

## Nurses' Knowledge, Attitudes, Practices and Associated Factors in the Care of Women Subjected to Intimate Partner Violence in the Western Province of Sri Lanka

**Sujatha Seneviratne<sup>1\*</sup>, Sepali Guruge<sup>2</sup>, Sivagurunathan Sivayogan<sup>3</sup> and Jayantha Jayasiri<sup>4</sup>**

<sup>1</sup>Department of Nursing and Midwifery, <sup>3</sup>Department of Community Medicine, <sup>4</sup>Department of Sociology and Anthropology, University of Sri Jayewardenepura, Nugegoda, Sri Lanka

<sup>2</sup>Daphne Cockwell School of Nursing, Toronto Metropolitan University, Toronto, Canada


### Abstract

Intimate partner violence (IPV) is recognized as a preventable public health problem. Previous studies in Sri Lanka report high prevalence rates of IPV. Nurses as the largest healthcare force can take on a significant role in the care of women subjected to IPV. This study aimed to describe nurses' knowledge, attitudes and practices related to providing care for women subjected to IPV in the Sri Lankan context. A cross-sectional study was conducted with 407 female nurses from 17 hospitals in the Western Province, using a stratified random sampling

---

\*Correspondence should be addressed to **Dr. Sujatha Seneviratne**, Department of Nursing and Midwifery, University of Sri Jayewardenepura, Gangodawila, Nugegoda, Sri Lanka.

**Email:** [senevir@sjp.ac.lk](mailto:senevir@sjp.ac.lk)

 <https://orcid.org/0000-0001-7108-7199>

(Received 14<sup>th</sup> October 2022; Revised 01<sup>st</sup> December 2022; Accepted 28<sup>th</sup> December 2022 © OUSL)



This article is published under the Creative Commons Attribution-Share Alike 4.0 International License (CC-BY-SA). This license permits use, distribution and reproduction in any medium; provided it is licensed under the same terms and the original work is properly cited

strategy. A pretested self-administered questionnaire was used. Most (85%) participants had poor overall knowledge related to IPV. Higher knowledge scores were found for: acts indicating IPV ( $80\pm 28.2$ ), health problems related to IPV ( $74.6\pm 24.4$ ), and reasons preventing disclosure ( $81.4\pm 19.6$ ). Knowledge scores were low for root causes of IPV ( $49.7\pm 19.0$ ), laws pertaining to IPV ( $31.0\pm 25.9$ ), and the available services ( $19.1\pm 25.07$ ). Good overall attitudes were evident among 54%, specifically, in the areas of inquiring about IPV (91%), offering the assistance (79.8%), and maintaining confidentiality (57%). Most (86.5%) had met women subjected to IPV, and the most frequent (52.3%) action they had taken was to inform a doctor. Higher levels of education, in-service learning, and learning about IPV in basic nursing education, were positively associated with knowledge and attitude levels. The results call for an urgent need for inclusion of IPV related content and skills-training in nursing curricula to enable nurses to identify, support, and provide care to women subjected to IPV.

**Keywords:** intimate partner violence, nurses, knowledge, attitudes, Sri Lanka

## **Introduction**

Intimate partner violence (IPV) is one of the most common forms of violence against women, and includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner [World Health Organization (WHO), 2019]. Both men and women can be subjected to violence by their partners, but women are the majority of victims of IPV worldwide (WHO and Pan American Health Organization, 2012). Compared to a global prevalence of one in three women experiencing violence, a recent scoping review of the studies conducted in Sri Lanka revealed that the prevalence of IPV in Sri Lanka ranged from 20-72% (Guruge et al., 2015). Women suffer many short and long-term health consequences of IPV, including physical injuries, sexually transmitted infections, negative pregnancy outcomes, mental health problems, and poor overall health (WHO, 2019).

Although women subjected to IPV often visit healthcare professionals, most victims do not disclose violence during such visits (WHO & Pan American Health Organization, 2012; Guruge et al., 2015). Among the

healthcare professionals, nurses are the largest work force in most countries around the world and in Sri Lanka (Ministry of Health and Indigenous Medical services, 2017), and as such, more likely to come in contact with women experiencing IPV.

Limited knowledge about IPV was reported in previous studies of nurses in many countries (Alem et al., 2015; Alhalal, 2020; Aljomaie et al., 2022; Ambikile et al., 2020; Ramsay et al., 2012; Sharma et al., 2018). Lack of knowledge and skills of Sri Lankan nurses related to the care of women experiencing IPV was identified in a qualitative study conducted with nurses from across the country (Guruge, 2012). A recent cross-sectional study reported that only 17% of nurses had received training on IPV (Guruge et al., 2021). Stigmatizing attitudes among nurses towards women survivors who seek hospital care have also been reported from Sri Lanka (Jayasuriya et al., 2011). Patriarchal attitudes and gender biases internalized by women themselves are evident in the Sri Lankan society, with many women believing that they should tolerate IPV (Kuruppuarachchi et al., 2010). Further, a survey of 1658 men and 653 women between the ages of 19-49, in four districts in Sri Lanka, revealed more gender inequitable attitudes among females than males; for example, more female than male participants believed that one should consider whether a rape victim had a “bad reputation” (De Mel et al., 2013). The findings of these studies indicate an urgent need to further assess attitudes of healthcare professionals in Sri Lanka towards IPV, as well as their competency in providing support and care to women experiencing IPV. The current study aimed to describe nurses' knowledge, attitudes and practices related to providing care for women subjected to IPV, and to identify factors that can enhance their knowledge and attitudes.

## **Methodology**

### **Study design, sampling and participants**

A descriptive cross-sectional study was conducted among female nurses working in 17 primary, secondary, and tertiary government hospitals from the Western Province of Sri Lanka, which comprises three districts and a population of 5.822 million. The province was selected because of two factors: a high lifetime prevalence of IPV

(Jayasuriya et al., 2011) of 34%, and the highest population and nursing density within the country (WHO, 2018). The target population consisted of female nurses from the Accident and Emergency (A&E) Units, Outpatient Departments (OPD), Primary Care Units (PCU), Obstetrics and Gynaecology Units (ObGyn), and Eye care Units (Eye), as these are the places where women subjected to IPV have primarily sought medical care in most countries (WHO and Pan American Health Organization, 2012).

Stratified random sampling used in this study is described below. The government hospitals in the Western Province that provide care for adults (excluding the specialized care hospitals) were stratified, according to the classification by the Ministry of Healthcare and Nutrition, Sri Lanka in 2008, to include primary, secondary and tertiary care. The hospitals within each stratum were selected randomly by a lottery draw method to achieve a representative sample of 17 hospitals from the three Districts in the Western Province. The draw was repeated when too many hospitals were drawn from one stratum. A proportionate number of nurses from the above-mentioned units of each selected hospital was obtained to achieve the sample size of 422 calculated according to Lwanga & Lemeshaw (1991). At the time of data collection, the participants were selected through systematic random sampling using nurses' attendance registers in each unit specified above. Within this study, the term 'care' was defined as intentional activities that a nurse will perform, within the multidisciplinary team, for the well-being of a patient.

### **Study instruments**

A semi-structured questionnaire was developed by the researchers based on the literature and expert opinion. A panel of three subject experts made decisions on selecting the knowledge domains/areas to be assessed through the questionnaire and prioritized according to their relative importance for nurses in their practice. The questionnaire consisted of three sections: Section A: socio-demographic information (10 items) and practices (09); Section B: attitudinal statements (17) in a five-point Likert scale (Strongly Agree to Strongly Disagree); Section C: knowledge questions (13) consisting of 10 multiple choice questions (to elicit Yes/No/Don't know responses) and three short answer

questions, covering 12 domains of knowledge related to IPV (Figure 2). Content and face validity of the questionnaire were assessed by the same panel of three subject experts. The questionnaire was then pre-tested with a sample of 20 nurses from a hospital in another province that was not included in the final sample. Based on their input, the questionnaire was revised to include an illustrative scenario of a woman subjected to IPV, as well as slight wording changes to one attitudinal item and two knowledge items to provide a clear understanding of the questions. The order of questions was also changed.

### **Ethical considerations**

Ethics approval was obtained from the Ethics Review committee of the Faculty of Medical Sciences, University of Sri Jayewardenepura (Ref. 74/14). Permission to collect data was obtained from the Ministry of Health Sri Lanka, and the authorities of each hospital. Nurses from each of the selected hospitals were informed about the study through their own Chief Nursing Officers. Written informed consent was obtained from all potential participants prior to their completion of the questionnaire.

### **Data analysis**

The completed questionnaires were analysed, using SPSS version 21. Descriptive and inferential statistics were used. One mark was allocated for correct answers to knowledge questions, and a zero mark for incorrect or 'Don't know' answers. A weighted system was employed to calculate overall knowledge scores, because of the use of an unequal number of questions for different knowledge domains (Streiner et al., 2015). The weighted system was reviewed and finalized, and the knowledge cut-off mark was decided by an expert panel of six members, consisting of consultant community physicians (02), a sociologist with research experience on IPV, a senior lecturer in forensic medicine, a GBV expert from the Ministry of Health and a senior lecturer in nursing using a modified Delphi technique. The marks for each of the 12 domains (out of 100) were multiplied by the respective weight and were added to get the overall knowledge score. The cut-off mark was established by the experts as the level of

knowledge that a nurse should possess to function as an effective healthcare team member in the care of a woman subjected to IPV. Accordingly, an overall mean knowledge score of  $\geq 60$  was categorized as 'Good' knowledge, and  $\leq 59$  as 'Poor' knowledge. An overall mean attitude score of  $\geq 7.82$  was considered to represent 'Good' attitudes, and below the mean as 'Poor' attitudes.

Identification of factors that enhance knowledge and attitudes was done using binary logistic regression to control confounding factors. The final model was selected on the basis of theoretical and statistical significance of factors for knowledge and attitudes to care for women subjected to IPV. The model estimates were presented with adjusted odds ratios and 95% CI ( $p < 0.05$ ).

## **Results**

### **Study participants**

A total of 407 completed questionnaires were received (The response rate was 96%). The mean age of the study participants was 38.6 ( $\pm 7.9$ ) years (range 26-61).

As shown in Table 1, 188 (46.2%) participants were between 31-40 years of age; 339 (83.3%) were married; and 268 (65.8%) were raising children. In total, 146 (35.9%) had 11-20 years of work experience; and 168 (41.3%) worked in ObGyn units. Most of the participants (370, 90.9%) were educated at the nursing diploma level, and 352 (86.5%) did not have any form of training related to IPV. Of the total sample, only 98 (24%) had learnt IPV related content at the pre-registration level, only 55 (13.5%) had undergone some form of in-service training related to IPV and only 24 (5.9%) participants stated that their learning was adequate to care for women who are subjected to IPV.

### **Knowledge on the care for women subjected to IPV**

The mean knowledge score of the participants was 48.10 ( $\pm 11.19$ ). The number of nurses who had good overall knowledge was 62 (15.2%), and poor overall knowledge was 345 (84.8%).

**Table 1.**

*Demographics, Workplace Characteristics and Prior Learning on IPV (N=407)*

<b>Characteristic</b>	<b>Frequency</b>	<b>(%)</b>
Age		
<30 years	68	16.7
31-40 years	188	46.2
Above 40 years	151	37.1
Marital status		
Married	339	83.3
Unmarried	68	16.7
Having children		
Yes	268	65.8
No	139	34.2
Highest educational level		
Diploma	370	90.9
Degree and above	37	9.1
Total years of service		
< 5 years	67	16.5
6-10 years	104	25.6
11-20 years	146	35.9
>20 years	90	22.1
Work area/Unit		
Gynaecology & Obstetrics	168	41.3
Accident/Emergency	69	17.0
Eye	19	4.7
Outpatient Dept./PCU	112	27.5
Surgical Casualty	39	9.6
Prior learning on care for women subjected to IPV		
Diploma/Undergraduate level		
Learnt	98	24.1
Not learnt	309	75.9
In-service training		
Attended	55	13.5
Not attended	352	86.5
Adequacy of learning to care for women subjected to IPV		
Adequate	24	5.9
Not Adequate	383	94.1

High levels of (mean) knowledge scores were found in the domains of: acts indicating IPV (80±28.2), health problems women were presented with (74.6±24.4), reasons preventing disclosure (81.4±19.6), reasons for women staying in violent relationships (79.2±23.1), and nurses' contribution in providing support for women experiencing IPV (67.8±15.6). Lower levels of knowledge were evident in the domains of root causes of IPV (49.7±19.0), non-health consequences (53.5±24.0), laws pertaining to IPV (31.0±25.9), services available in state sector (19.1±25.07) and in non-state sector (7.4± 22.1), and principles in providing women-centred care (33.7±26.5). Knowledge scores for each of the 12 domains are presented in Table 2.

**Table 2.**

*Mean Scores of Knowledges related to Care for Women Subjected to IPV in each Domain*

<b>Knowledge domain</b>	<b>Mean</b>	<b>±SD</b>
What may prevent women disclosing IPV	81.4	19.55
Acts indicating IPV	80.1	28.18
Reasons for women staying longer in violent relationships	79.2	23.11
Health problems presented in women subjected to IPV	74.6	24.41
Consequences of IPV affecting children	69.7	14.58
Contribution of a nurse in providing support for women experiencing IPV	67.8	15.56
Non-health consequences of IPV	53.5	24.02
Root causes of IPV	49.7	19.03
Principles in providing women-centred care	33.7	26.47
Existing law in Sri Lanka to help women subjected to IPV	31.0	25.86
Services available in government sector to help women subjected to IPV	19.1	25.08
Services available in non-government sector to help women subjected to IPV	7.4	22.11



**Table 3.**

*Frequency Distribution of Practices of Participants related to Care for Women Subjected to IPV*

<b>Response</b>	<b>Frequency</b>	<b>(%)</b>
Have ever met a woman subjected to IPV in the hospital (n=407)		
Ever met a woman survivor	352	86.5
Never met a woman survivor	55	13.5
Have ever met a woman subjected to IPV in the hospital and talked with them regarding their experiences of violence (n= 352)		
Talked regarding woman's experience of violence	263	74.7
Did not talk about woman's experience of violence	89	25.3
Last encounter of participants with a woman subjected to IPV at the workplace (n=407)		
During the last seven days	67	16.46
During previous month (8-30 days)	82	20.15
During past three months (31-90 days)	56	13.76
More than three months (Above 90 days)	52	12.78
No encounter reported	150	36.85
Have come across anyone in their social circle (relative, friend, neighbour) outside their work settings, subjected to IPV (n=407)		
Yes	323	79.40
No	84	20.60
Actions taken when they met women subjected to IPV# (n=352)		
I brought it to the notice of a doctor	184	52.3
I let her speak and listened to her	180	51.1
I gave information about services available to help women	164	46.6
I asked her to tell everything to the Police	135	38.4
I helped her by contacting one of the services available	76	21.6
I advised her to be tolerant	21	6.0

#Multiple responses elicited

### **Attitudes of participants towards care for women subjected to IPV**

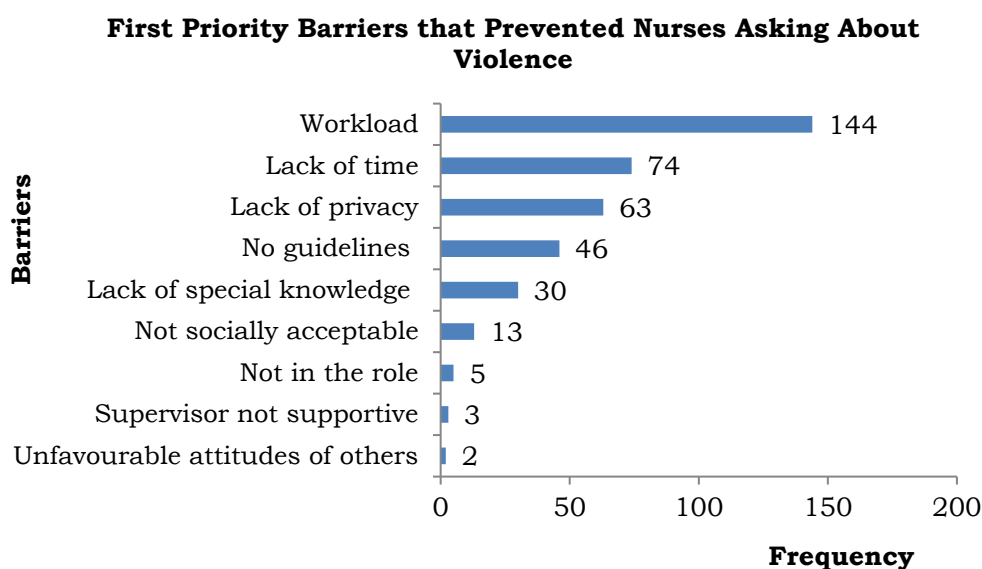
The mean ( $\pm$ SD) attitude score of the participants was 7.82 ( $\pm$ 5.00). About half of the study sample 218 (53.6%) had 'good' attitudes and 186 (46.4%) had 'poor' attitudes. Favourable attitudes were evident in the areas of: inquiring about IPV 370 (91%), offering assistance though there is a lack of resources 327 (79.8%), and maintaining confidentiality 232 (57%). However, 139 (34%) agreed that violence by a husband is justifiable if the wife behaves in a way to provoke him, and 147 (36%) agreed that women should tolerate violence for the sake of their children. Sixteen (3.9%) participants strongly agreed, and 131 (32.2%) agreed that a wife should continue to live with an abusive husband because of the welfare of their children, while 160 (39.3%) disagreed. Further, 156 (38.3%) disagreed, and 76 (18.7%) strongly disagreed while 117 (28.7%) agreed and 5 (1.2%) strongly agreed, that it was appropriate to talk about a survivor's problems with a colleague if the survivor is not present. About half of the participants, 54 (13.3%) strongly disagreed, and 177 (43.5%) disagreed, while 90 (22.1%) agreed and 13 (3.1%) strongly agreed with the statement, "Being a man, a husband should always be able to have power and control over his wife." A total of 221 (54.3%) disagreed, and 16 (3.9%) strongly disagreed with the statement, "There is no use of talking with women survivors, without addressing their social and financial problems," while 106 (26%) agreed and 14 (3.4%) strongly agreed.

### **Practices related to care for women subjected to IPV**

Participants' responses about their practices related to the care of women subjected to IPV are shown in Table 3. Of the 407 participants, 352 (86.5%) reported ever having met an IPV victim at the hospital where they work, and 263 (74.7%) reported having talked with an IPV victim about their experience of violence. In total, 67 (17%) of participants reported having had an encounter with a woman subjected to IPV during the previous week, while 92 (20%) reported having had an encounter with a woman subjected to IPV during the previous month. A total of 93 (35.3%) participants reported having personally identified a woman subjected to IPV (not identified by others) during the last three months. Further, 323 (79.4%) had come across a victim of IPV in their social circle.

The actions taken to help IPV victims are presented in Table 3. The most frequent actions taken were: 'bringing it to the notice of a doctor' 184 (52.3%), 'letting them speak and listening to them' 180 (51.1%), 'giving information on the services available' 164 (46.6%), and 'asking them to tell everything to the Police' 135 (38.4%).

Of the 117 participants who responded to the question on reasons for not being able to talk with women subjected to violence, 32 (7.9%) chose 'women did not like to talk', and 30 (7.4%) chose 'being busy and not having time to attend' as their reason. Primary barriers that prevented participants from asking women about violence, selected as their priority were: workload, lack of time, lack of privacy, no guidelines, and lack of specific knowledge on IPV (Figure 1).



**Figure 1.** Frequency Distribution of First Priority Barriers that Prevented Nurses asking Women about Violence (multiple answers elicited)

### **The factors enhancing knowledge and attitudes of participants**

Among the socioeconomic and work-related factors, only level of education and in-service learning on IPV facilitated the knowledge and

attitudes of nurses (Table 4). The participants who had obtained a bachelor's degree in nursing had better knowledge regarding IPV compared to the nurses prepared at the diploma level (OR 2.26, 95% CI = 1.4 - 4.95). The knowledge level of the nurses who had received in-service learning on IPV is nearly four times higher than the nurses who had not undergone such training (OR 3.79, 95% CI = 2.00 - 7.20). Regarding attitudes towards the care of women experiencing IPV (Table 3), nurses with a bachelor's degree had more positive attitudes towards the care of women subjected to IPV than those with a nursing diploma (OR 2.19, 95% CI = 1.05 - 4.56). The nurses who had in-service learning on IPV reported better attitudes than the nurses who have not had such training (OR 2.36, 95% CI = 1.26 - 4.34).

In addition, the level of knowledge (on IPV) acquired during basic nursing education showed a significant association with the attitudes of the nurses (OR 2.89, 95% CI = 1.57 - 5.30). Nurses with better knowledge levels showed more positive attitudes towards the care of women subjected to IPV than their counterparts (OR 2.89, 95% CI = 1.58 - 5.31).

## **Discussion**

The findings of this study show that nurses in the Western Province of Sri Lanka are not adequately prepared to care for women subjected to IPV. These findings corroborate the previous Sri Lankan qualitative study by Guruge in 2012 and are similar to the findings in studies of nurses in other countries (Alhalal, 2020; Aljomaie et al, 2022; Alshammari et al., 2018; Ambikile et al., 2020; Cortes et al., 2015; Djikanovic et al., 2011; Papadakaki et al., 2013; Sundborg et al., 2012). The current study found that about 85% of the participant nurses in the Western Province of Sri Lanka had inadequate overall knowledge of IPV, while about 55% showed good overall attitudes. The fact that half of nurses in the current study show good overall attitudes despite their inadequate knowledge of IPV could be due to their commitment to support women as their professional responsibility and duty. This could also be due to the increased awareness of the need for gender equality in Sri Lankan society as a result of its higher literacy rate (Gunawardena, 2015).

**Table 4.** Socio-demographic Factors Enhancing Knowledge and Attitudes of Participants (N=407)

Characteristics	Good Knowledge (n =62) n (%)	Poor knowledge (n = 345) n (%)	Unadjusted Odds Ratio (95% CI)	Good attitudes (n =218) n (%)	Poor attitudes (n = 189) n (%)	Unadjusted Odds Ratio (95% CI)
Age						
<40 years	37 (59.7)	219 (63.5)	0.85 (0.49 -1.48)	140 (64.2)	116 (61.4)	1.13 (0.75 - 1.69)
>40 years	25 (40.3)	126 (36.5)		78 (35.8)	73 (38.6)	
Having children						
Yes	36 (58.1)	232 (67.2)	0.67 (0.38 -1.17)	142 (65.1)	126 (66.7)	0.93 (0.62 -1.41)
No	26 (41.9)	113 (32.8)		76 (34.9)	63 (33.3)	
Marital status						
Married	47 (75.8)	292 (84.6)	0.57 (0.29 -1.09)	180 (82.6)	159 (84.1)	0.89 (0.53- 1.51)
Other	15 (24.2)	53 (15.4)		38 (17.4)	30 (15.9)	
Level of education						
Degree and above	10 (16.1)	27 (7.8)	2.26 (1.04 - 4.95)	26 (11.9)	11 (5.8)	2.19 (1.05 - 4.56)
Diploma	52 (83.9)	318 (92.2)		192 (88.1)	178 (94.2)	
In-service learning on IPV						
Yes	19 (30.6)	36 (10.4)	3.79 (2.00 - 7.20)	39 (17.9)	16 (8.5)	2.36 (1.26 - 4.34)
No	43 (69.4)	309 (89.6)		179 (82.1)	173 (91.5)	
Learnt IPV in basic nursing education						
Yes	18 (29.0)	80 (23.2)	1.35 (0.74 - 2.47)	61 (28.0)	37 (19.6)	1.60 (1.01 - 2.51)
No	44 (71.0)	265 (76.8)		157 (72.0)	152 (80.4)	

The current study found that only 24% of respondents received prior learning about IPV in their basic nursing education, either at diploma or undergraduate levels, and only 13.5% had received in-service education related to IPV. These findings confirm the results from a recent Sri Lankan study reporting only 17% having undergone prior training, and 80% expressing the need for more training on IPV (Guruge et al., 2021).

Regardless of prior education on IPV, most of the nurses (86.5%) in the current study have, in the course of their work, met a woman subjected to IPV, and (79.4%) have come across women victims of violence within their social circles, which indicate a high level of the problem of IPV and nurses' awareness of it. With regard to actions taken, out of 352 nurses who had met a woman subjected to IPV, 51% reported that they encouraged the woman to talk and listened to them, compared to most (82%) healthcare professionals in a previous study (Guruge et al., 2021). Further, 47% in the current study reported giving information about the available services compared to 20% providing IPV related information from the same (previous) study (Guruge et al., 2021).

In the current study, higher educational levels, total years of service, and having received in-service training on IPV were significantly associated with the level of overall knowledge, at  $p < 0.05$ . In contrast to the above result, a study from Kuwait found that higher knowledge scores were significantly associated with nurses having fewer years of experience (Alsafy & Kamel, 2011), while a study from India also found that higher scores of knowledges and attitudes are associated with a younger age and less total years of experience (Sharma et al., 2018). The latter groups may have gained knowledge from informal sources as reported in a previous study (Seneviratne et al., 2020).

The findings of this study show that nurses in the Western Province of Sri Lanka are not adequately prepared to care for women subjected to IPV. These findings corroborate the previous Sri Lankan qualitative study by Guruge in 2012 and are similar to the findings in studies of nurses in other countries (Alhalal, 2020; Aljomaie et al, 2022; Alshammari et al., 2018; Ambikile et al., 2020; Cortes et al., 2015; Djikanovic et al., 2011; Papadakaki et al., 2013; Sundborg et al.,

2012). The current study found that about 85% of the participant nurses in the Western Province of Sri Lanka had poor overall knowledge of IPV, while about 55% showed good overall attitudes. The fact that half of nurses in the current study show good overall attitudes despite their poor knowledge of IPV could be due to their commitment to support women as their professional responsibility and duty. This could also be due to the increased awareness of the need for gender equality in Sri Lankan society as a result of its higher literacy rate (Gunawardena, 2015).

The current study found that only 24% of respondents received prior learning about IPV in their basic nursing education, either at diploma or undergraduate levels, and only 13.5% had received in-service education related to IPV. These findings confirm the results from a recent Sri Lankan study reporting only 17% having undergone prior training, and 80% expressing the need for more training on IPV (Guruge et al., 2021).

Regardless of prior education on IPV, most of the nurses (86.5%) in the current study have, in the course of their work, met a woman subjected to IPV, and (79.4%) have come across women survivors of violence within their social circles, which indicate a high level of the problem of IPV and nurses' awareness of it. With regard to actions taken, out of 352 nurses who had met a woman subjected to IPV, 51% reported that they encouraged the woman to talk and listened to them, compared to most (82%) healthcare professionals in a previous study (Guruge et al., 2021). Further, 47% in the current study reported giving information about the available services compared to 20% providing IPV related information from the same (previous) study (Guruge et al., 2021).

In the current study, higher educational levels, total years of service, and having received in-service training on IPV were significantly associated with the level of overall knowledge, at  $p < 0.05$ . In contrast to the above result, a study from Kuwait found that higher knowledge scores were significantly associated with nurses having fewer years of experience (Alsafy & Kamel, 2011), while a study from India also found that higher scores of knowledges and attitudes are associated with a younger age and less total years of experience (Sharma et al., 2018).

The latter groups may have gained knowledge from informal sources as reported in a previous study (Seneviratne et al., 2020).

## Conclusions

Overall knowledge levels about IPV were poor among a majority of nurses in this study. Although they showed positive attitudes, some possessed traditional patriarchal attitudes and biases towards women experiencing IPV and majority have not offered adequate help. Poor knowledge was evident on principles of women-centred care, legal aspects, and resources available to IPV survivors within practice settings and in the community. Those with better knowledge of IPV had favourable attitudes regarding the care of women subjected to IPV. The study highlights the need for the authorities to take steps to include IPV related content and skills-training in nursing curricula so that nurses will develop favourable attitudes and practices needed to identify, support and provide care for women subjected to IPV.

## Acknowledgements

This work was supported by the University Research Grant, University of Sri Jayewardenepura, Sri Lanka [ASP/01/RE/MED/2015/35].

## References

- Alem, G., Zeleke, H., & Mengistu, D. (2015). Assessment of nurses' preparedness and identify barriers to care women exposed to intimate partner violence in East Gojjam Zone, Ethiopia, 2014. *Journal of Nursing Care*, 4(250), 2167-1168. DOI:10.4172/2167-1168.1000250.
- Aljomaie, H. A. H., Hollingdrake, O., Cruz, A. A., & Currie, J. (2022). A scoping review of the healthcare provided by nurses to people experiencing domestic violence in primary healthcare settings. *International Journal of Nursing Studies Advances*, 4. <https://doi.org/10.1016/j.ijnsa.2022.100068>.
- Alhalal, E. (2020). The effects of an intimate partner violence educational intervention on nurses: A quasi-experimental



study. *Nurse Education in Practice*, 47, 102854.  
doi: 10.1016/j.nepr.2020.102854.

- Ambikile, J. S., Leshabari, S., & Ohnishi, M. (2020). Knowledge, attitude, and preparedness toward IPV care provision among nurses and midwives in Tanzania. *Human Resources for Health*, 18(1), 1-7. <https://doi.org/10.1186/s12960-020-00499-3>.
- Al-Natour, A., Qandil, A., & Gillespie, G. L. (2015). Intimate partner violence screening barriers as perceived by Jordanian nurses: A qualitative descriptive study. *Journal of Nursing Education and Practice*, 5(9), 11-16. DOI: 10.5430/jnep.v5n9p11.
- Alotaby, I. Y., Alkandari, B. A., Alshamali, K. A., Kamel, M. I., & El-Shazly, M. (2013). Barriers for domestic violence screening in primary healthcare centers. *Alexandria Journal of Medicine*, 49(2), 175-180.  
<https://doi.org/10.1016/j.ajme.2012.07.005>.
- Alsafy, N. N., & Kamel, M. I. (2011). Knowledge of primary care nurses regarding domestic violence. *Alexandria Journal of Medicine*, 47(2). DOI: 10.1016/j.ajme.2011.02.002.
- Alshammari, K. F., McGarry, J., & Higginbottom, G. M. A. (2018). Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. *Nursing Open*, 5(3), 237-253.  
DOI: 10.1002/nop2.133.
- Alsabhan, E. H., Al-Mutairi, M. M., Al-Kandari, W. A., Kamel, M. I., & El-Shazly, M. K. (2011). Barriers for administering primary healthcare services to battered women: Perception of physician and nurses. *Alexandria Journal of Medicine*, 47(4).  
DOI: 10.1016/j.ajme.2011.08.003.
- Beynon, C. E., Gutmanis, I. A., Tutty, L. M., Wathen, C. N., & MacMillan, H. L. (2012). Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC Public Health*, 12(1), 1-12. DOI: 10.1186/1471-2458-12-473.
- Cortes, L. F., Padoin, S. M. D. M., Vieira, L. B., Landerdahl, M. C., & Arboit, J. (2015). Care for women victims of violence:

- empowering nurses in the pursuit of gender equity. *Rev Gaúcha Enferm*, 36(esp). DOI: 10.1590/1983-1447.2015.esp.57162.
- De Mel, N., Peiris, P., & Gomez, S. (2013). Broadening Gender: Why masculinities matter-Attitudes, practices and gender-based violence in four districts in Sri Lanka. *CARE International Sri Lanka*. [https://www.care.org/wp-content/uploads/2020/05/Broadening-Gender\\_Why-Masculinities-Matter.pdf](https://www.care.org/wp-content/uploads/2020/05/Broadening-Gender_Why-Masculinities-Matter.pdf).
- Djikanovic, B., Lo Fo Wong, S., Stevanovic, S., Celik, H., & Lagro-Janssen, A. (2011). Women's expectations of healthcare professionals in case of intimate partner violence in Serbia. *Women & Health*, 51(7), 693-708. DOI: 10.1080/03630242.2011.620697.
- Gunawardena, N. S. (2015). Women in Sri Lanka: achievements and challenges. *Journal of the College of Community Physicians of Sri Lanka*, 20(1). DOI: <http://doi.org/10.4038/jccpsl.v20i1.8067>.
- Guruge, S. (2012). Nurses' role in caring for women experiencing intimate partner violence in the Sri Lankan context. *International Scholarly Research Notices, Nursing*, 2012, 1-8. DOI: 10.5402/2012/486273.
- Guruge, S., Jayasuriya-Illesinghe, V., & Gunawardena, N. (2015). A review of the Sri Lankan health-sector response to intimate partner violence: Looking back, moving forward. *WHO South-East Asia Journal of Public Health*, 4(1), 6. DOI: 10.4103/2224-3151.206622.
- Guruge S, Illesinghe V, & Gunawardena N. (2021). Healthcare provider responses and preparedness towards caring for females who have experienced intimate partner violence in Sri Lanka. *OUSL Journal*, 16(2), 65-85. DOI: <http://doi.org/10.4038/ouslj.v16i2.7507>.
- Jayasuriya, V., Wijewardena, K., & Axemo, P. (2011). Intimate partner violence against women in the capital province of Sri Lanka: prevalence, risk factors, and help seeking. *Violence Against Women*, 17(8), 1086-1102. DOI: 10.1177/1077801211417151.
- Kurupparachchi, K. A. L. A., Wijeratne, L. T., Weerasinghe, G. D. S. S. K., Peiris, M. U. P. K., & Williams, S. S. (2010). A study of intimate partner violence among females attending a teaching

hospital outpatient department. *Sri Lanka Journal of Psychiatry*, 1(2). DOI: 10.4038/sljpsyc.v1i2.2577.

Lwanga, S. K., Lemeshow, S., & World Health Organization. (1991). *Sample size determination in health studies: A Practical Manual*. World Health Organization.  
<https://apps.who.int/iris/handle/10665/40062>.

Ministry of Women and Child Affairs (2016), The policy framework and national plan of action to address sexual and gender-based violence (SGBV) in Sri Lanka 2016-2020, Ministry of Women and Child Affairs, Colombo. <http://gbvforum.lk/r-library/document/SGBV%20National%20Action%20Plan.pdf>.

Ministry of Health and Indigenous Medical Services (2017), *Annual Health Bulletin 2017*. Ministry of Health and Indigenous Medical Services Sri Lanka.  
[http://www.health.gov.lk/moh\\_final/english/public/elfinder/files/publications/AHB/2020/AHB\\_2017.pdf](http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/AHB/2020/AHB_2017.pdf).

Papadakaki, M., Petridou, E., Kogevinas, M., & Lionis, C. (2013). Measuring the effectiveness of an intensive IPV training program offered to Greek general practitioners and residents of general practice. *BMC Medical Education*, 13(1), 1-11.  
DOI : <https://doi.org/10.1186/1472-6920-13-46>.

Poreddi, V., Gandhi, S., Palaniappan, M., & BadaMath, S. (2020). Violence against women with mental illness and routine screening: Nurses' knowledge, confidence, barriers and learning needs. *Archives of Psychiatric Nursing*, 34(5), 398-404.  
DOI: 10.1016/j.apnu.2020.07.015.

Ramsay, J., Rutterford, C., Gregory, A., Dunne, D., Eldridge, S., Sharp, D., & Feder, G. (2012). Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *British Journal of General Practice*, 62(602), e647-e655. DOI: 10.3399/bjgp12X654623.

Seneviratne, S., Guruge, S., Sivayogan, S., & Jayasiri, J. (2020). The status of intimate partner violence-related education for nurses in Sri Lanka: A cross-sectional survey of the nursing curricula, *OUSL Journal*, 15(2), 19-44.

DOI: <http://doi.org/10.4038/ouslj.v15i2.7490>.

Sharma, K. K., Vatsa, M., Kalaivani, M., & Bhardwaj, D. N. (2018). Knowledge, attitude, practice and learning needs of nursing personnel related to domestic violence against women: A facility-based cross-sectional survey. *International Journal of Community Medicine and Public Health*, 5, 996-1003.

DOI: <https://dx.doi.org/10.18203/2394-6040.ijcmph20180750>.

Streiner, D. L., Norman, G. R., & Cairney, J. (2015). *Health measurement scales: A practical guide to their development and use*. USA, Oxford University Press.

DOI: 10.1093/acprof:oso/9780199231881.003.0006.

Sundborg, E. M., Saleh-Stattin, N., Wändell, P., & Törnkvist, L. (2012). Nurses' preparedness to care for women exposed to intimate partner violence: A quantitative study in primary healthcare. *BMC Nursing*, 11(1),1-11.

DOI: <https://doi.org/10.1186/1472-6955-11-1>

World Health Organization. Country Office for Sri Lanka. (2018). Country profile on gender-based violence in Sri Lanka. World Health Organization. Country Office for Sri-Lanka. <https://apps.who.int/iris/handle/10665/273193>.

World Health Organization. (2019). *Violence against women: intimate partner and sexual violence against women: evidence brief* (No. WHO/RHR/19). World Health Organization.

[https://apps.who.int/iris/bitstream/handle/10665/77432/WHO\\_RHR\\_12.36\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf?sequence=1)

World Health Organization & Pan American Health Organization. (2012). Understanding and addressing violence against women: Intimate partner violence, World Health Organization.

<https://apps.who.int/iris/handle/10665/77432>.