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"Assessment of knowledge and attitude of nurses towards violence against women, a cross sectional study from a tertiary care hospital Tamil Nadu, India."

Alan Samuel John, Dr. R. Karthick,
Vettath Bethel, Elanjimel PO, Chengannur, Alappuzha, Kerala. Pin 689511
Dept. of Forensic Medicine, Govt. Mohan Kumaramangalam Medical College Hospital, Salem. Pin. 636001

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ABSTRACT:

Background

Gender-based violence (GBV) is a global public health issue, with prevalence ranging from 13% to 61%. Nurses have a vital role in identifying and caring for survivors of violence. However, in India, evidence on nurses' knowledge, attitudes, and practices towards GBV is limited. This study aims to explore their understanding of GBV and legal knowledge to develop country-specific policy guidelines. Literature review suggests training and education to improve nurses' knowledge, confidence, and skills in managing GBV cases.

Objectives

The research aims to assess nurses' knowledge, attitudes, and beliefs in caring for women who have experienced violence, determine their knowledge of judicial aid for gender-based violence, and evaluate the care provided for victims of gender violence at a tertiary care hospital in Salem.

Methods

The study was conducted at a tertiary care hospital in Salem, Tamil Nadu, using mixed methods. Quantitative data was collected using a semi-structured questionnaire, and qualitative data through in-depth interviews. The data was analyzed using SPSS and thematic analysis, respectively. Ethical clearance was obtained, and participation was optional and anonymous.

Results

117 nurses from Emergency and OBG Departments participated in a study exploring their knowledge and attitudes towards domestic violence. 75.2% responded to the questionnaire. Most participants were married and had 6 months to 30 years of working experience. The proportion of agreement among participants varied for different forms of violence, with the highest agreement for harassment through emails or texts. Nurses showed a lack of knowledge and inadequate training regarding domestic violence management. Major barriers to optimal care were identified, including infrastructure deficits and sub-optimal training.

Interpretation

Study among nurses of a tertiary care hospital on their knowledge and attitude towards domestic violence (DV) showed weak awareness of prevalence, justifying certain types of abuse, and lack of communication with victims. Majority did not receive any training to deal with DV victims. Suggestions for improvement include education, training, and emotional support for victims. Small sample size limits generalizability.

Conclusion

In conclusion, this study highlights the knowledge and attitude of nurses towards domestic violence and emphasizes the need for comprehensive educational programs to enhance their capacity to deal with women who experience abuse. The absence of clinical guidelines and protocols to manage victims of abuse in tertiary care settings also calls for urgent policy interventions. Continuous training and workshops covering legal, medical, and cultural aspects of domestic violence are necessary to bridge the gap in knowledge and skills.

Key Words: Abuse, Knowledge, Legal, Nurses, Psychological, Trauma, Victims, Violence.

I. INTRODUCTION:

Violence against women is one of the largest problems related to human rights all over the world and is now widely recognized as an important public health problem, owing to its health consequences. The prevalence of intimate partner violence (IPV) varies widely across countries, ranging from 13% to 61%. (1) In India, lifetime physical violence against women is found to be 28.8 %. (2)

It is important to give aid to someone who is ill-treated physically or emotionally. Healthcare operators play a crucial role in identifying the signs

of the violence endured while taking care of the abused. World Health Organization reports that a health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault, and hence has made suggestions for clinical and policy guidelines in the health sector. (3) The medical team taking care must be equipped well to recognize abusive wounds and should be ready to take necessary actions. Nurses have a crucial role in developing conversations with the victim. Every aid which can be offered by nurses, including mental support, will be influenced by their understanding of the gravity of the situation which in turn can improve the overall medical care quality.Women experiencing IPV are more likely to have contact with nurses, doctors, and midwives even though they often do not disclose the violence. (4) Studies show that the detection rate of domestic violence is low. (5) Nurses have a professional responsibility to recognize and provide sufficient care to the victims of domestic violence. They must be equipped with the adequate knowledge, training, and practical experience. Domestic violence is a serious public health problem which increases especially during public health emergencies and pandemics that involve quarantine measures. The Spanish government launched an action guide to help women who were experiencing domestic violence at home during quarantine due to COVID-19. (6)

Many studies have been undertaken worldwide to understand the attitudes and behaviors of health care professionals towards victims of gender-based violence, including intimate partner violence. Studies from low-and-middle income countries of Africa indicate that societal and individual factors including social acceptance of abuse, understaffing and ineffective interventions act as potential barriers to screening for intimate partner violence. (7) Nurses' responses were also found to be affected by weak police responses and personal experiences of IPV.(8) Studies done in the USA also indicate that work environment and peer influences determine the behavior of nurses towards abused patients. Legal knowledge and attitudes towards victims varied widely among emergency nurses in South Korea.(9)

There is a lacuna of evidence with respect to knowledge, attitudes, and practices of nurses towards such women in India. Legal knowledge among nurses about gender-based violence is also not explored yet. This information is necessary for framing adequate country-based policy guidelines for health professionals in public healthcare systems.

II. REVIEW OF LITERATURE

According to Kahan et al., "Since primary care providers, including nurses, frequently are the first in the community to encounter the battered woman, they must be equipped with the necessary knowledge, training, and experience to identify the problem and manage the patient properly."(10)There are very few studies regarding the knowledge, attitude, and practices of nurses towards DV in India. As per an article published by ICRW "India's National Health Policy (NHP) did not recognize violence against women as a health care issue until 2017. The policy now clearly mandates that all survivors of violence must receive free services and recommends that gender sensitization training be carried in all health facilities and that it be included in the medical curriculum. Though these are important steps, it is now critical that different states in India ensure that these guidelines are adopted and implemented uniformly. As of 2018, only nine states have adopted the national guidelines related to sexual assault and only some states, such as Delhi, Goa, Haryana, Kerala, Madhya Pradesh, Maharashtra, Meghalaya, Orissa, and Uttar Pradesh have taken some initiative to train health professionals on use of these guidelines as well as addressing IPV or domestic violence. In the absence of clear policies and widely implemented clinical guidelines, the health systems response will remain checkered and unsystematic".(11) A similar study done among Australian nursing and midwifery students depicted that attention toward curriculum was required and that students had a limited understanding of domestic violence, suggesting a critical need to address capacity development in undergraduate nursing (12). The results of another study by Rodríguez et al., talk about the importance of developing non-technical skills like active listening, communication skills, empathy, and generating confidence and clearly show the need for training among nursing professionals. (13) In another similar study by Maquibar et al., participants perceived that training has increased their knowledge and self-confidence in identifying the cases and dealing with them. (14) Francis Doran and Marie Hutchinson say in their published work that of how important it is for nurses to understand the relationship between exposure to violence and women's ill health, and be able to respond appropriately. (15) It is beneficial if nurses are equipped with necessary medico-legal

knowledge so they can help the victim. A study done among Turkish emergency department personals also agrees with it, noting how "informing the victims about their legal rights and starting the legal procedure right after the incident could be a life-saving intervention." (16)

Aims and Objectives

Among nurses working at a tertiary care hospital in Salem,

1. To describe the knowledge, attitudes, and beliefs of nurses who have attended to women who suffered from any form of violence.
2. To find out the level of knowledge of nurses with respect to judicial aid for gender-based violence.
3. To assess the care given for victims of gender violence

III. MATERIAL AND METHODS

Study design & setting:

It was an "Explanatory Mixed Methods study" with the quantitative component (Cross-sectional analytical) followed by the qualitative component (Cross-sectional descriptive). The study setting was a tertiary care hospital in Salem district of Tamil Nadu. Study participants were the nurses working at tertiary care hospital in Tamil Nadu who had current or past experience working in Emergency department or Obstetrics and Gynecology_department.

Data_Collection: Ethical clearance for the study was obtained from The Institutional Ethics Committee. Permission was obtained from the respective authorities for data collection. Afterobtaining research and ethical clearance, the list of all eligible participants was obtained from the administrative wing of the institute. Nurses working in the Departments of Emergency medicine and Obstetrics & Gynecology were approached for consent. Participation was optional and data collection was done anonymously. After obtaining consent, quantitative data collection was done using a semi-structured questionnaire. The questionnaire was first pre-tested among a few non-selected participants to ensure validity. It included socio-demographic data (age, marital status, years of experience,), nurses' knowledge & perception regarding DV, questions regarding their academic training & other practical aspects. The questionnaire-based data obtained were analyzed before moving on to the qualitative component. Following analysis of quantitative data, those participants who expressed willingness to take part in the interview were approached for consent. For the qualitative component, in-depth interviews were conducted using an interview guide until data saturation occurred.

Statistical Analysis:

Quantitative Data: After entering the data into Microsoft excel the statistical analysis of the qualitative component was done using SPSS. Continuous variables like age and years of experience were summarized using mean (SD) if normally distributed and median (IQR) if non-normally distributed. Categorical variables like attitude and knowledge scores were measured using proportions.

Qualitative Data: All the interviews were audio-recorded and later transcribed. The transcripts were analysed manually for generating codes, categories, sub-themes, and themes.

IV. OBSERVATIONS AND RESULTS

117 nurses working in Emergency & OBG Departments showed willingness to fill the questionnaire. Out of them, 88 participants returned fully filled questionnaires (response rate of 75.2%). The age of the participants ranged from 23 to 56 years (mean ± SD being 35.6 ±8.2). Of the participating nurses, 93.18% were married and 6.82 % were unmarried. The working experience of nurses ranged from 6 months to 30 years. Median (IQR) years of experience was 10 (5-15.5). The distribution of age and experience of participants is illustrated in figure 1 and figure 2 respectively. The marital status of participants is illustrated in figure 3.

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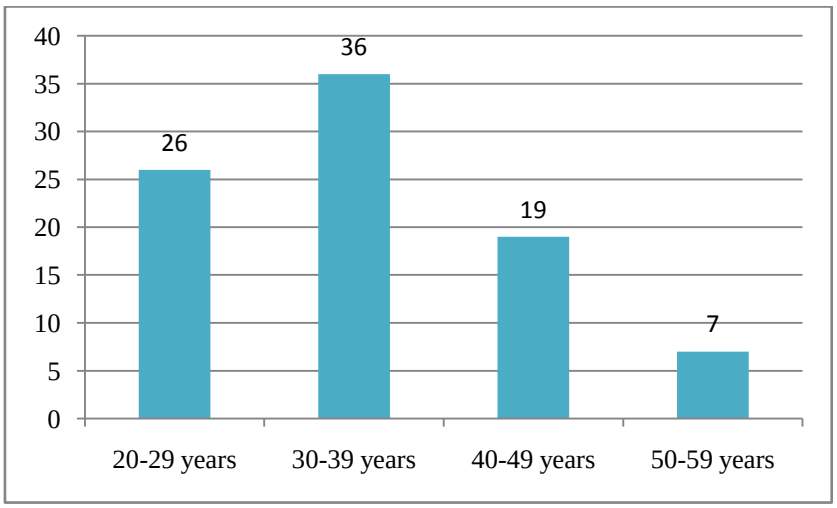

Figure 1: Age distribution of participants (n=88)

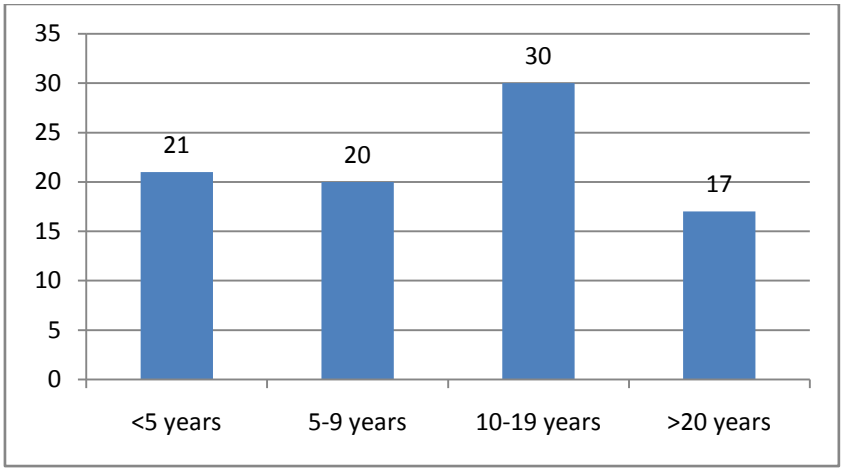

Figure 2: Distribution of participants by work experience (n=88)

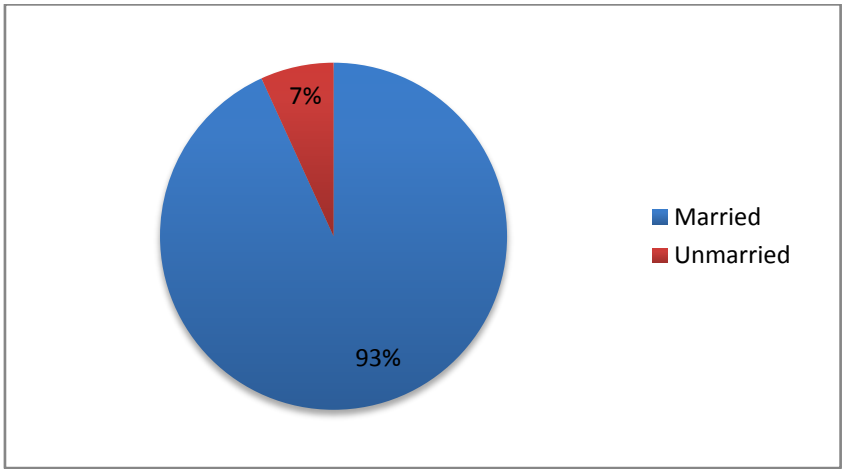

Figure 3: Martial status of participants (n=88)

Considering each item of domestic violence (DV), Table 1 illustrates the proportion of agreement among participants about the definition of DV which tells their perception of DV. The proportion of participants who agreed after considering statements as forms of violence were

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37.93 % for "Slapping and pushing", 48.8% for "forcing the partner to have sex", 47.13% for "throwing or smashing objects to frighten or threaten", 45.35% for "repeatedly criticizing to make the partner feel bad or useless". A higher proportion (56.32%) of participants agreed that "harassment by repeated emails or text messages" was a form of violence.The mean (SD) score for knowledge about various forms of violence ranged from 1.9 (1.1) to 2.2 (1.3) out of 5.

Table 1: Participating nurses' perception of statements as types of domestic violence.

Statement (…..is form of violence)	Yes, always	Yes, usually	Yes, sometimes	No	I don't know	Mean Score
Slapping or pushing	37.93	27.59	19.54	14.94	0	2.1± 1.0
Forcing the partner to have sex	48.84	22.09	15.12	12.79	1.16	1.9 ± 1.1
Trying to scare or control by threatening to hurt family members	38.37	18.60	30.23	10.47	2.33	2.2 ±1.1
Throwing or smashing objects to frighten or threaten	47.13	26.44	11.49	11.49	3.45	1.9 ± 1.2
Repeatedly criticizing to make the partner feel bad or useless	45.35	25.58	10.47	16.68	2.33	2.0 ± 1.2
Controlling social life by preventing from seeing friends or family	34.28	22.09	30.23	11.63	1.16	2.2 ± 1.0
Repeatedly keeping track of location, calls/activities through mobile phone other devices without consent	40	29.41	12.94	15.29	2.35	2.1 ± 1.1
Stalking by repeatedly following or watching at home or at work	46.25	16.25	17.5	13.75	6.25	2.2 ± 1.3
Harassment by repeated emails or text messages	56.32	12.64	14.94	14.94	1.15	1.9 ± 1.2

Data are presented as raw percentage (n= 88 participants)

The knowledge attitude and general conceptions of nurses regarding violence were further explored and illustrated in Table 2. More than half of the participants (53.57 %) strongly agreed to the statement "Violence against women is common in our community" (mean 1.8 ± 1.1). Strong disagreement (43.37 %) was shown to the statement "If a woman claims to be sexually assaulted but has no other physical injuries, she probably should not be taken seriously", (mean 3.6 ± 1.4). Interestingly a great proportion (56.63%) of nurses strongly agreed to the statement "Domestic

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violence is a private matter to be handled in the family", (mean2.1 ± 1.4). 36% strongly agreed and 18% somewhat agreed to the statement "Women often say 'no' when they mean 'yes'". Around 28.7% of nurses strongly disagreed to the statement that "It is a serious problem when a man tries to control his partner by refusing her access to their money"

Table 2: General conceptions about domestic violence

Statement	Strongly agree	Somewhat agree	Neither agree nor disagree	Somewhat disagree	Strongly disagree	Mean Score
Violence against women is common in our community	53.57	26.19	9.52	5.95	4.76	1.8 ± 1.1
If a woman does not resist – even verbally – then it is not rape	40.96	18.07	18.07	15.66	7.23	2.3 ± 1.3
Many allegations of sexual assault made by women are false	12.05	28.92	12.05	13.25	33.73	3.3 ± 1.5
Women are more likely to be raped by someone they know than by a stranger	31.03	40.23	11.49	10.34	6.90	2.2 ± 1.2
If outside help/advice about domestic violence issue is needed, I would know where to go	37.21	24.42	10.47	22.09	5.83	2.5 ± 1.8
A lot of what is called domestic violence is really just a normal reaction to day-to-day stress and frustration	30.49	24.39	15.85	19.51	9.7	2.7 ± 2.5
Domestic violence can be excused if it results from people getting so angry that they temporarily lose control	22.62	44.05	16.67	10.71	5.95	2.3 ± 1.1
Domestic violence can be excused if the violent person was themselves	26.19	22.62	22.62	15.48	13.10	2.6 ± 1.3

abused as a child							
Domestic violence can be excused if the violent person genuinely regrets what they have done, afterwards	19.28	28.92		12.05	26.51	13.25	2.8 ± 1.3
Sometimes a woman can make a man so angry that he hits her when he didn't mean to	39.76		28.92	6.02	13.25	12	2.6 ± 2.8
Women often say 'no' when they mean 'yes'	36.05		18.60	17.44	6.98	20.8	2.7 ± 2.5
Domestic violence is a private matter to be handled in the family	56.63		10.84	9.64	12.05	10.84	2.1 ± 1.4
It is a woman's duty to stay in a violent relationship in order to keep the family together	30.59		11.76	16.47	21.18	20	2.9 ± 1.5
Domestic violence can be excused if the victim is heavily affected by alcohol	6.98	26.74		30.23	18.60	17.44	3.1 ± 1.2
Domestic violence can be excused if the offender is heavily influenced by alcohol	4.65	30.23		27.91	16.28	20.93	3.2 ± 1.2
A man is less responsible for rape if he is drunk or affected by drugs all the time	14.12	22.35		15.29	12.94	35.30	3.3 ± 1.5
If a woman is raped while she is drunk or affected by drugs, she is partially	32.18	21.84		18.39	5.75	21.85	2.7 ± 1.8

responsible						
A female victim who does not leave an abusive partner is partly responsible for the abuse continuing	28.57	30.95	22.62	8.33	9.52	2.4 ± 1.2
It is not hard as people say it is for women to leave an abusive relationship	28.74	31.03	19.54	13.79	6.90	2.4 ± 1.2
If a woman keeps going back to her abusive partner then the violence cannot be very serious	20.48	20.48	24.10	22.89	12.05	2.8 ± 1.3
It is acceptable for police to give lower priority to domestic violence cases if it is a recurrent complaint	28.57	22.62	26.19	11.90	10.71	2.5 ± 1.3
It is common for sexual assault accusations to be used as a way of revenge	17.65	12.94	27.06	20.0	22.35	3.1 ± 1.3
If a woman claims to be sexually assaulted but has no other physical injuries, she probably should not be taken seriously	10.23	9.64	22.89	13.25	43.37	3.6 ± 1.4
Women who wait weeks or months to report sexual harassment or assault are probably lying	13.95	19.77	19.77	20.93	25.58	3.3 ± 1.4

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Women who are sexually harassed should sort it out themselves rather than report it	20.99	8.64	23.46	13.58	33.33	3.2 ± 1.5
In my opinion, if a woman reports abuse by her partner, it is shameful for her family	20.93	18.60	15.12	17.44	27.91	3.1 ± 1.5
It is a serious problem when a man tries to control his partner by refusing her access to their money	11.49	20.69	19.54	19.54	28.74	3.3 ± 1.3
Many women tend to exaggerate the problem of male violence	20.93	25.58	13.95	22.09	17.44	2.8 ± 1.4
Women going through custody battles often exaggerate claims of domestic violence in order to improve their case	24.42	32.56	19.77	10.47	12.79	2.5 ± `1.3

Data are presented as raw percentage (n= 88 participants)

Table 3 illustrates the last section of the close-ended questionnaire which explored the medico-legal and practical aspects regarding DV. 47.13% of nurses stated that they weren't aware of the medico-legal aid that could be given to the victims of violence. 50.57% of nurses indicated that they do not try to establish communication with the victims if they come in contact with them. A great proportion of nurses (68.6%) revealed that they did not receive any education or training at all as undergraduate students to deal with the victims of violence. While 31.4% of nurses told they got education or training but 81.16% among them told the training received was inadequate. 72.94% of nurses agree that workshops/training would help them better deal with the victims of violence.

Table 3: Questions regarding medico-legal and practical aspects.

Questions	Yes	No
Are you aware of the medico-legal aid that can be given to the victims of violence?	52.87	47.13
Do you try to establish communication with the victims if you come into contact with them?	49.43	50.57

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Did you receive any education/ training to deal with the victims of violence as an undergraduate nursing student?	31.40	18.84	68.6	81.16
Do you think it was adequate?				
During your career did you receive training from workshops or conferences to deal with victims of violence?	7.06		92.94	
Do you think training/workshops will help you better deal with the victims in future?	72.94			27.06
Is there a well-written protocol or procedures in your department to guide you in assessing & managing a case of domestic violence?	37.21		62.79	

Data are presented as raw percentage (n= 88 participants)

The qualitative component was explored by in-depth interviews conducted in person. The overarching themes identified were characteristics and existing patterns encountered, barriers to optimal care, and how the current systems may be improved. Major lacunae highlighted included infrastructure deficits (lack of private spaces), lack of dedicated staff or working protocols regarding the subject, and sub-optimal training received by nurses during academic learning as well as practical training. These are elaborated in detail in tables 4, 5, 6 ---.

Table 4: Result of in-depth interviews – Theme 1

THEME	SUB-THEMES	CATEGORIES	CODES	QUOTES
Existing Scenario and Systems	Patient characteristics	Age	Age differences between husband & wife	"A case was reported where a girl of 20 years was severely assaulted by her husband above 35 years of age, but she reported that the injuries happened while she fell down. She was afraid of her husband." (33F; M; 11E)*
			Usual age of victims	"Most of the women are above 30 years." (33F; M; 11 E)

		Reasons for assault	Alcoholism	"Last few days there were plenty of cases as it was Diwali."(43F ; M; 20E)
			Lack of communication	"Majority of the men under the influence of alcohol and some due to misunderstanding"(33F; M; 11E)
			Family issues	"Almost all cases are due to some or other family related problems" (39F;M; 15 E)
		Types of injuries	Physical assault	"Commonly seen injuries are black eyes, wounds, contusions and bruises"(53F; M ;30 E)
			Sexual assault	"Last case reported was sexual abuse on a 8 year old female by 2 or 3 males of around 25 years about one or 2 months back." (33F; M;11 E)

*F – Female, M – Married, E – Experience

Table 5: Result of in-depth interviews – Theme 2

THEME	SUB-THEMES	CATEGORIES	CODES	QUOTES
Barriers in Care Provision	Infrastructure	Lack of privacy	No private rooms	"There is no private space to talk to them in GH." (33F; M; 11E)*
	Health workforce	Lack of dedicated staff	Lack of social worker	"There are no social workers in GH other than for handling child adoption procedures"(33F; M; 11E)
			Lack of counselor	"There is no counselor in GH to give them mental support" (33F; M; 11 E)
			Lack of psychiatric/ psychologist support	"Domestic violence cases are not referred to psychiatric department for counseling"(43F; M 20 E)
		Time constraints	High casualty case load	"We don't get time for detailed talking as emergency ward is always full of patients" (39F; M ;15 E)

			No time for emotional support	"And also the atmosphere of the emergency ward is not suitable for an emotional guidance" (53F; M ;30 E)
	Capacity-Building	Lack of training	Abuse not part of curriculum	"All the experiences I have in this regard is by attending practical cases" (33F; M;11 E)
				"Through academic curriculum I got only minimal knowledge."(43F ; M; 20E)
			No training on legal aids	"If nurses are enlightened about the legal support that can be provided to such victims, it would be better" (33F; M;11 E)

*F – Female, M – Married, E – Experience

Table 6: Result of in-depth interviews – Theme 3

THEME	SUB-THEMES	CATEGORIES	CODES	QUOTES
Room for improvement	Institutional level betterment	Staff training	Academic base	"This could be made a part of undergraduate training where students would learn to detect, counsel and refer the severely unwell survivors to specialists" (53F; M ;30 E)*
			Practical Training	"I feel it would have been better to have seminars/workshops for nurses equipping us to better deal with such cases."(39F; M ;15 E)
			Establishment of protocols	"If there is a well-defined protocol for dealing such cases, it will be more helpful. After recording their history, there should be a provision for some compulsory counseling support given by the nurses self"(39F; M ;15 E)

			Additional staff	"Also if it possible to increase the number of staff attending the emergency department, we could give more time to help them out."(39F; M ;15 E)
		Infrastructure	Private room	"A private space will be better" (53F; M ;30 E)
	Victim Care	Emotional support	Individual counseling	"I think it would be better to give such patients counseling and psychiatric support" (43F ; M; 20E)
			Family Counseling	"Also if family counseling sessions can be given to both the partners it might also help in reducing the problem at least in some cases"(53F; M ;30 E)
		Systematic support	Rehabilitation Facilities	"For such cases who do not want to go back, if there is a women cell (NGO)for rehabilitation functioning in GH under the supervision of police department, it would be helpful"(39F; M ;15 E)
			Social workers	"Social service should be available on call for necessary support." (43F; M; 20E)

*F – Female, M – Married, E – Experience

V. DISCUSSION

This study conducted among nurses of a tertiary care hospital gives important information about current knowledge and perception of nurses toward DV, which will be useful for planning future implementation for improving care in the hospital setting. The response rate in this study was 75.2% which is relatively higher than in many other similar studies. This may be due to the increasing interest of nurses in India to improve their knowledge in order to provide better healthcare. The response rate of similar studies in Kuwait, Sweden, and Canada were 61.1 % (17), 57% (18), 59.78% (19) respectively. A study conducted in Pennsylvania had a response rate of 75% which is similar to this study. (20) There was a study with 86% response rate which is higher than this study. (21) Relatively lower response rate of this study may be due to the lack of time and heavy workload of the nurses.

Attitude and knowledge of nurses and other healthcare professionals have existed as an obstacle to providing adequate care to the victims of domestic violence. In this study, it was seen that despite education and experience of nurses, some of the nurse justified domestic violence in various circumstances. In few other studies while nurses expressed a positive attitude towards physical

violence they had a negative response to psychological abuse. (22) Different from that, in this study nurses expressed a positive attitude to both physical and psychological abuse. Additional to that in this study there was a positive response (56.73%, mean 1.9 ± 1.2) to digital forms of harassment. This study showed that the awareness of the prevalence of DV among primary care nurses is weak in agreement with another similar study in the US where 70% of nurses believed that DV was rare or very rare. (23) Different from that in this present study 53.57% of nurses strongly agreed with the statement "Violence against women is common in our community" with a mean of 1.8 ± 1.1. Interestingly a great proportion (56.63%) of nurses strongly agreed to the statement "Domestic violence is a private matter to be handled in the family", (mean2.1 ± 1.4). This was a negative response from the nurses who are the primary healthcare providers. It indicated their general attitude about domestic violence as something to be concealed within the boundary of family. 36% strongly agreed and 18 % somewhat agreed to the statement "Women often say 'no' when they mean 'yes'" which is another negative response from the nurses about a misconception prevalent among people. Gender roles were used to justify certain violence. Nurses agreed that it is the woman's job to stay in an abusive relationship in order to protect the marriage. This kind of thoughts may be due to the existing gender stereotypes in our culture. Relatively majority of the nurses agreed that it's not a serious problemwhen a man tries to control his partner by refusing her access to their money.

Nurses are supposed to be equipped with non-technical skills like empathy, active listening, and readiness to deploy emotional support especially when dealing with victims of violence. 50.57% of nurses indicated that they do not try to establish communication with the victims if they come in contact with them. A great proportion of nurses (68.6%) revealed that they did not receive any education or training at all as undergraduate students to deal with the victims of violence. The efficiency of training programs in managing victims of domestic violence has been depicted in various studies (24-26). It is very crucial to train and educate undergraduate nursing students as a part of their academic curriculum to deal with the victims of DV. 72.94% of nursing professionals think that workshops/training would help them better deal with the victims of violence.

The interviews conducted among the nurses working in a tertiary hospital revealed the nature of violence faced by women of the locality. The participants agreed to the fact that the victims were treated for their physical injuries only and were not given any emotional support mainly due to the lack of facilities at the hospital and the inadequacy of the training that they had received. They suggested the need for trained personnel for emotional support and social guidance and adequate facilities at the hospitals. They also pointed out the need for amendments in academic curriculum and treatment protocols. Nurses suggested the need for a trained counselor and social worker specially equipped for dealing with victims of abuse. They were willing to undergo training and workshops so as to equip them to provide quality care to patients. The empathy that they expressed towards the broken and wounded faces that they encounter and their eagerness to help suggested the possibility of a better future for treatment of victims of abuse through appropriate policy implementation.

Strengths: The design of this study included a novel qualitative component that was not explored before in the similar studies. Qualitative component explored direct input and suggestions from the nursing professionals themselves for improving the existing structure and approach.

Limitations: A small sample size may have affected the generalizability of the study.

VI. CONCLUSION

This study provides an idea about the knowledge and attitude of nurses which can serve as the first step in ensuring quality treatment to the women presenting with abuse in our healthcare settings. Even though female nurses are somewhat knowledgeable about DV, many more educational programs are required. Since no medical curriculum covers DV related topics (especially legal rights of women, medical consequences of violence, intervention strategies, and gender roles) in-depth, awareness programs and workshops should be conducted to fill the lacunae in knowledge and build capacity of nurses in dealing with women who present with any forms of abuse. Policy guidelines and interventional packages for women presenting with signs of abuse can be strengthened in public healthcare systems. This study showed that there were no clinical guidelines or protocol at the tertiary care level to deal with the victims of abuse. There is a crucial need for written protocol and guidelines to assist nurses in DV case management. Along with this, there should be continuous training through workshops covering

everything relevant to DV like legal, medical and, cultural aspects.

VII. SUMMARY

Domestic violence against women has been recognized as serious public health problem. Nurses play a crucial role in managing the victims of DV. So, they must be equipped with necessary training and knowledge. This study was aimed at assessing the knowledge and attitude of nurses of Emergency & Obstetrics and Gynecology departments, towards female victims of violence and the adequacy of the care given to them. Analysis of data collected based on questionnaires (quantitative) and in personal interviews (qualitative) revealed the inadequacy in providing emotional support to the victims of violence and the lack of appropriate infrastructure and trained personnel at the hospitals. Nurses were not informed about the legal aid that could be given to the victims of violence. Nurses didn't have knowledge regarding DV from an academic base; rather all they have is from their own practical experiences. It pointed out the need for a holistic approach in dealing with the victims of violence that includes physical treatment, emotional support, legal guidance, and rehabilitation facilities as per requirement. Nurses suggested the need for a social worker and counselor dedicated to the abuse cases. Also it pointed out the need for equipping the nurses in providing such holistic care. This area of health care in India is not much explored and calls for much intense attention.

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Conflict of Interests

No conflicts of interest were identified among the study's authors, researchers, or funding source.

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