Perceptions of Nurses Working in Primary Health Centres on Factors Influencing Their Readiness to Manage Family Violence in Kaduna State, Nigeria

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Abstract

Background. Family violence (FV) is a serious public health issue in Nigeria and globally. Despite being a public health issue, there is no literature indicating that FV has ever been investigated in Sabon-Gari, Kaduna State, Nigeria.

Aim: This study aimed to assess nurses' perceptions of factors influencing their readiness to manage family violence.

Methods: A descriptive cross-sectional study design was employed to collect information from the respondents in the selected primary health care facilities of Sabon-Gari L.G.A, Kaduna state, Nigeria. The collected data were coded, entered, and analysed using SPSS software version 24. Twenty-four (24) registered nurses working in 24 different primary health care centres were purposively selected out of 31primary health care centres of Sabon-Gari local government of Kaduna State

Results: The majority of the nurses have a positive perception and high knowledge level on management of family violence victims (aggregate mean=3.4). The highest perception of the nurses was that nurses should be considered as the key figure in the management of family violence patients (mean value = 3.8), and the lowest perception of nurses was "nurses status within health care hierarchy (mean value = 2.9). The study also revealed a poor level of nurses' involvement in managing family violence victims (aggregate mean = 2.42).

Conclusion: The study concluded that despite having a positive perception and high knowledge level of management of family violence victims, nurses have a poor level of involvement in managing family violence victims.

Recommendations: It was recommended, among other things, that the government should empower healthcare providers to support victims of family violence beyond counselling and treatment of injuries, expand education and training opportunities about FV, and enforce mandatory reporting policies for nurses and other healthcare providers to involve law enforcement.

Keywords: *Knowledge, Perception, Family Violence, Nurses involvement, Primary Health Centre.*

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Background

Family violence (FV) is a significant public health issue worldwide. It is a leading yet preventable cause of ill health, disability and death, affecting one in three women worldwide (World Health Organization, WHO, 2017). FV is defined as an episode or a series of controlling behaviour, coercion and threats against people of 16 years and above by either current or past intimate partners and/or family members despite sexual orientation or gender (United Kingdom Home Office, 2013). Family violence is a global problem that is more prevalent among people of low socioeconomic values, especially where extended family members share the same personal space within a family home shared with extended family on the husband's side. FV can be practised by family members, and it is not limited to intimate partners only (Smithey & Thompson, 2022).

Violence is defined as behaviour involving force intended to hurt, damage, hurt, or kill someone (Miller & Roloff, 2014). It is the strength of emotion or an unpleasant destructive neutral force (Bunno and Onigata, 2022). Violence is an act carried out with the intention or perceived intention of physically hurting or harming another person". It can also be defined as the exercise of power to impose one's will on another person or have one's will dominate another person's life (Hibshman, 2021). When this violence comes with regard to gender relations, especially when directed against women, it becomes pervasive as it touches all aspects of women's lives, from home to the workplace (Eneroth et al., 2017).

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. Individuals exposed to violence require comprehensive and gender-sensitive healthcare services that address the physical and mental health consequences of such traumatic events (Colombini et al., 2017; Ogunlade et al., 2022).

Within the healthcare team, nurses are numerical in strength and strategic in interrogating sensitive issues like family violence during health facility visits (Jack et al., 2017). 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 (Allender et al., 2013). The contexts in which community health nurses operate create variations in the services that are suitable for family violence prevention, identification, screening, treatment, and interventions. 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(Miele, 2017). It also gives nurses insight into assessing and understanding the interpersonal relationships and patterns of family functioning with the possibility of identifying violence before it starts or escalates (Colombini et al., 2017; Ogunladeet al., 2022).

Family violence occurs in all countries, rich or poor, developed or developing, with no regard to caste, creed, colour, social status, wealth, urban or rural residence, or the ages of the victims and aggressors (Lynch and Logan, 2015). Sabon-Gari local government area of

Zaria is not an exception to the problem of family violence. Many people still consider family violence to be a private matter, and they believe that what happens in homes should stay in the home (Straus, Gelles, & Steinmetz, 2017). However, the increase in the reported cases does indicate that women are developing an awareness of their right to be free from violence (Asmani, 2023).

Researchers have long been interested in nurses' role in caring for women experiencing FV, but the issue has not been investigated in Sabon-Gari Zaria, Nigeria. 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 cultural dynamic dimension and guided by the professional ethics of nursing (World Health Organization, WHO 2017). There is a chance of over-involvement, which could be dysfunctional and have 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 to close the gap in planning appropriate interventions that could improve nurses' capacity to effectively identify victims of family violence and appropriately intervene within the Nigerian context.

Objectives of the Study

The main objective of the study was to assess nurses' perceptions of factors that influence their readiness to manage family violence. Specifically, the study assessed

1. the knowledge level of nurses working in primary healthcare settings on family violence?
2. nurses level of involvement in the management of family violence patients.

Methods and Materials

A descriptive cross-sectional study design method was employed to collect information from the respondents in the selected primary health care facilities of Sabon-Gari L.G.A, Kaduna state. This method allows the researcher to draw samples of the entire population, study it and generalize the findings on the entire population. The data were entered and analysed on SPSS 24.

Settings

Sabon-Gari local government area has 11 political wards, a secondary health facility, and 31 primary health care centres (Sabon-Gari local government secretariat, 2023). According to the Nigerian 2006 population census, Sabon-Gari had a population of 286,671 in itstwo (2) districts (Sabon-Gari and Basawa districts), which have 11 wards, some 235 settlements with the population of women within childbearing age(15-45years)put at 64,256 (Sufiyan et al., 2013). Considering that the 2006 Nigerian population census made an annual population growth projection of 2.5% for Nigeria, the population of Sabon-Gari in 2023 will be 408,506, and that of women of childbearing age will be 91,565. It is an urban local government area consisting of various ethnic groups, with Hausa as the predominant

group, others being Fulani, Nupe, Yoruba, Igbo, and Baju, among others. The majority of the Sabon-Gari population, mainly the Hausas, practices Islam, although Christianity is also widely practised.

Population

The participants in this study consisted of registered nurses working in the primary health centres situated within selected communities. The 31 primary health care centres (PHCs) of the Sabon-Gari local government had 24 registered nurses with work experience of one year and above. The breakdown is as follows: Abdu Kwari PHC - 3 nurses, Basawa PHC - 2 nurses, Chikagi PHC -2 nurses, Hanwa PHC -2 nurses, Hayin Dogo PHC -3 nurses, Jama'ah PHC- 2 nurses, Kwata PHC2 nurses, Madugu PHC-1nurse, Sakadadi PHC - 2 nurses, Samaru PHC- 1 nurse, Ungwa Jaba-2 nurses, and Zabi PHC - 2 nurses(Sabon-GariLocal Government Secretariat, 2023).

Sample and Sampling

Because the population is small, the 24 nurses working at the Department of Health in the Sabon-Gari local government area formed the population sample. The twenty-four (24) registered Nurses were chosen based on the census population determination, which stated that "a census is an attempt to collect data on every person in a population." Since data is sought for the entire population, the intended sample size is equal to the population.

Inclusion and Exclusion Criteria

The inclusion criteria for participants were registered Nurses who 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 practising as nurses.

Data Collection Instruments and Analysis

The data were collected using a questionnaire developed by the researcher based on the requisite of the study's objectives. The questionnaire was written in English, with clear instructions on how to fill it. Data was collected over an eight-week period between March and May 2023.The lead researcher collected the data by personally visiting the PHCs. Frequency distribution was used in data analysis, with knowledge levels presented in percentages, while Perception and Management were presented as Mean and Standard Deviation.

The four-point Likert scale employed for the decisional mean is itemised as follows: strongly agree (SA),Agree(A), strongly disagree (SD), and disagree (D). SA=4, A=3, SD=2, D=1. 4+3+2+1=10/4=2.5 average decisional mean. This implies that any mean value less than 2.5 is negative and any value greater than 2.5 is positive. The following mean limits and ranges were used to assess Nurses' perceptions of factors that influence their readiness in the management of family violence victims, Nurses' level of preparedness toward health care, and the level of Nurses' involvement in the management of family violence victims. They are listed below;

0-2.49 Poor perception/poor level of preparedness/poor level of involvement

2.5-2.9. Fair perception/Fair level of preparedness/Fair level of involvement

3.0-3.49. Good perception/Good level of preparedness/Good level of involvement
3.5-4. Very good perception/very good level of preparedness/very good level of involvement.
For the percentages, a simple percentage response was used to grade nurses' knowledge level of FV. The collected data were coded, entered, and analysed by using SPSS software version 24.
The mean gives an idea of the average response to each question, while the standard deviation indicates how much the responses vary from the mean. A higher standard deviation suggests more response variability, while a lower standard deviation suggests greater consistency.

Data variables, Sources of data, and Technique

Data variables were confined to only age, gender, ethnicity, marital status, level of education, area of practice, duration of practice, and professional qualification. Other variables that aided in data collection were nurses' knowledge of and perception of family violence victim management and the level of nurses' involvement in this area.

Ethical Considerations

An introductory letter from the Head of the Department of Nursing Science, Ahmadu Bello University, Zaria Nigeria, helped the researchers to secure ethical approval for the study from the Review Board of the Department of Health in the local government secretariat office and also from the coordinators and nurse managers of the selected primary health centres. Informed consent was sought from respondents after a thorough explanation of the intent and purposes of the study with assurance of their anonymity and the confidentiality of the information they availed. Their participation was informed, willful, and voluntary.

Results

Table 1. Sociodemographic data of the respondents.

Variables	Frequency (N = 24)	Percentages (%)
Age (in years)		
27-32	9	37.5
33-38	5	20.8
39 and above	10	41.7
Gender		
Male	2	8.3
Female	22	91.6
Ethnic group		
Hausa	12	50
Fulani	2	8.3
Igbo	1	4.2
Others tribes	9	37.5
Marital Status		
Married	24	100
Professional Qualification		
Basic nursing	16	66.67
Basic nursing and other specialty	2	8.33
Nurse-midwife	3	12.5
Bachelor of Nursing Science (BNSC)	3	12.5
Practice Area		
Outpatient Department (OPD)	12	50
Medical ward	5	20.8
Labour ward	7	29.2
Duration of Practice		
2 - 4 years	3	12.5
5 years and above	21	87.5

Table 1 above revealed that 37.5% of respondents are between the ages of 27 and 32, 20.83% are between the ages of 33 and 38, and 41.67% are over 39 years old. The result also showed that 22 (91.67%) are females, and 2 out of the respondents, or 8.3%, are males. In terms of tribe, the majority of the nurses are Hausa - 12 (50%). Others areFulani - 2 (8.3%), Igbo- 1

(4.2%), and other tribes - 9 (37.5%). Table 1 also showed that 100% of the respondents were married. Furthermore, Table 1 equally showed that 16 (66.67) of the respondents have Basic Nursing qualifications, 2 (8.33%) have Basic Nursing and other speciality qualifications, 3 (12.5%) have Nurse-Midwife qualifications, and 3 (12.5%) have Bachelor of Nursing Science (BNSC) degree. Finally, Table 1 showed that 12 (50%) of the respondents work in an OPD, 5 (20.8) work in a medical ward, and 7 (29.2%) work in a labour ward.

Table 2: Perception of Nurses on Management of Family Violence.

STATEMENTS	Mean	S.D
1.Victims' ability to disclose family violence	3.6	0.896
2. Practitioners ability to explore family violence cases	3.6	0.7021
3. Work or organisational support	3. 3	3. 3
4.Threat to personal safety	3.5	0.707
5.Having a commitment	3.1	1.4
6. Lack of knowledge	3.3	1.02
7. Heavy workload on nurses	3.4	0.77
8. Language barrier	3.0	0.978
9. Nurses' status within the healthcare hierarchy	2.9	1.13
10. Collaboration with other health team.	3.6	0.57
11. Lack of communication and collaboration between stakeholders within the healthcare system	3.2	0.55
12. Victims' inability to disclose family violence cases.	3.4	0.587
13. Ability to recognise family violence cases.	3.5	0. 31
14. Inability to recognise family violence	3.2	0.87
15. Acknowledging family violence as a health issue	3.6	0.236
16. Provision of private space to facilitate disclosure of family violence cases.	3.6	0.293
17. Provision of favourable space to address family violence.	3.3	0.7117
18. Nurses should be considered as a key element in the management of family violence patients in PHCs	3.8	0.41
19. There should be the maintenance of confidentiality in the management of family violence victims.	3.5	4.4
Aggregate mean	**3.4**	

Table 2 above showed an aggregate mean of 3.4, which implies that the general perception of nurses about the factors that influence their readiness in the management of family violence victims is good and positive. The highest perception of the nurses was that nurses should be considered as the key element in the management of family violence patients, with a mean value of 3.8, and the lowest perception of nurses was "nurses status within the healthcare hierarchy with a mean value of 2.9.

Table 3: Nurses' Knowledge Level of Family Violence

RESPONSES	Frequency (no)		Percentage (%)	
1. Nurses' understanding of family violence	**YES**	**NO**	**YES**	**NO**
i] FV is a form of conflict that happens betweenhusband and wife in a family relationship	9	15	37.5	62.5
ii] FV is when couples fight and maltreat each other due to argument, misunderstanding and deprivation.	2	22	8.3	91.7
iii] FV is a behaviour involving force intended to hurt, damage or kill someone. It is the strength of emotion or an unpleasant destructive neutral force.	13	11	54.2	45.8
1. Nurses' knowledgeof forms and types of family violence (FV). Which is a type of FV? i. Physical violence ii. Psychological or Emotional violence. iii. Sexual violence iv. Economic violence				
a] All of the above	18	6	75	25
b] i only	4	20	16.7	83.3
c] ii and iii only.	2	22	8.3	91.7
3. Nurses understanding of the causes of family violence				
a] Disobedient	22	2	91.7	8.3
b] Drug influence and alcohol use	23	1	95.8	4.2
c] Expression of suspicion of infidelity by a partner	22	2	91.7	8.3
d] Unemployment	22	2	91.7	8.3
e] Financial issue	24	0	100	0
f] Gender inequality	22	2	91.7	8.3
g] Cultural influence	22	2	91.7	8.3
h] Witnessing family violence during childhood	23	1	95.8	4.2
I] Religion	20	4	83.3	16.7
J] Poor communication and relationship	24	0	100	0
k] Low education level	23	1	95.8	4.2
l] Unplanned pregnancy	24	0	100	0
m] Young age	22	2	91.7	8.3
4. Nurses knowledge of the effects of family violence (FV)				
i.]Psychologicaleffects such as depression, low self -esteem and anxiety.	24	0	100	0
ii] Physical injuries such as bruises, broken bones, and worsening of chronic illnesses	24	0	100	0
iii] Obstetric problems such as miscarriage, stillbirth, pre -term birth, maternal depression and anxiety	24	0	100	0
iv] Fetal problems such as low birth weight,malnutrition, fetal injury	23	1	95.8	4.2
5. Nurses Knowledge of the w arning signs that a woman victim of FV in health facility may present with (i.e. the most evident sign)				
a] Chronic unexplained pain	3	21	12.5	87.5
b] Anxiety	15	9	62.5	37.5
c] Multiple injuries	3	21	12.5	87.5
d] Depression	3	21	12.5	87.5

Table 3 above revealed that Family violence is defined by the majority of nurses as "when couples fight and maltreat each other due to argument, misunderstanding and deprivation (91.7%). This was followed by the definition that it is"a form of conflict that happens between

husband and wife in a family relationship" (62.5 %). However, some nurses (45.8%) see FV as a behaviour involving force intended to hurt, damage or kill someone, a strength of emotion or an unpleasant destructive neutral force

While 25% of the nurses indicated that FV types or forms included Physical violence, Psychological or Emotional violence, Sexual violence, and Economic violence, the majority of the nurses (91.7%) indicated that FV types and forms included only Sexual violence and Economic violence. However, a considerable percentage of the nurses (83.3%) indicated that FV only involves Physical violence.

Furthermore, Nurses' understanding of the causes of family violence include disobedience (91.67%), drug and alcohol use (95.83%), expression of suspicion of infidelity by a partner (91.67%), unemployment (91.67%), gender inequality (91.67%), cultural influence (91.67%), witnessing family violence as a child (91.67%), religious factor (83.37%), low level of education (95.83%), and young age (91.67%). All the respondents (100%) alluded that unwanted pregnancy, poor communication skills, and financial problems were contributory causes of family violence.

Concerning Nurses' knowledge of the effects of family violence (FV), all the respondents, 24(100%), affirmed that psychological effects like depression, low self-esteem, and anxiety are consequential effects of FV. All the respondents equally affirmed that obstetric issues like miscarriage, stillbirth, and preterm birth are among the aftermath effects of family violence. Similarly, all the respondents (100%) also asserted that physical injuries such as bruises, broken bones, and the worsening of chronic illnesses are the consequential effects of family violence. However, 23 (95.8%) of the respondents acknowledged fetal issues like low birth weight and mental health issues as aftermath effects of family violence.

Table 3 also showed that the respondents further indicated that the top warning signs that a woman who has experienced family violence may exhibit in a primary healthcare facility, include anxiety (62.5%), chronic unexplained pain (12.5%), multiple injuries (12.5%), and depression (12.5%).

Table 4: Nurses' level of involvement in the management of family violence victims.

STATEMENTS	Mean	S.D
1. Have you managed or treated any form of family violence in your facility?		
i. I have only involved myself in the management of female victims in my facility.	0.9	0.4
ii. I have been involved in the management of several family violence victims.	0.83	0.03
iii. I have been partially involved in the management of family violence victims.	3.03	0.6
iv. I had no contact with or managed any form of family violence	0.9	0.4
2. What were the roles you performed in the management of family violence?		
i. Identification of family violence victims	0.83	0.03
ii. Safety attention, precaution, counsellingand treatment of victims	3.3	0.49
iii. Referral of complex situations.	0.83	0.03
iv. I have not performed any of the above-listed action	1.3	5.5
v. I have performed allthe above-listed actions.	3.03	0.627
3. What were your experiences on the strategies used to identify family victims.		
i. From the victims' expression.	3.3	0.49
ii. By listening to the couple's conversion while they explain issues	3	0
iii. Through obvious signs of anxiety	3.3	0.49
iv. Using specific /direct questions while taking the history of present complain	2.9	0.28
v. Observing injuries sustained from physical/sexual violence	2.9	0.28
vi. Reports gotten from family and relatives of the victims	3.3	0.5
4. How do you intervenein the management of family violence victims?		
i. No recommended guidelines for intervention in family violence	2.7	1.09
ii. Counseling the victims only and sometimes with the perpetrator too.	3.3	0
iii. Regular Wound care and dressing from injuries sustained from violence	3.3	0
iv. Victims were managed within stipulated days of occurrence with medications	2.9	0.28
v. Marital or spousal reorientation.	3.3	0.49
vi. There were no standard protocols for the management of family violence.	2.9	0.282
vii. Management strategies are dependent on the extent and frequency of violence	3.67	0.62
5. Who seeks care for family violence in your facility?		
i. Mostly married women	3.3	0.49
ii. Rarely married men	3	0
ii. Sometimes, unmarried girls	3.3	0.49
ii. Most times, teenage girls and children	3	0
6. What were the common symptoms they present at your facility?		
i. Mostly married women show had injuries, miscarriage & intrapartum bleeding	1.79	0.26
ii. Married men showed signs of psychological trauma.	3.3	0
iii. Young girls and children showed signs of injuries from physical violence and rape.	1.79	0.26
Aggregate mean	**2.42**	

Table 4 above showed an aggregate mean of 2.42, which implies that the general level of Nurses' involvement in the management

of family violence victims is poor. The result indicated that 24.1% showed a poor level of Nurse involvement in the management of family violence victims, with mean values falling between 0 and 2.49. Moreover, 20.7% showed a fair level of Nurses' involvement in the management of family violence victims, with mean values falling between 2.5 and 2.9. In contrast, 51.7% indicated a good level of nurses' involvement in the management of family violence victims, with the mean values falling between 3.0 and 3.49. However, only 3.5%showed a very good level of involvement in the management of family violence victims, with mean values falling between 3.5 and 4, respectively.

Discussion of findings

Sociodemographic data of the respondents

Findings from this study revealed that nearly half of the respondents (41.7%) are over 39 years old. This simply denotes that the majority of the nurses are in their middle adulthood and predictably experienced in their jobs. The result also showed that 91.67%are females, and 8.3% are males and were all married. This indicates that females dominated the nursing profession in the study area and that nurses in the study area, irrespective of gender, are family-oriented. In terms of tribe, the majority of the nurses are Hausa (50%), followed by 8.3% Fulani, 4.2% Igbo, and 37.5% members of other tribes. The dominance of nurses of Hausa ethnicity is understandable as the study area is situated in Hausa land. Also, 12.5% are nurse midwives, 8.3% have a basic nursing degree plus another specialisation from a school of post-basics, and 66.7% have a nursing degree as their level of study. This indicated that the majority of the nurses had advanced their education beyond basic nursing or midwifery certificates, which in turn positively added value to their professional practice and put them in a vantage position as a useful resource for tackling FV.

Perception of nurses on management of family violence victim

Generally, the perception of nurses on the factors that influence their readiness in the management of family violence victims is positive and good, with an aggregate mean of 3.4. The majority of the nurses perceived that the following factors affect how they treat victims of family violence: victims' unwillingness to disclose family violence, practitioners' capacity to investigate family violence cases, workplace or organisational support, threats to one's own safety, commitment, lack of knowledge, nurses' workload, nurses position in the healthcare hierarchy, language barrier, nurses' collaboration with the other health team, victims' inability to disclose family violence cases, victims' inability to recognise family violence cases, and poor communication and collaboration between healthcare stakeholders. This is in line with the study of Alhalal (2020) and Li et al. (2024), which reported similar factors as influencing nurses' perceptions, readiness and capacity to manage family violence.

Nurses' involvement in the management of family violence

The result of the study revealed a poor

level of nurses' involvement in the management of family violence victims, with an aggregate mean of 2.42. This aligned with Ogunlade et al. (2022), who also observed a gap in the involvement of nurses in the management of family violence victims. The findings equally agreed with Ogunlade et al. (2022) conclusion that 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. The nurses also identified safety attention, precautionary measures, counselling, wound dressing, referral of complex situations, and marital or spousal orientations as their management strategies whenever they receive family violence victims. This result is quite consistent with the result of Ogunlade et al. (2022), who also listed management strategies of family violence victims as wound care and dressing for physical injuries, risk assessment, risk management, safety planning and measures, and counselling the victims and perpetrators.

Knowledge of nurses on management of family violence victim

The result of the study on nurses' knowledge of FV showed that most of the respondents (54.167%) unanimously defined family violence as "behaviour involving force intended to hurt, damage or kill someone, which is in line with the definition portrayed by Bunno and Onigata, (2022). The majority of the nurses (75%) affirmed that forms of violence encompassed physical, psychological or emotional, sexual, and economic violence, which is in accordance with the studies conducted by Ozgenturk et al. (2012), who stated that " family violence does not mean only physical acts such as hitting, kicking, injuring, with the intention to kill or killing, but also includes psychological, economic, and sexual violence as other forms of violence that are less visible but are frequently used. Moreover, sexual violence is a severe type of violence against women, especially sexual abuse commonly seen as rape or forceful unwanted sexual act (Farvid & Saing, 2021). The current study revealed that all the nurses (100%) identified financial issues, poor communication in relationships and unplanned pregnancy as the causes of family violence. Almost all the nurses (95.83%) selected drug influence and alcohol use, witnessing family violence during childhood, and low levels of education as causes of family violence. Likewise, almost all the nurses (91.67%) picked disobedient, gender inequality, expression of suspicion of infidelity by a partner, unemployment, cultural influence, and young age as causes of FV. However, 83.3% picked religion as one of the causes of family violence. These findings are in agreement with studies that found that causes of FV are multifactorial and multidimensional and that family abuse victims frequently lack effective communication skills (Mengistie, 2015; Shuaib et al., 2013). According to Finnbogadottir et al. (2016) and Walker et al. (2017), women with low levels of education, financial difficulties and unintended pregnancies were three-fold more likely to experience family violence during pregnancy. Current findings also agree with Oyelami (2019), who itemized causes of family violence

to include low educational level, smoking and drug abuse, unwanted pregnancy and low income. The majority of nurses (95.8%) in the current study also identified fetal problems like low birth weight and mental health problems as part of the major effects of family violence. All nurses (100%) reported psychological effects such as depression, low self-esteem, and anxiety, and physical injuries such as bruises, broken bones, and worsening of chronic illnesses, and obstetric problems such as miscarriage, stillbirth, and pre-term birth as major effects of family violence. These findings aligned with a previous study by Mehlhose and Risius (2020), which identified anxiety as both a warning sign and an effect of FV. Current findings are also consistent with the findings of Almutairi and Jahan (2022), which posited that the most obvious warning signs that a woman who is a victim of family violence may present with are chronic unexplained pain (12.5%), anxiety (62.5%), multiple injuries (12.5%), and depression (12.5%).

Conclusion and Recommendations

Based on the findings of the study, it was concluded that the majority of the nurses have a positive perception and a sound level of knowledge of the management of family violence victims. Despite this, nurses also have a poor level of involvement in the management of family violence victims. Consequently, the following recommendations were made: The government should

1. empower healthcare providers to support victims of family violence beyond counselling and treatment of injuries.
2. expand education and training opportunities about FV and enforce mandatory reporting policies for nurses and other healthcare providers to involve law enforcement.
3. encourage advocacy groups among nurses to manage the reporting and management of family violence, enactment and enforcement of strict penalties for perpetrators of family violence, and multi-sectoral interventions involving law enforcement agents, non-governmental organisations, healthcare systems, and religious institutions.

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