


# Burden of Intimate Partner Violence among Nurses and Nursing Students in a Tertiary Hospital in Abakaliki, Ebonyi State, Nigeria

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## Abstract

**Introduction:** Nurses are the largest healthcare workforce and are not immune to intimate partner violence (IPV) and its consequences.

**Objective:** This study is aimed at determining the prevalence, types of IPV, and its determinants among female nurses and nursing students in a tertiary teaching hospital in Abakaliki, Ebonyi State, Nigeria.

**Methods:** This cross-sectional study was done in a teaching hospital in Abakaliki between 1st March 2018 and 31st May 2018 to evaluate the prevalence of IPV in the past 12 months among 460 female nursing students and 460 nurses in the facility. Data were obtained with a structured questionnaire and a Composite Abuse Scale. The data were analyzed using IBM SPSS Statistics version 20 and represented using frequency table, percentages, and odds ratios. The level of significance is at P-value < 0.05.

**Results:** The prevalence of IPV was 48.2% for the nursing student and 58.7% for the nurses. The most common form of IPV among nursing students was Emotional and/or Harassment abuse (27.1%) while it was Severe combined abuse (23.9%) among the nurses. The significant determinants of IPV among nursing students were age [OR = 0.61 (95%CI 0.41–0.92)] and year of study [OR = 0.67 (95%CI 0.51–0.89)]. Male partner being unemployed was associated with increased odds of a female partner experiencing violence. Nurses' marital status and being in the low socioeconomic class were associated with increased odds of a nurse witnessing IPV.

**Conclusion:** The prevalence of IPV in the studied group is unacceptably high. Efforts are therefore needed to prevent IPV in the study groups. Health care managers in the study area should make policies to support nurses/nursing students who have experienced IPV.

## Keywords

Intimate partner violence, domestic violence, nurse, student, Abakaliki, Nigeria

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## Introduction

Intimate partner violence is a vital social and public health problem. This is so because it retards women's economics, social development and ability to develop self. It also affects the physical, mental health and overall development (Sharma & Vatsa, 2011). This type of violence is marked by patterns of coercive behaviour aimed at controlling the other in an intimate romantic relationship. The perpetrator employs physical, psychological, sexual and financial

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abuse strategies to exert power over the intimate partner or victim (Kordom et al., 2014). Globally, about 20–50% of women suffer from domestic violence (Kordom et al., 2014). In one study involving nurses and nursing students, prevalence of life time IPV was 25.25% (Kordom et al., 2014). The risk factors identified for IPV in nurses and nursing students were history of childhood trauma such as physical and sexual abuse, problem with husband's family, financial problems, difficulties at work, disobedience by wife, and wife's refusal to have sex (Sharma & Vatsa, 2011). In the same study, 45.81% of the women were beaten during pregnancy, 40% were injured as a result of physical or sexual violence by their husband. Minor injuries ranged from 25 to 66.7% while major injuries ranged from 8.3 to 16.7% and about 33.3% were badly hurt necessitating health care attention (Sharma & Vatsa, 2011). Intimate partner violence has great and far reaching impact on the victim. This includes affectation on physical and mental health causing inability to concentrate, loss of confidence in own abilities, inability to work, leaving the home, separation or divorce (Sharma & Vatsa, 2011). Nurses are prone to traumatization after IPV and this affects their professional wellbeing (Bracken et al., 2010). There may be cognitive, behavioural and affective changes in victims of IPV due to stressful and traumatic incidents (Van der Wath et al., 2016). Coping is one of the various ways adopted by a woman to manage an IPV. This reflects a person's cognitive and behavioral attempts to alter the problems caused by a stressful event and regulate the stress. Positive emotions are produced when there is a good coping ability while negative emotions occurs when there is a less favourable outcome (Van der Wath et al., 2016). There are various ways of coping which includes self-care strategies, seeking support from others, care giving skills and conflict resolution, all this can reduce chances of developing traumatization (Van der Wath et al., 2016). Peer and social support have a protective effect on the occurrence of post-traumatic stress symptoms (Van der Wath et al., 2016).

### Literature Review

Intimate partner violence refers to any behaviour by a current or former male intimate partner within the context of marriage, cohabitation or any other formal or informal union that causes physical, sexual or psychological harm (Violence against women prevalence estimates, 2018). It also include stalking by a current or former intimate partner (Breiding et al., 2015). It is a preventable public health problem that affects millions of women worldwide which is a violation of the human rights of women (Follingstad et al., 1990; Sasseti, 1993; World Health Organization, 2016a). Globally, it has been estimated that 27% (95% CI 23% - 31%) of women aged 15–49 years who have ever been in intimate partner relationships have either experienced some form of physical and/or sexual violence (Violence

against women prevalence estimates, 2018) with highest burden in low/middle-income countries (Violence against women prevalence estimates, 2018; World Health Organization, 2013). According to a 2018 estimate, the life-time point estimate of IPV in Nigeria was 24% (95% CI17-33) (Violence against women prevalence estimates, 2018) with the point prevalence ranging from 9-97% within the country. (Ajah et al., 2014; Amoran et al., 2017; Ansari et al., 2017; Fawole et al., 2016; Okemgbo et al., 2002; Onanubi et al., 2017; Umana et al., 2014).

The most common forms of IPV in sub-Saharan Africa, including Nigeria, includes sexual, physical, and psychological abuse. These forms of IPV often co-exist; it has been reported that 23–56% of women who reported ever experiencing physical or sexual IPV had experienced both (World Health Organization, 2012). Major perpetrators of this abuse are male partners. Unequal power relations, alcohol and drug dependence (Esere et al., 2009; World Health Organization, nd), jealousy (Esere et al., 2009), low educational attainment (Onoh et al., 2013), multiple sexual partners (Matseke et al., 2012; Ntaganira et al., 2008), inability to meet financial needs (Ntaganira et al., 2008), childhood abuse and being raised in a family with a history of domestic violence (Adebayo, 2014; Matseke et al., 2012) have been implicated for this abnormal behaviour by male partners. The patriarchal traditional African society with the subordinate nature of women and the resulting pervasive gender inequality is a big contributing factor of IPV in our society (Bowman, 2003).

IPV impacts negatively on the social and economic wellbeing of a woman. It hampers on women's productivity within the family thereby adversely affecting the "building blocks - family" of society. Children are prone to violence and perpetration of IPV in the future (Adebayo, 2014; Ntaganira et al., 2008;), depressive illness, productivity loss, and huge health-related cost (National Center for Injury Prevention & Control [NCIPPC], 2003). IPV could lead to femicide (NCIPPC, 2003). In 2017, Africa had the highest rate of intimate femicide of 1.7 per 100,000 female population with the second-highest rate in the American continent (United Nations Office on Drugs & Crime, 2019). IPV can increase the risk of HIV transmission (Siemienuk et al., 2013) via forced sex with an infected partner, limited or compromised negotiation of safer sex, and increased risk behaviour of a traumatized woman. IPV, therefore, poses a threat to the attainment of SDG goal 3.3 (Sustainable Development Knowledge Platform - the United Nations) and of the Global Agenda of ending the AIDS epidemic as a public health issue by 2030 (World Health Organization, 2016b, 2016c).

Nurses are not immune to IPV even though they are at the forefront of its prevention and management. A study done in the United States of America (USA) by Bracken et al. (2010), found that 18.6% of nurses in their study reported physical IPV, 7.7% reported sexual IPV while 22.8% reported

psychological IPV by their intimate partners. In a similar study by Díaz-Olavarrieta et al. (2001) in Mexico, 18% and 42% of nurses were reported to have witnessed physical and/or sexual abuse and emotional abuse respectively. In South Africa, a higher burden of emotional violence (90.3%) was reported by Christofides and Silo (2005) while 28.7% of the nurses studied had witnessed physical abuse by their partner. It has also been recognized that a nurse that is experiencing an IPV is not likely going to provide her best to the care of the patient (Bracken et al., 2010). An abused nurse is prone to late coming to work, work absenteeism, and lack of concentration at duty post which will affect her productivity. It thus highlights the importance of hospital managers in recognition of the possible existence of such a problem among its nursing employees.

Information about its prevalence (IPV) among the nurses will help the health managers in putting measures in place for early identification of individuals with IPV thereby leading to appropriate proactive prevention and intervention programs. It will also assist in the integration of information on IPV into in-services and educational trainings for nurses and those under training. Education of nurses on IPV has been reported to improve care given to the individuals who have experienced violence (Alhalal, 2020; Schoening et al., 2004). In this background, this study is therefore aimed at determining the prevalence and different forms of IPV among female nurses and nursing students in AE-FUTHA South East of Nigeria. The study will also determine the participant's response to the personal experience of IPV.

## Methods

### Study Design

This is a cross-sectional study which assesses the burden of IPV among female nurses and female nursing students in a tertiary teaching hospital in Abakaliki, Ebonyi state.

### Study Setting

Ebonyi state is one of the states in the southeast geopolitical zone of Nigeria. Alex Ekwueme Federal Teaching Hospital, Abakaliki is the only specialist teaching hospital in the state, receiving the referral from private and mission hospitals in the state and neighboring states. It is sited in Abakaliki, the state capital. It has a nursing and midwifery school for the training of qualified nurses and midwives. The total number of nurses employed in the hospital and nursing students as of 30<sup>th</sup> December 2019 was 1100 and 500 respectively. Apart from been a citadel of teaching and learning; It provides 24 h/7days medical services via the emergency/general outpatient department and specialized units. The hospital is manned by Consultants and Resident doctors with the help of trained nurses.

### Study Population

Women included in the study were nurses and nursing students in our facility who were in intimate partner relationships in the last 12 months and who self-identified as not being pregnant. Pregnant women were excluded to have a uniform group and to remove the contribution of pregnancy to the incidence of IPV. Others excluded were those who refused to give consent or those who were sick and were incapacitated to answer the questionnaire. The systematic sampling method was used for the selection of the study population. The attendance register of each department, during "our" first visit to the department, served as the sampling frame. Since there are 13 departments in the hospital, the total sample size was divided equally among the departments. The sampling interval was calculated based on the total population of female nurses in each department divided by sample size. 20% of the sample population was recruited each day from each department. These women were informed of the study, consent sort, and those that met the inclusion criteria were recruited into the study;  $n$ th,  $n + k$ th,  $n + 2k$ th,  $n + 3k$ th,  $n + 4k$ th, etc of the study population was selected. The same systematic sampling method was used for the selection of the study population for female nursing students. Their attendance register served as the sampling frame. They were recruited between 1<sup>st</sup> March 2018 and 31<sup>st</sup> May 2018.

### Sample Size

The sample size was calculated using the formula for a cross-sectional study ( $N = Z^2 PQ/D^2$ ) Where  $N$  = required sample size.  $Z = 1.96$  at confidence level of 95%;  $P$  = estimated population of 44.6% (Onoh et al., 2013),  $D$ ; margin of error at 5% and  $Q = 1 - P$ . The sample size for each group of the study population was 456 after the addition of a 20% attrition rate. This gave a total sample size of 912 for the study.

### Ethical Consideration

Ethical approval for this study was obtained from the Health Research and Ethics Committee of Federal Teaching Hospital Abakaliki, Ebonyi state. The ethical approval number is FETHA/REC/VOL/2017/630.

### Data Collection

Each participant was asked to complete a survey using the Composite Abuse Scale version 2013 questionnaire with some modifications. Pretesting was done among 30 nurses/nursing students selected at random from the hospital and not included in the final study population. Information obtained includes socio-demographic characteristics of the respondents and their partner such as age, marital status,

educational level of the mother, father's occupation, partner's employment status, ethnic group, and place of residence. The questionnaire was divided into three sections. Section A contains the social demographic data of the respondents and their partners while Section B assessed the type of IPV witnessed by the respondents (see below for more detail) while Section C measured the reaction to IPV by the respondent. They were asked to fill the questionnaire while those who were not able were interviewed alone in one of the offices dedicated to the study by trained research assistants. The questionnaire was filled based on their response. The social class of the study population was determined based on the social class classification of Olusanya et al. (1985). The educational level of the women and the occupation of the husband or partner was used in the classification. The social class of the study participant and those that were not married was based on that of their parent. They were graded into social classes 1 to 5.

### Composite Abuse Scale (CAS)

Composite abuse scale is an easily administered self-report measure that provides standardized subscale scores on four dimensions of intimate partner abuse consisting of 30 items presented in a six-point format requiring respondents to

Types of IPV	Items
<b>Severe Combined Abuse</b>	Raped me; Used a knife or gun or other weapons; Took my wallet and left me stranded; Tried to rape me; Kept me from medical care; Locked me in the bedroom; Refused to let me work outside the home; Put foreign objects in my vagina
<b>Emotional Abuse factor</b>	Told me that I was not good enough; Told me that I was stupid; Did not want me to socialize with my female friends; Told me that I was crazy; Became upset if dinner/housework was not done when they thought it should be; Blamed me for causing their violent behavior; Tried to turn my family, friends and children against me; Told me that no one else would ever want me; Told me that I was ugly; Tried to keep me from seeing or talking to my family; Tried to convince my family, friends and children that I was crazy
<b>Physical Abuse</b>	Pushed, grabbed or shoved me; Hit or tried to hit me with something; Shook me; Slapped me; Threw me; Kicked me, bit me or hit with a fist; Beat me up
<b>Harassment Abuse</b>	Harassed me over the telephone; followed me; Hung around outside my house; Harassed me at work

answer "never", "only once", "several times", "monthly", "weekly" or "daily" in twelve months. It assesses the following: Severe Combined Abuse Factor, Emotional Abuse factor, Physical Abuse factor, and the Harassment factor. The CAS, as shown below, is made up of 4 subscales: Severe Combined Abuse (8 items; possible score 0-40), Physical Abuse (7 items; possible score 0-35), Emotional Abuse (11 items; possible score 0-55) and Harassment (4 items; possible score 0-20). The subscale score was calculated and was compared with a predetermined cut-off score for each subscale as shown in supplementary file 1 to determine whether they have had that abuse. A subscale score greater than the set score (please see supplementary file 1) would determine that the respondent has such abuse. The respondent was adjudged to have witnessed an abuse if the overall total score is 7 or above Permission was obtained for the use of Composite Abuse Scale from Kelsey Hegarty of the Department of General Practice, The University of Melbourne.

### Abuse Categorization

Following those with a total score of 7 and above, the type of abuse experienced by each respondent was categorized as shown below. Severe combined abuse took precedence over the other forms of abuse so that any participant who had experienced Severe combined abuse fell into the Severe combined abuse category (Category 1). The second category includes all participants who had experienced Physical Abuse in combination with Emotional Abuse and/or Harassment. Participants who have experienced at least one episode of Physical Abuse, but no other forms of abuse, fell into the third category, Physical Abuse Alone. The final category contains all participants who had experienced Emotional Abuse and/or Harassment, but not any other form of abuse (supplementary file 2).

### Validation of CAS

To test the reliability and internal consistency of the CAS, we surveyed 36 female nurses in the Department of Obstetrics and Gynaecology of AE-FUTHA. Respondents completed the questionnaires twice in 2 weeks and responses were matched and compared for test-retest reliability. The internal consistency for the scale was good (Cronbach's alpha = 0.72)

### Data Analysis

The data obtained were analyzed using IBM SPSS statistic 20 software. Frequency table, simple percentages, and odds ratio analysis were used for categorical variables where applicable. The student t-test was used for continuous variables. The test of significance was at  $p < 0.05$ .

## Results

A total of 912 questionnaires were distributed, each study population receiving 456 questionnaires. Fifty-four and fifty-six questionnaires of the nurses and nursing students respectively were not included in the final analysis because of incomplete information. This gave an overall response rate of 87.9%. The prevalence of IPV among the nursing student was 47.5% while the rate was 59.2% among the nurses.

Table 1 above shows the socio-demographic characteristics of the respondents. The mean age of the nursing students and nurses was 23.0 (95%CI 22.4–23.6) years and 35.4 (95% CI 34.4–36.4) years respectively which is statistically significant ( $p = 0.001$ ). The majority (268, 67.0%) of the nursing students were between the age bracket of 25–30 years unlike in nurses where the majority (164, 40.8%) were above 35 years or more. More than 50% of the nursing students were single while 1.5% were divorced. On the nurses' group, most (266, 66.2%) were married. More than 90% of the respondents were Christian and Igbo's nationality in Nigeria. Three percent of the nursing students were grand multipara (five or more deliveries).

In table 2, the mean male partner age of the respondents was 40.3 years (95% CI 39.2–41.4) for the nurses and 30.0 years (95% CI 29.0–31.1) for the nursing students

**Table 1.** Socio-Demographic Characteristic of the Study Population.

Variable	Nursing student n (%)	Nurse n (%)
<b>Age</b>		
≤19	54(13.5)	-
20–25	6(1.5)	16(4.0)
25–30	268(67.0)	98(24.4)
30–35	70(17.5)	124(30.8)
≥35	2(1.0)	164(40.8)
<b>Marital status</b>		
Single	304(76.0)	122(30.3)
Married	88(22.0)	266(66.2)
Separated	2(0.5)	-
Divorced	6(1.5)	14(3.5)
<b>Residence</b>		
Rural	128(32.0)	120(29.9)
Urban	272(68.0)	282(70.1)
<b>Social class</b>		
Lower	278(69.5)	258(64.2)
Upper	122(30.5)	144(35.8)
<b>No of children</b>		
0	304(76.0)	124(30.8)
1	34(8.5)	62(15.4)
2	26(6.5)	36(9.0)
3	10(2.5)	82(20.4)
4	14(3.5)	36(9.0)
5	6(1.5)	20(5.0)
6	6(1.5)	42(10.4)
Total	400	402

( $p = 0.001$ ). Most had tertiary education as their highest level of education while 38.7% of the male partners were unemployed.

The profile of IPV among the study is represented above in Table 3. The overall incidence of IPV was 53.5% with a higher burden among the nurses. There were more respondents in the nursing student's group with no history of IPV when compared with the nurses' group. More than one third of the respondent said they were afraid of their male partner which is more on the nursing student arm 150(37.7%) vs.124 (30.8%). The commonest type of IPV seen in our study was Severe combined abuse for the nurses and Emotional and/or Harassment abuse for the nursing students. Physical abuse was seen only among nursing students. The mean score of Severe combined abuse for nurses and nursing students were 48.5 (95% CI32.4–64.6) and 13.0 (95%CI9.9–16.1);  $p = 0.001$ , respectively. There is no significant difference between the two groups in the mean score of Physical, Emotional, and/or Harassment abuse for nurses 10(95%CI 7.8–12.2) and nursing student 11(95%CI9.6–12.4),  $p = 0.431$ . The Emotional and/or Harassment abuse score for nurses was 5.2 (95%CI3.6–6.7) while it was 4.1 (95%CI 3.4–4.7)  $p = 0.178$  for nursing students.

Table 4 represents the respondent's behavior following an assault by her partner. The majority said they would resort to prayer. Seventy percent or more would keep quiet and bear in silence in the face of IPV while 11.7% of the nurses would resort to begging which is higher than the finding among the student. Less than 14% of the nurses would 'fight back' which is comparable to a 9% response among the nursing student. When the respondent was asked whether they would like to report a case of an assault from her partner

**Table 2.** Demographic Characteristic of the Male Partner of the Respondent.

Variable	Nursing student n (%)	Nurse n (%)
≤19	8(2.0)	-
20–25	54(13.5)	8(2.0)
25–30	98(24.5)	18(4.5)
30–35	158(39.5)	102(25.4)
≥35	82(20.5)	274(68.2)
<b>Education</b>		
None	-	-
Primary	-	20(5.0)
Secondary	176(44.0)	176(43.8)
Tertiary	224(56.0)	206(51.2)
<b>Occupation</b>		
Not employed	192(48.0)	118(29.4)
Employed	208(52.0)	284(70.6)
<b>Religion</b>		
Christianity	394(98.0)	396(98.5)
Islam	6(2.0)	6(1.5)
Total	400	402

60% of the nursing student said they would while it was 75.1% for the nurses.

Tables 5 and 6 show the determinants of IPV among the study population. Students who were 23 years or less in age were at increased odds of witnessing violence from her partner and which is significant. It is evident from the table

**Table 3.** Profile of IPV among the Study Respondent.

Variable	Nursing student n (%)	Nurse n (%)
<b>IPV</b>		
Yes	190(47.5)	238(59.2)
No	210(52.5)	164(40.8)
<b>Afraid of partner</b>		
Yes	150(37.5)	124(30.8)
No	250(62.5)	278(69.2)
<b>Types of IPV</b>		
Severe combined abuse	56(14.0)	96(23.9)
Physical, Emotional&/OR Harassment abuse	22(5.5)	68(16.9)
Physical abuse	6(1.5)	-
Emotional&/OR Harassment abuse	107(26.7)	74(18.4)
None	210(52.5)	166(41.3)
Total	400	402

**Table 4.** Respondent Reaction and Attitude Towards IPV<sup>†</sup>.

Variable	Nursing student n (%)	Nurse n (%)
<b>Reaction to IPV</b>		
Keeping Quiet	140(17.5)	146(14.0)
Crying	86(10.8)	132(12.6)
Praying	216(27.0)	192(18.4)
Fight back	78(9.8)	144(13.8)
Involve 3 <sup>rd</sup> party	84(10.5)	58(5.5)
Leave house	100(12.5)	138(13.2)
Kill me approach	34(4.2)	114(10.9)
Begging	62(7.8)	122(11.7)
<b>Whom to report</b>		
Police	62(11.8)	110(14.7)
Parent	148(28.1)	184(24.5)
Sibling	44(8.4)	64(8.5)
Church	56(10.6)	76(10.1)
Friends	28(5.3)	52(6.9)
Health worker	42(8.0)	60(8.0)
Relation of partner	94(17.9)	112(14.9)
Counsellor	10(1.9)	30(4.0)
Partner's parent	32(6.1)	56(7.5)
School authority	10(1.9)	6(0.8)
<b>Reason for not reporting</b>		
Fear of further attack	102(27.7)	100(25.8)
Shame	96(26.1)	108(27.8)
Against my religion	82(22.3)	86(22.2)
Against my culture	88(23.9)	94(24.2)

<sup>†</sup>Multiple answers allowed.

that those students who were in the upper social class, not married, and whose year of study is more than 3 years were at a lower risk of IPV. Male partners of these students having tertiary education and being employed were associated with a reduced risk of their female partners witnessing violence (Table 5). From Table 6, low socio-economic class and being married is highly associated with a nurse witnessing violence (IPV). There is no significant association between the age of a nurse male partner and the history of an assault however male partners being unemployed markedly increases the risk of our respondent having witnessed IPV.

## Discussion

The finding from this study shows that IPV is common among the nurses and nursing students in the area of study. The overall prevalence rate of IPV was 53.5%. It was 47.5% among the nursing students while it was 59.2% among the graduate nurses. This difference in the burden of IPV seen in our study might be attributed to the difference in the marital status as the majority of the nurses are co-habiting with their male partner and as such might be exposed to more episodes of abuse. The prevalence of IPV among graduate nurses in our study was similar to the rate of 59.0% reported by Al-Natour et al. (2014) in Jordan. Our rate was however higher than the rates reported by Christofides and Silo (2005) in South Africa (39.0%),

**Table 5.** Determinant of IPV among the Nursing Students.

Variable	IPV among the nursing students		OR95%CI
	Yes n (%)	No n (%)	
<b>RESPONDENT</b>			
<b>Age</b>			
≤23 years	36(18.9)	74(35.6)	0.61(0.41-0.92)*
> 23 years	154(81.1)	134(64.4)	Ref
<b>Social class</b>			
Lower	122(64.2)	156(75.0)	0.77(0.58-1.04)
Upper	68(35.8)	52(25.0)	Ref
<b>Marital status</b>			
Married	60(31.6)	34(16.3)	1.49(1.13-1.98)
Singled	130(68.4)	174(83.7)	Ref
<b>Year of study</b>			
≤3 years	118(62.1)	164(78.8)	0.67(0.51-0.89)*
3 years	72(37.9)	44(21.2)	Ref
<b>PARTNER</b>			
<b>Age</b>			
≤30 years	118(62.1)	146(70.2)	0.83(0.62-1.11)
>30years	72(37.9)	62(29.8)	Ref
<b>Occupation</b>			
Not employed	84(44.2)	108(51.9)	0.85(0.63-1.14)
Employed	106(55.8)	100(48.1)	Ref
<b>Education</b>			
Below Tertiary	80(42.1)	114(54.8)	0.77 (0.57-1.03)
Tertiary	110(57.9)	94(45.2)	Ref

**Table 6.** Determinant of IPV among the Nurses.

Variable	IPV among nurses		OR 95% CI
	Yes n (%)	No n (%)	
<b>RESPONDENT</b>			
<b>Age</b>			
≤30 years	60(25.2)	54(32.9)	0.85(0.65–1.12)
>30 years	178(74.9)	110(67.1)	Ref
<b>Social class</b>			
Lower	174(73.1)	106(64.6)	1.19(0.90–1.55)
Upper	64(26.9)	58(35.4)	Ref
<b>Marital status</b>			
Married	194(81.5)	86(52.4)	1.92(1.35–2.73)
Singled	44(18.5)	78(47.6)	Ref
<b>PARTNER</b>			
<b>Age</b>			
≤30 years	20(8.4)	6(3.7)	1.33(0.96–1.83)
>30years	218(91.6)	158(96.3)	Ref
<b>Occupation</b>			
Not employed	70(29.4)	48(29.3)	1.00(0.78–1.29)
Employed	168(70.6)	116(70.7)	Ref
<b>Education</b>			
Below Tertiary	166(69.7)	80(48.8)	1.46(1.12–1.91)
Tertiary	72(30.3)	84(51.2)	Ref

Carmona-Torres et al. (2017) (31.0%), and Rodríguez-Borrego et al. (2012) (33.0%) in Spain and (2010) (25.0%) in USA. Rate as high as 42.1% and 42.3% have been reported among female students in Philadelphia, USA, and in Ibadan, Nigeria respectively (Lokhmatkina et al., 2010; Umana et al., 2014) which agrees with our rate.

This study also shows that majority of the respondents are not afraid of their male partner even among those that are abused which is in tandem with an earlier report (McLindon et al., 2018). This might be the result of an adaptation and tolerance shown by these women to maintain their relationship. Evidence suggests that most abused women often adopt strategies to maximize their safety and that of their children and their seeming inaction is not a lack of action (National Population Commission & United Nations Population Fund, 2014). The commonest form of abuse seen among the respondents is Severe combined abuse which is followed by Emotional and/or Harassment abuse. This is not in keeping with the findings of McLindon et al. (2018) in Australia where Emotional and/or Harassment abuse was more common. The difference in the study population might account for this difference from our study. There is a significant difference in the incidence of Severe combined abuse between the two groups. Severe combined abuse is reported more in nurses than in the nursing students. Severe combined abuse is the worst abuse a woman can witness and the increased percentage of respondents reporting it in this study is a worrisome finding. It could lead to femicide (Bracken et al., 2010). This high prevalence of Severe combined abuse seen in this study agrees with a similar study in Russia (Lokhmatkina et al., 2010) but

much higher than the rate of 2.1% reported by McLindon et al. (2018) in Australia.

The rate of psychological abuse among the women studied is high; this is in keeping with the findings from previous studies (Al-Natour et al., 2014; Bracken et al., 2010; Carmona-Torres et al., 2017; Christofides & Silo, 2005; McLindon et al., 2018). Physical, Emotional, and/or Harassment abuse is more prevalent among nurses while Emotional and/or Harassment abuse was more common in nursing students. In a work done in Oyo state (Umana et al., 2014), Nigeria, the proportions of students who had experienced psychological, physical, and sexual IPV were 41.8%, 7.9%, and 6.6% respectively which tends to align with our findings. Nurses and nursing students in the study area need to be supported, helped by colleagues and hospital/school managers to help alleviate the psychological burden of IPV seen in our study. Individual who have experienced violence (nurses/nursing students) must talk openly about IPV, encouraged to seek legal redress and a safe working/school environment be created to allow disclosure of IPV without the risk of stigmatization (Wathen et al., 2014).

Intimate partner violence is not without consequences to an individual and may cause body injuries, poor academic performance, loss of self-confidence, school absenteeism, hatred for men, and suicidal ideation (Esere et al., 2009; Umana et al., 2014). Previous studies have documented the prevalence of different forms of IPV such as physical, emotional, and sexual abuse in Nigeria (Ajah et al., 2014; Okemgbo et al., 2002; Onoh et al., 2013; Umana et al., 2014). The current study differs from these studies as it

used a scale - Composite Abuse Scale - to quantify the IPV. This is one of the strengths of the study, a scalar value has been used to measure the magnitude of abuse experienced by these women. It can give a face value and not the mere saying that a woman has witnessed a violence from her partner. This will enable easy global comparison of the magnitude of IPV on women. The mean score of Severe combined abuse for nurses and nursing students were 48.5 (95%CI32.4–64.6) and 13.0 (95%CI9.9–16.1);  $p = 0.001$ , respectively. There is no significant difference between the two groups in the mean score of Physical, Emotional and/or Harassment abuse for nurses 10(95%CI 7.8–12.2) and student 11(95%CI9.6–12.4),  $p = 0.431$ . The Emotional and/or Harassment abuse score for nurses was 5.2 (95% CI3.6–6.7) while it was 4.1 (95%CI 3.4–4.7),  $p = 0.178$ .

Violence against women (IPV) is better prevented than managed. Early intervention such as increasing financial security of the household as well as provision of support programs (Perrin et al., 2010; Wathen et al., 2014) and management of immediate and late consequences of IPV have been advocated for reducing IPV. This then highlights the importance of sensitizing the health managers in the study area to put measures in place in assisting nurses/nursing students that have suffered violence. Education of the populace on the negative effect of IPV will help to reduce risks to IPV. Creation of domestic violence unit in the hospital with institutionalized first responder programs and empowerment are important in the provision of succor and support to nurses and nursing students that have witnessed IPV (Trabold et al., 2018; Wathen et al., 2014). Reporting an abuse will assist in IPV reduction. It is, however, encouraging that the majority of the respondents believe that IPV should be reported although disapprovingly majority will report to their parent and the relation of her partner thus corroborating the finding of Carmona-Torres et al. (2017) in Spain. A sizable number of the respondents were of the view that IPV should not be reported thus corroborating the finding in sub-Saharan Africa (Umana et al., 2014). Our finding is also supported by an earlier finding in Spain (Carmona-Torres et al., 2017). This is a disturbing finding as an opportunity for the elimination and prevention of IPV may be lost. Disclosure of an abuse in a work place is helpful as it helps to reduce impact of IPV thus improving her wellbeing. Disclosure could lead to cross talk between employer and employee leading to workplace supports such as paid leave and creation of safety policies to ameliorate the impact of domestic violence on the work lives of the nurses and nursing students.

Intimate partner violence has been argued to operate at individual, relationship, community, and societal levels (Rodríguez-Borrego et al., 2012); individual factors include personal factors within the individual that increases the likelihood of experiencing violence or being a perpetrator of violence. Femaleness, young age, unemployment, lack of education, low socioeconomic status, growing up in a

family with a history of IPV, smoking, alcoholism, and use of drugs are some of the individual factors (Fawole et al., 2016; Onanubi et al., 2017; Umana et al., 2014). Some of the aforementioned factors were seen in the index study. Nurses in low social class have increased odds of witnessing violence than students. Our study showed a significant association between being young among the student and having witnessed IPV which is corroborated by the findings from earlier studies (Abramsky et al., 2011; Carmona-Torres et al., 2018). Student's respondent age less than or equal to 23 years were at 48.7% (OR = 0.487 95% CI 0.243–0.976) increased odds of having IPV while increasing respondent year of study was associated with decreasing likelihood of experiencing IPV (0.518 95% CI 0.269–1.006). The contribution of the increasing year of study in reducing the risk of assault might not be unrelated to the influence of education on women's empowerment and her ability to assert her right in any relationship. It could also result from the pervasive effect of respondent age that increases with the level of education. It is evident from our study, although not significant, of the association between being married and IPV, thus highlighting the burden of IPV among married women. The male partner's being young, unemployed, and having less than tertiary education is associated with increased odd of his partner experiencing violence. Above is supported by previous studies Krug, Mercy, Dahlberg, & Zwi, 2002; (Carmona-Torres et al., 2018; Fawole et al., 2016; Onanubi et al., 2017; Uthman et al., 2010). The odd of a male partner being abusive is increased in graduate nurses than nursing students. Difference in the level of education and social class between the two groups might account for the observation as increased in education cum level of social class as seen in the students were able to extract more respect from their partner.

### *Limitations of the Study*

Our study is limited by the fact that it is not possible to determine causal relationships between the socio-demographic variables of the women and IPV but only to test for associations. Being a hospital based study with its bias, findings from our study cannot be generalized to total population of nurses and nursing students in the area of study. There may have been recalling bias and some respondents may have been reluctant to disclose an experience of violence due to social desirability bias. The prevalence of IPV seen in our study might be influenced by the tool (CAS) used in accessing it. An effort was however made to reduce these errors by encouraging respondents to recall any IPV in the last year. The respondent was educated on the study instrument and the internal consistency of the scale assessed for its ability to access IPV in our study area. Our study, however, provides useful information that could guide students, parents, school authorities, hospital managers, and policymakers on how to avoid violence in schools and the general population.



## Implications for Practice and Recommendations

The study shows that students less than 23 years and those in the early years in school are more vulnerable to partner assault. These findings highlight the urgent need for comprehensive intervention programs to target vulnerable students in the study area. The degree of IPV among the graduate nurses is worrisome. This finding makes it paramount that the hospital manager in our facility should invest in comprehensive primary prevention intervention efforts to prevent IPV in the study population. Our findings demonstrate the need to implement action and intervention plans, both to support individuals experiencing violence and to mitigate the problem associated with IPV in the study population. We advocate the creation of workplace supports such as paid leave, creation of safety policies that limit the perpetrator's access to the workplace, time-off, emotional and financial support to help ameliorate the impact of domestic violence on the victim (Perrin et al., 2010; Wathen et al., 2014). Advocacy and cognitive behavioural therapy interventions should be developed in the institution to assist individuals who have experienced violence (Tirado-Muñoz et al., 2014). As a long-term policy, education of menfolk and community in general on the negative effects of IPV on the woman and the society in general and the need to have attitudinal cum societal change. It is also important that a curriculum on IPV prevention, identification and management be developed for nursing students in the study area and Nigeria in general to proactively prepare nurses on how to manage it (Tufts et al., 2009).

## Conclusion

The prevalence of IPV in the studied group was high as over half (53.5%) of the respondents reported having experienced at least one form of IPV. The commonest form of IPV was Emotional and/or Harassment abuse followed by Severe combined abuse. The level of Severe combined abuse in our study is disturbing which exposes the gravity of torture and pain that women undergo unnoticed in Nigeria. It is however encouraging that the majority of respondents believed that IPV should be reported; they should be encouraged to do so to the appropriate authority especially Severe combined abuse.

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## Authors' Contributions

CCA & IHA: conceptualization/study design, data collection/analysis, and interpretation of findings and drafting and writing of the manuscript. OSU, BCO, BIN, LRE, COO, GUE, FCO & CCI:

interpretation of findings, data collection and drafting of the manuscript. All participated in the review of the final manuscript. All the authors approved the manuscript.

## Availability of Data and Material

All data generated or analyzed during this study are included in this published article.

## Competing Interests

The authors declare that they have no competing interests.

## Consent for Publication

Not applicable

## Declaration of Conflicting Interests

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

## Ethical Consideration

Ethical approval for this study was obtained from the Health Research and Ethics Committee of Alex Ekwueme Federal University Teaching Hospital Abakaliki, Ebonyi state. The ethical approval number is FETHA/REC/VOL1/2017/630

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