethiopia, 2023

Variables	Category	Frequency	Percentage
Sex	Male	306	50.6
	Female	299	49.4
Age in year	20-29	251	41.5
	30-39	313	51.7
	≥40	41	6.8
Religion	Orthodox	244	40.3
	Muslim	183	30.2
	Protestant	98	16.2
	Catholic	80	13.2
Marital status	Single	268	44.3
	Married	295	48.8
	Divorced	42	6.9
Profession	General practitioner	43	7.1
	Public health officer	108	17.9
	Midwife	185	30.6
	Nurse	269	44.5
Educational level	MSc	48	7.9
	BSc	479	79.2
	Diploma	78	12.9
Work experiences in years	0.5-5	389	64.3
	6-10	177	29.3
	11-15	33	5.5
	>15	6	1.0
Working department	MCH	148	24.5
	Emergency	73	12.1
	Family planning	44	7.3
	EPI	27	4.5
	OPD	146	24.1
	IPD	167	27.6
Received IPV training	No	520	86.0
	Yes	85	14.0

3.2. Perceived Knowledge of the Respondents in Managing IPV

The perceived knowledge section assesses respondents' understanding of 12 items related to IPV management activities using a 7-point Likert scale. For descriptive purposes, the 7-point Likert scale was grouped into four categories: Nothing, Little (combining "very little" and "a little"), Moderate amount (combining "moderate amount" and "a fair amount"), and Very much (combining "quite a bit" and "very much"). Among the 605 respondents, 220 (36.4%) had

little knowledge about the legal reporting requirements for IPV, and 204 (33.7%) had little knowledge about their role in detecting IPV. Additionally, 137 respondents (22.6%) did not know the signs and symptoms of IPV, while 141 respondents (23.3%) lacked an understanding of the reasons why IPV victims might not disclose their experiences (Figure 1). Overall, 287 respondents (47.4%) demonstrated poor knowledge, while 318 respondents (52.6%) exhibited good knowledge in this study.

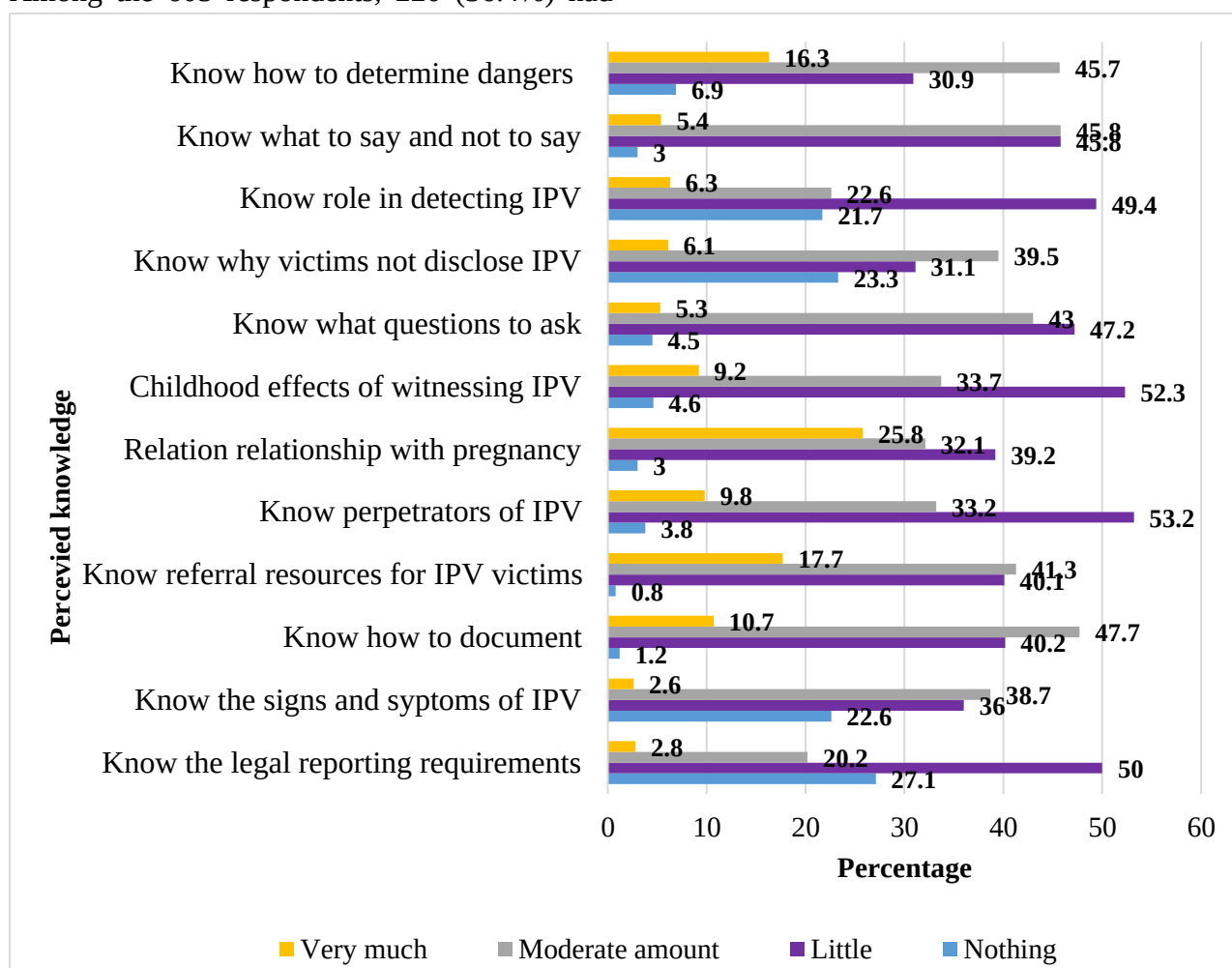


Figure 1: Perceived knowledge of respondents for IPV management in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

3.3. Attitudes of the respondents in managing IPV

The statements assessing positive attitudes toward managing IPV measured the respondents' perspectives. About 56.4% of respondents agreed that they should inquire about IPV, while only 37 participants stated they were comfortable

discussing the topic with their patients. Additionally, more than two-thirds (68.1%) of respondents disagreed that their workplace encouraged them to respond to IPV. The majority (68.4%) of respondents reported insufficient private space available to provide care for IPV victims. Approximately 76.8% of respondents

disagreed with the notion that women are responsible for the violence if they stay after repeated episodes of abuse (see Table 3). Overall, 287 respondents (47.4%) demonstrated poor knowledge, while 318 respondents (52.6%) exhibited good knowledge. In summary, out of

the total respondents, 251 individuals (41.5%) demonstrated an unfavorable attitude towards managing intimate partner violence (IPV), while 354 individuals (58.5%) displayed a favorable attitude.

Table 3: Attitude of respondents towards managing IPV in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Response			
	Strongly disagree (%)	Disagree (%)	Agree (%)	Strongly agree (%)
Responsibility for asking patients about IPV	8.6	35	45.5	10.9
I feel comfortable discussing IPV with my patients	11.6	51.4	33.2	3.8
Victims have the right to make their own decisions	6.3	27.3	45.6	20.8
My workplace encourages me to respond to IPV	10.2	57.9	29.3	2.6
There is adequate private space for me to provide care	15.7	52.7	27.9	3.6
I can gather the necessary information to identify IPV	16.7	56	23	4.3
I can match therapeutic interventions to IPV patients' readiness to change	10.2	56.7	27.6	5.5
I can make appropriate referrals to IPV victims for services	3.5	30.7	51.1	14.7
Victims can leave the relationship if they want	8.3	32.2	30.2	29.3
Victims often have valid reasons for remaining in an abusive relationship	6	47.1	41.5	5.5
If patients refuse to discuss abuse, only treat injuries	4	38.2	36	21.8
If victims remain in a relationship after repeated violence, they must accept the responsibility	35.5	41.3	17.5	5.6

3.4. Practice of Respondents in Managing IPV

The practice of the respondents was assessed using 15 items, designed to measure how frequently they perform certain tasks. In this report, 150 respondents (35.4%) indicated that they almost always inquire about intimate partner violence (IPV) when encountering a patient with an injury, and 127 respondents (30.0%) reported doing the same for patients presenting with depression. A majority of respondents, 130 (30.7%), consistently documented patient

statements accurately. Regarding the use of body maps to record patient injuries, 145 respondents (34.2%) reported never using them. Similarly, 185 respondents (43.6%) indicated that they never photographed the victim's injuries for documentation purposes. Approximately 127 respondents (30.0%) reported almost always providing victims with validating or supportive statements, while 147 respondents (34.7%) stated that they almost always provided victims with referral and/or resource details (see Table 4).

Table 4: Practice of respondents in managing IPV in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Response				
	Never No (%)	Seldom No (%)	Sometimes No (%)	Nearly always No (%)	Always No (%)
Asked about the possibilities of IPV when seeing patients with injuries	22 (3.6%)	144 (23.8%)	252 (41.7%)	129 (21.3%)	58 (9.6%)
Asked about the possibilities of IPV when seeing patients with chronic pelvic pain	45 (7.4%)	131 (21.7%)	237 (39.2%)	144 (23.8%)	48 (7.9%)
Asked about the possibilities of IPV when seeing patients with irritable bowel syndrome	31 (5.1%)	162 (26.8%)	224 (37.0%)	112 (18.5%)	76 (12.6%)
Asked about the possibilities of IPV when seeing patients with headache	49 (8.1%)	183 (30.2%)	199 (32.9%)	128 (21.2%)	46 (7.6%)
Asked about the possibilities of IPV when seeing patients with depression/ anxiety	27 (4.5%)	130 (21.5%)	276 (45.6%)	91 (15.0%)	81 (13.4%)
Asked about the possibilities of IPV when seeing patients with eating disorder	22 (3.6%)	140 (23.1%)	284 (46.9%)	90 (14.9%)	69 (11.4%)
How often have you documented patients' statements of IPV?	50 (8.3%)	163 (26.9%)	193 (31.9%)	95 (15.7%)	15.7 (82.8%)
How often have you used a body map to document patient injuries?	59 (9.7%)	133 (22.0%)	228 (37.7%)	125 (20.7%)	60 (9.9%)
How often have you photographed the victim's injuries?	155 (25.6%)	392 (64.8%)	58 (9.6%)	0	0
How often have you notified appropriate authorities when mandated?	50 (8.3%)	154 (25.5%)	204 (33.7%)	139 (23.0%)	58 (9.6%)
How often have you conducted a safety assessment for victims?	56 (9.3%)	163 (26.9%)	193 (31.9%)	95 (15.7%)	98 (16.2%)
How often have you helped IPV victims develop a safety plan?	61 (10.1%)	145 (24.0%)	222 (36.7%)	99 (16.4%)	78 (12.9%)
How often have you offered validating statements?	26 (7.1%)	180 (29.8%)	198 (32.7%)	114 (18.8%)	70 (11.6%)
How often have you provided basic information about IPV?	34 (5.6%)	174 (28.8%)	196 (32.4%)	124 (20.5%)	77 (12.7%)
How often have you provided referral information?	58 (9.6%)	123 (20.3%)	242 (40.0%)	118 (19.5%)	64 (10.6%)

3.5. Healthcare Providers' Perceived Readiness in Managing IPV

Nine items, each rated on a 7-point Likert scale, were used to assess healthcare providers' perceived readiness to manage IPV. The mean score was calculated by summing all individual scores, with potential scores ranging from 9 to 63.

The mean perceived readiness score for managing IPV was 26.4 ± 7.5 (95% CI: 25.8 to

27.0), with a range of 46. Among the individual items, the assessment of IPV victims' readiness to change had the highest mean score (3.51), followed by the mean score of 3.44 for identifying IPV indicators based on patient history and physical examination. In contrast, the item with the lowest mean score was fulfilling state reporting requirements for IPV, with a mean score of 2.08. The mean of all individual item mean scores was 2.93 (Figure 2).

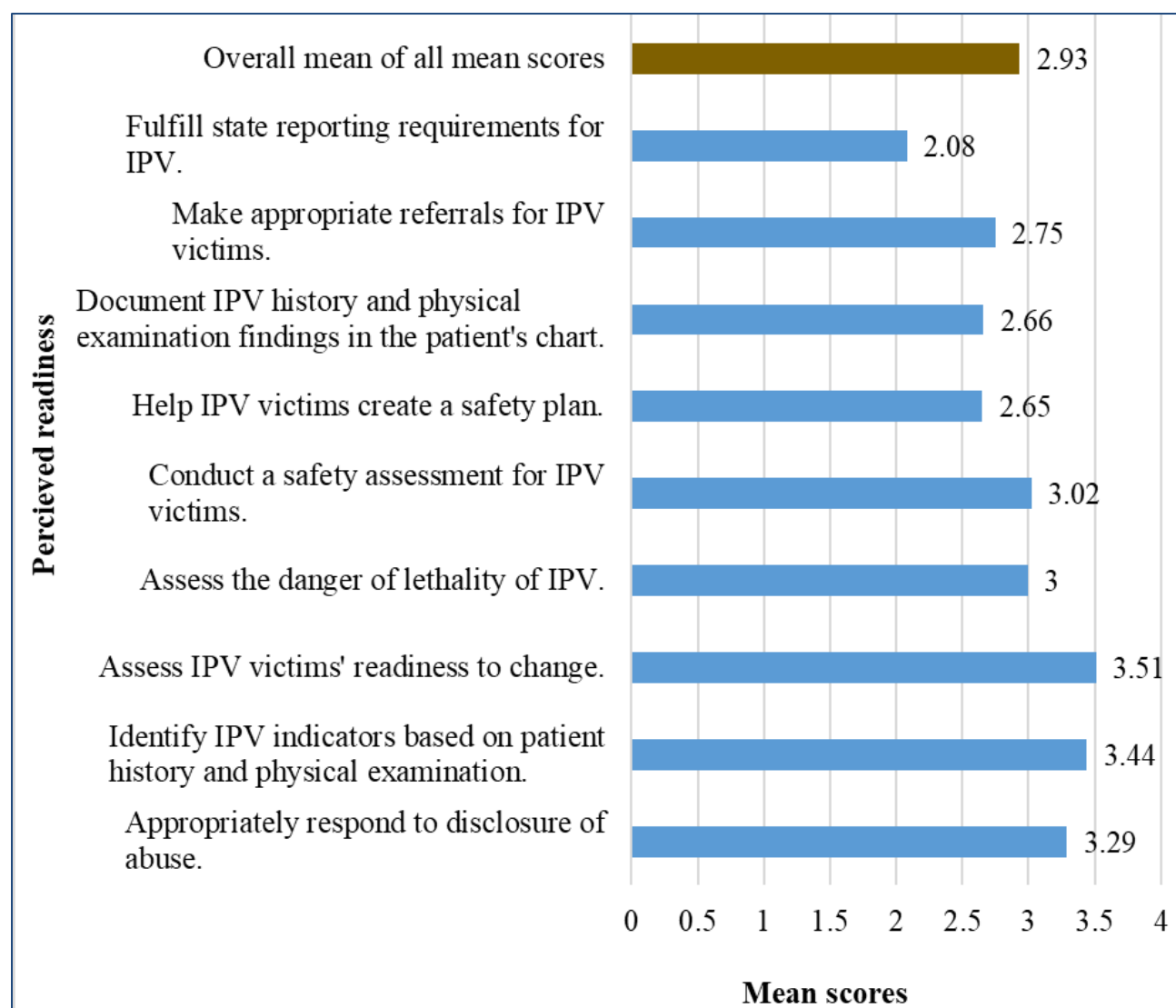


Figure 2: Perceived readiness of respondents in managing IPV in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

3.6. Factors Affecting Respondents'

Perceived Readiness in Managing IPV

Before conducting the regression analysis, we confirmed that the assumptions of linear regression were met. Normality was assessed using histograms and plots. Linearity and homoscedasticity were evaluated through scatter plots, and multicollinearity was examined using the variance inflation factor (VIF). Since all the assumptions were satisfied, linear regression analysis was performed.

3.7. Socio-Demographic Related Factors for Readiness in Managing IPV

A bivariable analysis was conducted to assess the significance of each socio-demographic variable with respondents' perceived readiness to manage IPV. Religion, working department, profession, and level of education showed significant associations with the outcome variable. However, sex and marital status did not exhibit a significant association with the outcome variable (Table 5).

Table 5: Simple linear regression analysis for Sociodemographic barriers to provider's readiness in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Categories	Unstandardized β	P-value	95% CI of β
Sex	Male	1		
	Female	-0.14	0.82	-1.35, 1.10
Age		0.11	0.11	-0.23, 0.24
Religion	Orthodox	1		
	Muslim	-1.49	0.04	-2.93, -0.06
	Protestant	2.15	0.02	0.399, 3.91
	Catholic	-0.15	0.88	-2.035, 1.74
Marital status	Married	1		
	Single	0.105	0.87	-1.15, 1.36
	Divorced	1.310	0.29	-1.14, 3.76
Work experiences		0.04	0.69	-0.16, 0.24
Working department	MCH	1		
	Emergency	-2.49	0.02	-4.58, -0.39
	Family planning	-1.76	0.17	-4.28, 0.76
	OPD	0.06	0.94	-1.65, 1.77
	EPI	-4.6	0.003	-7.67, -1.53
	IPD	0.18	0.83	-1.47, 1.84
Profession	Midwife	1		
	General practitioner	-0.39	0.75	-2.8, 2.02
	Public health officer	-1.86	0.03	-3.53, -0.19
	Nurse	-2.66	0.000	-4.07, -1.26
Level of education	BSc	1		
	MSc	0.07	0.95	-2.16, 2.3
	Diploma	-2.88	0.002	-4.68, -1.08

3.8. Healthcare Provider-Related Factors for Readiness in Managing IPV

In simple linear regression, IPV training, reporting IPV if mandated, familiarity with institutional policies, adequate knowledge about IPV referral resources, perceived knowledge of

providers in managing IPV, attitude towards IPV management, and practice of IPV management all showed significance with providers' perceived readiness to manage IPV (Table 6).

Table 6: Simple linear regression analysis for health providers related barriers to providers in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Categories	Unstandardized β	P-value	95% CI of β
IPV lost attention due to fear of legal aspects	No	1		
	Yes	-0.19	0.75	-1.4, 1.01
Trained about IPV	No	1		
	Yes	7.41	0.000	5.78, 9.04
Report legally if mandated.	No	1		
	Yes	2.75	0.000	1.43, 4.06
Familiar with the institution's policies	No	1		
	Yes	3.43	0.000	1.88, 4.98
Have adequate knowledge about referral resources.	No	1		
	Yes	2.36	0.000	1.09, 3.63
Perceived knowledge about IPV management		0.33	0.000	0.27, 0.39
Attitude toward IPV management		0.56	0.000	0.45, 0.70
Practice of IPV management		0.41	0.000	0.36, 0.47

3.9. Health Facilities Related Factors to Perceived Readiness in Managing IPV

Similarly, bivariable analysis was conducted to assess the significance of the association between health facility-related factors and the outcome variable. The availability of a protocol for

handling IPV in practical areas, the presence of a camera, IPV education materials, adequate referral resources, and private space for management all showed statistical significance with providers' perceived readiness to manage IPV (Table 7).

Table 7: Simple linear regression analysis for institutions related barriers to perceived readiness in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Categories	Unstandardized β	P-value	95% CI of β
Presence of protocol	No	1		
	Yes	1.57	0.000	0.82, 2.32
Presence of camera	No	1		
	Yes	11.88	0.000	6.69, 17.08
Presence of IPV education materials	No	1		
	Yes	1.46	0.000	0.75, 2.17
Presence of adequate referral resources	No	1		
	Yes	1.98	0.004	0.62 3.33
Presence of private space	No	1		
	Yes	2.02	0.002	0.73, 3.31

3.10. Factors Associated with Provider's Perceived Readiness in Managing IPV

Multiple linear regression analysis was performed to determine the effect of independent variables on providers' perceived readiness to manage intimate partner violence (IPV). Variables with a p-value < 0.25 and considered important by the researcher were included in the

final regression model. Consequently, received IPV training, perceived knowledge, availability of protocols for dealing with IPV, attitude towards IPV management and presence of private rooms were identified as significant factors influencing perceived provider readiness to manage IPV.

In this study, when all other variables in the model were held constant, received IPV training showed a significant association with the dependent variable. Specifically, the perceived readiness score of healthcare providers who received IPV training increased by 5.72 ($p < 0.001$; 95% CI of β : 4.23, 7.21). The results of this study indicated that having a protocol for managing intimate partner violence (IPV) in institutions was significantly associated with the dependent variable. Specifically, the presence of such a protocol increased providers' perceived readiness score by 3.18 ($p < 0.00$; 95% CI of β : 0.86, 54.9) while controlling for other variables in the model.

Providers who felt knowledgeable about IPV management had an increased perceived readiness score of 0.19 ($p < 0.001$; 95% CI of β : 0.13, 0.25) while holding all other variables in the model constant. Similarly, provider attitude was significantly associated with the outcome variable. Controlling for the effects of other variables in the model, healthcare providers with a positive attitude towards IPV management had an increased perceived readiness score of 0.24 ($p < 0.001$; 95% CI of β : -2.52, 0.01). The presence of such a private room for IPV management increased providers' perceived readiness score by 3.43 ($p < 0.001$; 95% CI of β : 1.88, 4.98) while controlling for other variables in the model. (Table 8).

Table 8: Multiple linear regression analysis for factors in managing IPV in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Variables	Categories	Unstandardized β	P-value	95% CI of β
Religion	Orthodox	1		
	Protestant	0.48	0.059	-0.02, 0.97
Level of education	BSc	1		
	Diploma	-0.50	0.65	-2.61, 1.62
Trained about IPV	No	1		
	Yes	5.72	.000	4.23, 7.21
Report IPV where it is legally mandated	No	1		
	Yes	-0.77	0.169	-1.88, 0.33
Perceived knowledge about IPV management		0.19	.000	0.13, 0.25
Attitude toward IPV management		0.24	.001	0.10, 0.38
Practice of IPV management		0.34	.052	-2.52, 0.01
Presence of IPV education resources	No	1		
	Yes	-1.02	0.12	-2.31, 0.27
Presences of adequate IPV referral resources	No	1		
	Yes	1.63	0.082	-3.48, 0.21
Availability of protocol for dealing with IPV	No	1		
	Yes	3.18	0.000	0.86, 5.49
Presence of private rooms	No	1		
	Yes	3.43	0.000	1.88, 4.98

3.11. Findings of Qualitative Study

3.11.1. Background information

Ten key personnel were selected and interviewed to explore enablers and barriers to healthcare providers' readiness for IPV management readiness and care provision. Seven head departments and three senior staff at the IPV center participated in this study until saturation of data was reached.

3.11.2. Barriers to the readiness of healthcare providers for IPV management

A framework (Table 9) was developed using the inductive themes emerging from the study. The framework has codes, sub-themes, and one theme. The sub-themes that emerged from the analysis were: self-related barriers, health facility-related barriers, and patient-related barriers.

3.11.3. Healthcare provider-related barriers

One barrier to healthcare providers' low readiness to manage intimate partner violence (IPV) is attributed to their poor attitude toward its management. This poor attitude is partly due to the perception that addressing IPV is not their responsibility, but rather a legal issue or something better handled by psychologists. As one 30-year-old informant stated "... we healthcare professionals did not give adequate concern to IPV because we thought it was more of a legal issue. Rather, we only treat the physical/medical problems the woman presents with."

The sensitive nature of intimate partner violence (IPV), which may be managed by the individuals themselves or with the help of close relatives, can lead to a poor attitude toward IPV management. A 34-year-old respondent reported "... this issue is very sensitive. I think, this is not our duty but rather that of the police officers or courts because it is a legal issue. ... IPV should be managed by the negotiation of the individuals, or close relatives to limit the interference of third parties

to save their relationship. However, for psychological injuries, clinical psychologists should be required in health facilities." Another 30-year-old informant also stated, "Actually, due to its sensitivity, we did not ask why they did not disclose the abuse."

Healthcare providers often fail to document cases of intimate partner violence (IPV) in special circumstances due to negligence. A 27-year-old respondent expressed this concern "...we only treat the injury like any other medical or surgical case, but documentation with a map is not practiced in our health facility due to not being sensitive to the issue."

Poor knowledge about intimate partner violence (IPV) and its management has repeatedly been mentioned as a barrier to effective IPV intervention. A 33-year-old key respondent also stated, "Firstly, to be honest, all healthcare professionals in this healthcare facility had no full information about intimate partner violence. Hmmm... even we do not know the definition itself. Due to this, we did not link the patients to anywhere. Another 36-year-old respondent stated, "... I do not believe that none of us have even a little knowledge about IPV. If we do not have adequate knowledge regarding the issue, we cannot provide the needed care."

The lack of training on IPV and its management hinders healthcare providers' ability to effectively care for IPV victims. A 34-year-old respondent stated, "... if we receive at least in-service training regarding IPV, we can try to provide holistic treatment for the victims, because we do not know more about how to care for the victims, whom to link them with, and we do not even consider it our responsibility." Another 32-year-old respondent stated that Some of us have also received special training on how to manage IPV. However, the main problem is the victims' unwillingness to discuss the issue." The sensitivity and fear of legal consequences

also limit healthcare providers' ability to fully manage cases of intimate partner violence (IPV). A 33-year-old key respondent stated..." Such cases are very sensitive because they bring legal aspects into consideration."

3.11.4. Health facility-related barriers

Nearly all respondents reported that their healthcare facility lacked the necessary resources and guidelines for managing IPV. One respondent, a 36-year-old, shared the following insight, "How can we provide adequate care unless the institution itself takes responsibility by fulfilling the necessary materials like clear guidelines and protocols."

Healthcare facilities lacked emphasis on the management of intimate partner violence (IPV), follow-up care, and the encouragement to address IPV effectively. They also demonstrated limited readiness to manage such cases. A 28-year-old respondent stated, "How do we manage IPV without the institution itself emphasizing IPV management and encouraging of staff motive? If someone wants to address this issue, we are not informed about how to manage it, especially whom to link these abused patients with."

The lack of adequate referral resources and the absence of effective linkage between health facilities and third parties, such as gender offices, law enforcement, and legal bodies, was repeatedly reported by key informants. A 36-year-old respondent revealed, "How can we be ready and provide care unless the institution itself takes its responsibility by providing necessary materials such as guidelines, referral materials, private rooms, and form legal linkages to other institutions like gender office, policeman and responsible legal bodies to manage IPV victims?" Another 28-year-old respondent also reported, "To manage such sensitive and complex issues, specific guidelines and resources

are needed on how to handle it. However, health facilities or the responsible bodies have not fulfilled these. Moreover, health facilities should have legal linkages with policemen, courts, or any social/women's affairs departments".

It is well known that IPV cases are managed with a high level of privacy and confidentiality. However, many key respondents reported that the lack of adequate private rooms hinders their ability to properly address and manage IPV cases. A 34-year-old respondent stated, "By the way, this topic is very sensitive according to our community norms, so it requires strict privacy. However, we do not have any separate rooms to manage and communicate in detail." In contrast, only one of the respondents stated, "In our institution, we have adequate and separate rooms for managing IPV (32-year-old respondent).

3.11.5. Patient-related barriers

It has been reported that victims of intimate partner violence (IPV) often conceal the root causes of the violence and the methods to address it because they do not believe they can find a solution through healthcare providers. A 30-year-old informant stated, "Sometimes, they even lie. For example, let me tell you one example: a woman injured by her husband comes to the outpatient department and complains that she had fallen in the hall and injured her hand. I believe they lack confidence in finding a solution for their abuse. In our community, it is commonly believed that marital conflicts should remain private, rather than being exposed to third parties. This approach is intended to either prevent repeated abuses or to preserve the marriage. Another 32-year-old respondent stated that "... the main problem is the victims' unwillingness to discuss the issue in addition to our poor attitude towards IPV management and readiness to manage it."

Table 9: Framework for barriers in managing IPV among healthcare providers in public hospitals of the Gurage zone, SNNPR, Ethiopia 2023

Theme	Sub-themes	Codes
Barriers to IPV management readiness and care provision	Self-related barriers	Attitude towards IPV management
		Knowledge about IPV management
		Having trained in IPV management
		Fear of legal issues
	Health facility-related barriers	Lack of guidelines
		Lack of encouragement
		Lack of referral resources
		Lack of private rooms
	Patient-related barriers	Hiding the case to discuss

4. Discussion

The present study examined the average perceived readiness score for managing IPV, which was determined based on nine items. Interestingly, individual item measures showed lower mean scores on average, potentially contributing to the overall low mean perceived readiness score. Notably, the item evaluating victims' readiness to change had a higher mean score compared to other items, whereas fulfilling state reporting requirements for IPV had a lower mean score. This underscores the fact that while providers can administer medical treatment for victims' injuries, they remain ill-prepared to address IPV.

The mean score for each item in our study was lower compared to previous studies conducted in Saudi Arabia and the United States, where scores were 3.10 and 4.98, respectively (Alhalal, 2020; Renner et al., 2021). This could stem from unequal healthcare focus on violence. Establishing an IPV screening program served as fundamental evidence for this, offering a chance to enhance healthcare providers' confidence in managing IPV alongside early identification and intervention for IPV victims. However, this finding is in line with a study conducted in Sidam region, Ethiopia. (Teshome et al., 2023).

The study findings underscored that most healthcare professionals lacked IPV-related in-service training, with only 14% having received it. Nevertheless, the World Health Organization

stresses the significance of healthcare professionals being equipped to respond to and identify psychological and physical health signs linked to violence, as well as how to inquire about violence in the presence of victims (García-Moreno et al., 2015). Similarly, research has demonstrated the significance of training in improving a provider's preparedness to address and handle IPV (Hegarty et al., 2020). Training programs typically cover crucial areas such as recognizing when and how to inquire about violence, engaging in discussions about violence with victims who disclose it, offering initial psychological support, promoting safety measures for IPV victims, and enhancing identification and reporting of violence through improved documentation, as well as referring victims to appropriate resources (Kalra et al., 2021). This content was directly related to items used to measure the perceived readiness of providers in managing IPV, which positively influences the proper identification and response to IPV. A study conducted in Greece confirmed that training has a significant effect on providers' perceived preparedness in managing IPV (Papadakaki et al., 2013). Furthermore, the findings of this study unveiled a significant association between training and perceived readiness in managing IPV ($P < 0.001$). The absence of in-service IPV training decreased providers' perceived readiness scores in managing IPV. The lack of IPV training is also a concern highlighted in the qualitative findings. A 34-year-old respondent expressed, "If we receive

at least in-service training regarding IPV, we can attempt to provide holistic treatment for the victims, as we lack knowledge about how to care for them and whom to link them with. We even do not consider it our responsibility." The findings emphasize that in-service IPV training was the primary method of preparing healthcare providers to assist IPV victims. This finding correlates with previous studies linking training to improved IPV identification in healthcare settings. Training was associated with higher perceived preparation scores and more active IPV identification ($p < 0.001$) (Renner et al., 2021). Similarly, providers lacking IPV training showed a lower level of preparedness for managing IPV (Alvarez et al., 2018). Furthermore, the findings suggest training needs that are relevant to all providers, and providing training for healthcare providers on how to respond to IPV should be a central component of interventions to help them feel well-prepared to manage IPV. This aligns with a study conducted in Australia, where training made students feel more knowledgeable and prepared for IPV management (John et al., 2010). A Tanzanian study also agreed that a lack of IPV training experience affected perceived preparedness for IPV care provision (Ambikile et al., 2020b). Additionally, a study in Ethiopia stated that nurses who had training were more ready to provide proper care for IPV victims (Alem et al., 2015).

The study results revealed that the majority (60%) of health providers reported that their institution did not have an IPV management protocol. Such a protocol guides providers on how to identify victims subjected to IPV, what type of questions to ask to identify IPV, what to do if victims do not disclose, providing physical care, creating a safety plan, offering psychological support, and recording IPV-related issues (Organization, 2020). This protocol helps providers build confidence and improve their perceived readiness in managing IPV.

Furthermore, the study findings showed that having a protocol in place to guide providers on IPV management had statistical significance with providers' readiness in managing IPV. A qualitative finding also emphasizes that the absence of protocols for IPV management made them not fully ready for IPV management. A 36-year-old respondent revealed, "How can we provide adequate referral resources unless the institution itself takes responsibility by fulfilling the necessary materials like guidelines, referral materials, private rooms, and linkages to other institutions to manage IPV victims?" Another 28-year-old respondent also reported, "To manage such sensitive and complex issues, specific guidelines and resources are needed on how to manage it. However, health facilities or the responsible bodies did not fulfill these. Not only these, but health facilities should also have a legal linkage with policemen, courts, or any social/women affairs departments." This implies the absence of protocols about IPV management in facilities has condensed providers' perceived readiness in managing IPV because, without protocols, the standard operating procedure for a victim was not effective. This finding is concurrent with a study conducted in the USA and a previously conducted systematic review (Alvarez et al., 2017; Renner et al., 2021). This may be attributed to the importance of standardized protocols in guiding service delivery and supporting the provision of safe, high-quality, respectful, and effective healthcare that is consistent across locations. The findings of this study also indicate that providers' perceived knowledge is associated with their perceived readiness. It is also noted that knowledge is the primary requirement for addressing IPV. A 36-year-old respondent stated, "I do not believe that any of us lack even a basic understanding of IPV. Obviously, if we possess adequate knowledge about the issue, we can provide the necessary care." Another respondent, aged 34, also remarked, "This issue

is highly sensitive; I believe it is not solely our responsibility but rather that of the police or the courts, as it is a legal matter. I lack comprehensive knowledge about the issue itself; my focus lies only in treating the injuries they endure. However, for psychological injuries, clinical psychologists should be available in healthcare facilities.”

This suggests that the perceived readiness of providers regarding the management of IPV victims was significantly predicted by their perceived knowledge level of the issue. The majority of respondents in this study scored low on items assessing their perceived knowledge of the identification and management of IPV. Furthermore, they reported being unaware of their role in detecting IPV. This implies that providers' feelings about IPV knowledge predominantly affected their perceived readiness to manage IPV. This finding is supported by a study conducted in Sweden, which found that obtaining knowledge independently increased providers' perceived readiness scores in managing IPV (Sundborg et al., 2012). Similarly, a Nigerian study supported this finding, indicating that perceived preparedness for IPV management was significantly affected by the level of perceived knowledge ($P < 0.001$) (Olaleye Atinuke et al., 2015). This could be attributed to the fact that perceived knowledge is the initial and prerequisite requirement for perceived readiness in managing IPV.

Likewise, respondents' attitudes were significantly associated with their perceived readiness to manage IPV. This study highlighted that providers were not comfortable discussing IPV. This could be due to either a lack of knowledge about IPV or a fear of its legal aspects. These findings suggest that the reasons why providers are not addressing IPV may include low confidence and lack of encouragement, potentially affecting their perceived readiness to manage IPV. This finding

is consistent with previous studies (Alhalal, 2020; Jones et al., 2018). This could be attributed to the awareness of one's attitudes, which plays an important role in shaping one's perceptions. Additionally, personal discomfort with the issue may influence a provider's perception of managing IPV, but this can be overcome through training.

The availability of private rooms for managing IPV victims was significantly associated with healthcare providers' readiness to manage IPV and provide care. The qualitative finding also revealed this report. A 34-year-old respondent stated, “By the way, this topic is very sensitive according to our community norms, so it requires strict privacy. However, we do not have any separate rooms to manage and communicate in detail.” This could be because private rooms enhance privacy and comfort, reduce stigma and fear, improve assessment and intervention, and facilitate better coordination of care. Overall, private rooms create a supportive environment that promotes better communication, safety, and care for IPV victims, thus increasing healthcare providers' readiness and ability to manage such cases effectively.

5. Conclusions

Intimate partner violence (IPV) is a public health problem that disproportionately affects women's health and well-being, with its effects well-documented in the literature. The findings of this study revealed that providers had limited perceived readiness to manage IPV, which is concerning as preparedness was found to be associated with the ability to identify women exposed to IPV.

Not undergoing IPV training, the presence of protocols in facilities dealing with IPV management, and the perceived knowledge and attitudes of healthcare providers towards IPV management were statistically significant associated variables that had a substantial impact

on a healthcare provider's perceived readiness in managing IPV.

6. Recommendations

Based on the study findings, several recommendations are proposed to improve the management of intimate partner violence (IPV). The Ministry of Health should develop and implement formal protocols for identifying and addressing IPV cases, while health facilities are encouraged to provide training programs to enhance the readiness of health providers in managing such cases. Health professionals must stay motivated and well-acquainted with institutional IPV management policies to ensure effective support for victims. Researchers are urged to conduct national studies to assess the readiness of providers in handling IPV. Furthermore, non-governmental organizations should collaborate with the Ministry of Health to deliver IPV-related training for healthcare providers.

Author's Contributions

Fentahun Tamene conceived the study and wrote the original draft of the manuscript. Fenathun Tamene and Megertu Obsa analyzed data and its interpretation. Mangistu Abera, Yibeltal Mesfin, Muche Argaw, Kassa Genetu, and all others reviewed the draft manuscript for intellectual content and participated in the revision. All authors read and approved the final version of the manuscript.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest concerning the research, authorship, and/or publication of this article.

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Data Sharing Statement

The data sets used in this study were available from the corresponding author when reasonably requested.

Ethical Consideration

The Institutional Ethical Review Committee of Wolkite University, College of Medicine and Health Sciences approved the study. Participants were informed about the study's objectives and provided written consent before completing the questionnaires. Confidentiality was maintained throughout, and participation was voluntary, with the option to withdraw at any time. Coding was used to eliminate names and other personal identification of respondents throughout the study process to ensure participants' confidentiality. Moreover, there are no invasive procedures in this study and it was conducted following the Declaration of Helsinki.

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