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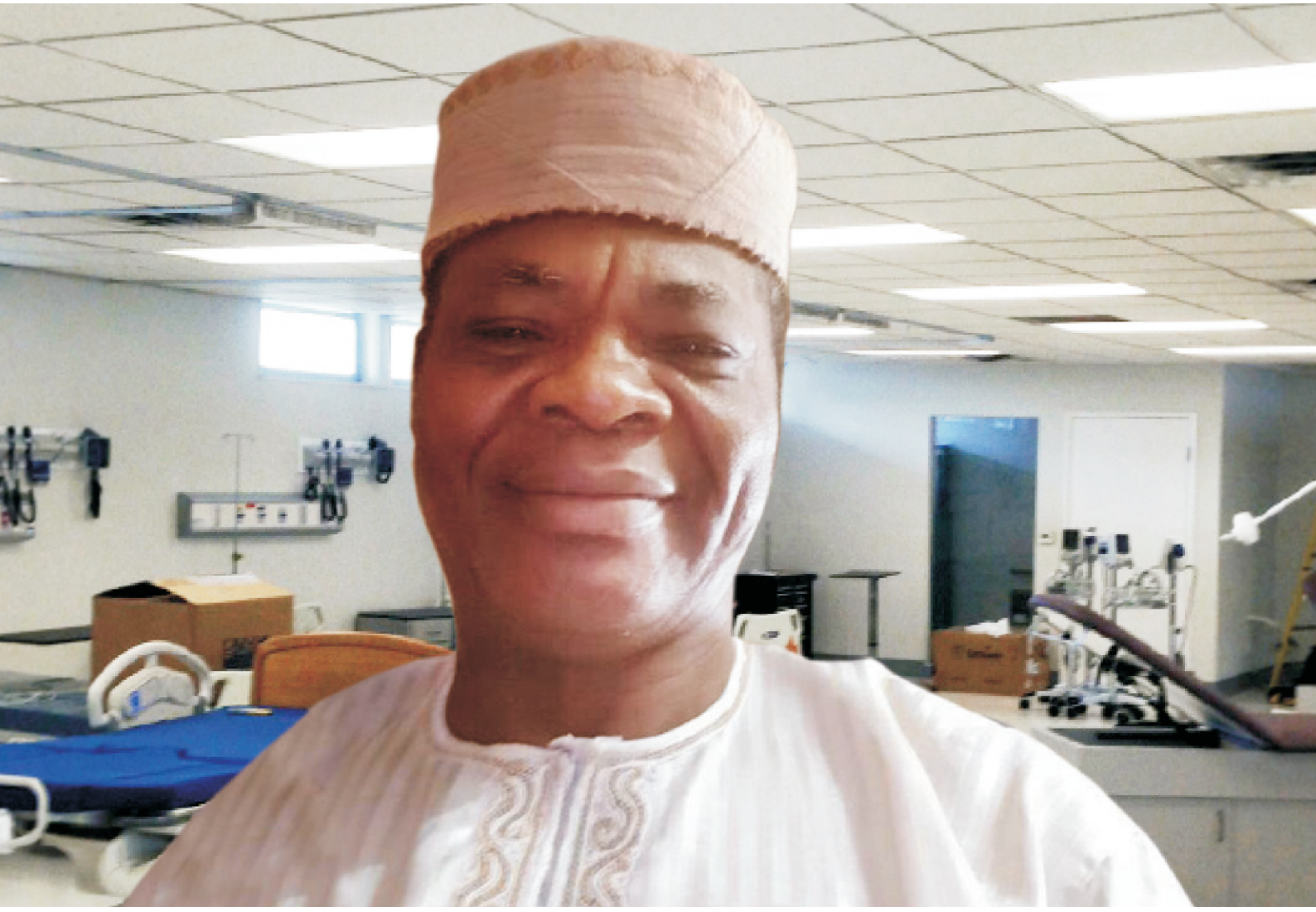

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TABLE OF CONTENTS

1. Evaluation of Nurses' Actions and Opinion on Pain Assessment of Hospitalised Patients
Ogwa, E. T. & Ndie, E. C. 1

2. Ultraviolet Radiation on Gunshot Wounds: Clinical Case Reports
Anyebe, E. E.; Ajayi, A.; Opaluwa, S. A.; Olawale J.; Muhammed Z. B. & Saror, L. A. 8

3. Assessment of Knowledge and Compliance with Coronavirus Protocols Among Healthcare Professionals
Dalhat Sani Khalid, Salihu Abdurrahman Kombo, Idris Abdulrashid & Yahaya Hamza Sani 16

4. Availability of Essential Components of Maternal Healthcare in Health Institutions
Chika C. H. Odira; Pauline O. M. Ezenduka & Edith N. Chiejina 25

5. Factors Associated with Overweight and Obesity Among Adolescents
Grace O. Daniel; Treng N. Urbanus; Emmanuel A. Oyedele; Folashade Wina; Nadyen J. Shikpup; Peter Udeh & Bonji Gaknung 40

6. Health-Seeking Behaviours of Women Presenting with Advanced Stages of Breast Cancer
Agatha Ogunkorode; F. E Ojo; D. T. Esan & I. D. Owoeye 52

7. Sociocultural Beliefs and Practices on Placenta Disposal and Processing Among Multiparous Women
Deborah Tolulope Esan, Agatha Ogunkorode; Barakat Bolajoko; Aderonke Julienna Adetunji & Oladapo T. Okareh 65

8. Parental Control, Social Media Utilisation and Risky Sexual Behaviour Among Adolescents
Constance O. Izekor; Florence O. Adeyemo; Deliverance Brotobor; Patricia O. Akowe & Queen Stella Otaigbe 75

9. Comparative Assessment Of Nosocomial Infection Preventive Measures Utilized By Clinician Nurses in Intensive Care Unit
Ehwarieme Timothy A; Omorogbe Christie E. & Nzelueaka Helen A. 84

10. Alternative Medicine Use and Its Perceived Effectiveness in Management of Hypertension
Oluwaseyi Abiodun Akpor; Tolulope Funmilola Ojo; Risikat Idowu Fadare; Oluwafunmilayo Esther Fadare; & Oluwaseun Eniola Adegbilero-Iwari 103

11. Assessment of Modern Contraceptives Uptake Among Women of Reproductive Age
Olubiyi Simeon Kayode[i] Adeyemo F. O.; Umar N. J.; Olawuyi Victoria Fehintola; Olubiyi M. Vincent; Olubunmi Oluwakemi Yejide & Irodi C. Canis 113

12. Community Health Extension Workers and Traditional Birth Attendants' Neonatal Resuscitation Practices of Babies Born With Asphyxia
Deborah Tolulope Esan, Agatha Ogunkorode & Eseoghene Ogburu 122

13. Midwives' Current Screening Practice of Intimate Partner Violence Among Pregnant Women in Northern Nigeria
Ayishetu U. Musa-Maliki & Sinegugu E. Duma 132

14. Nurses Perception of Cancer Patient Quality of Life
Bolaji-osagie, Sarah O.; Oko-ose, Josephine & Isibor Ewere Anita 141

15. Knowledge, Attitude And Practice of School Health Program Among Secondary School Teachers
Olubiyi S. Kayode; Onasoga A. Olayinka; Yusuf A. Gambari; Ezeaka Patience; Irodi C. Canis; Olufayoke V. Mide-atolani; Ogunleye O. R. & Olubiyi Bisola 155

16. Traditional Birth Attendants' Knowledge of First-aid Management and Skills of Selected Labour Emergencies in Ogbomosho, Oyo State, Nigeria: An Intervention Study
Christiana O. Sowunmi; Adetunmise O. Olajide; Olaolorunpo Olorunfemi; Mercy O. Iwaola & Oluyemisi F. Adeyemo 163

MIDWIVES' CURRENT SCREENING PRACTICE OF INTIMATE PARTNER VIOLENCE AMONG PREGNANT WOMEN IN NORTHERN NIGERIA

AYISHETU U. MUSA-MALIKI & SINEGUGU E. DUMA

ABSTRACT

Screening refers to the application of standardised questions according to a procedure that does not vary from place to place. This has the advantages of early identification, prompt management and referral of intimate partner violence (IPV) victims, it is cost-effective and not harmful to women. The aim of this study is to investigate the midwives' current screening practice for IPV among pregnant women in a Northern Nigerian hospital. Descriptive qualitative research design was used for this study. Purposive sampling technique was used to select instrument used to ten midwives for this study. The instrument used to collect data was non participant observations and individual face-to-face interviews which was achieved through data saturation in the antenatal clinic of a tertiary hospital. Thematic data analysis was carried out, using Yin's five stages of analytical cycle. The findings revealed that two themes emerged from the data, selective screening for IPV and discriminatory screening of HIV-positive women for IPV. It was found that routine screening for IPV was not practiced by midwives. In conclusion, Routine screening for IPV is a very important midwifery practice for the safety of both pregnant women and their foetus. This is not currently being practised, to achieve this, explicit policies on IPV screening and adequate training of midwives must be implemented by Ministries of health, Nursing and Midwifery Council, and hospital managers.

Keywords: Midwives screening practice; Routine Screening; Intimate Partner Violence

INTRODUCTION

Intimate partner violence (IPV) is a serious public health and women's rights issue because it is a violation of women's fundamental rights . It has been identified as a major cause of mortality and disability globally among pregnant women and their unborn child '. It causes serious health consequences to both mother and child that may range from mild to severe, physical to psychological, and short to long-term effects . For the women, it causes delayed entry for antenatal care, poor nutrition, sexually transmitted diseases, injuries, weight gain, post-traumatic stress disorder, premature labour, miscarriage, homicide and suicide .

The effects of IPV on the child include; low birth weight, respiratory distress syndrome, delayed and irregular breast feeding and perinatal death . Yet IPV can be prevented and mitigated if identify early through screening. Screening can be defined as a public health service where members of a defined population who do not necessarily perceive that they are at risk of or are already affected by a disease or its complications, are asked questions to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications. The term 'screening' may also refer to the application of standardised questions according to a procedure that does not vary from place to place .

Routine screening for IPV has the advantages of early identification of victims of IPV, thereby ensuring prompt management and referral to prevent future reoccurrence. It raises awareness of IPV and reduces the stigma that is associated with IPV in society. It is cost-effective and not harmful to women . Midwives are in a unique position to screen pregnant women for IPV because of their midwife-patient relationship and frequent contact with the women during their ANC, family planning, and any other visits .

In Nigeria, the Demographic and Health Survey of 2013 shows that IPV prevalence among pregnant women differ among the geo-political zones, with the highest rate reported in the South at 9% and the lowest in the North west at 2% . These relatively low statistics of IPV in Nigeria are presumably due to lack of screening and reporting . Compared to prevalence

in developed countries where screening is being conducted. The prevalence of IPV among pregnant women in developed countries is 1% to 20% (15).

A study conducted in 2007 by the National Institute of Statistics in Italy reveal that 11.5% of pregnant women in that country are victims of IPV, similar rates are found in Turkey and England . Existing literature have shown that IPV exists in different countries, irrespective of ethnicity or culture, but the rate of occurrence differs, and also that pregnancy does not hinder the occurrence of IPV . Various organisations (such as; Institute of Medicine, American Academy of Paediatrics, American Nurses Association, American Medical Association and US Preventive Services Task Force) encourage routine screening of all women presenting either in ANCs, emergency departments, orthopaedic departments or family clinics for IPV . Such organisations in Nigeria or Africa have not called for screening pregnant women for IPV.

The American College of Obstetricians and Gynecologists (2012) observes that screening for IPV should be conducted at the first antenatal visit of pregnant women and subsequently once every trimester and again once postpartum, making a total of four times in one pregnancy . The America College of Nurse-Midwives advocates for proper assessment, intervention and referral of violence victims to be integrated into the health care services provided to women. As such, universal screening of all women presenting to the health care settings is important to reduce the effects of violence in the women's lives .

In developed countries such as Australia, United Kingdom, and United States of America, midwives routinely screen pregnant women for IPV in ANCs on their initial visits, which are on booking days. They explain that it is easier to screen on this day because it gives them the opportunity to become more acquainted with their patients . Also, the midwives repeatedly screen pregnant women during their subsequent visits since they are aware that the pregnant women may not divulge abuse to them at the first contact. This repeated screening gives pregnant women more time to develop trust and be at ease with the midwives during screening . report similar screening practices by midwives in the United Kingdom. They found that screening is mostly conducted at the first booking visit of pregnant women, although this may be too early for developing a relationship of trust with the pregnant women. They therefore recommend a repeated screening at six months so as to give sufficient time to establish a relationship between the midwives and the pregnant women.

In Africa, observe that midwives in Zimbabwe do not routinely screen pregnant women for IPV in the ANC, but rely on observation for obvious signs of abuse as well as history-taking. The midwives also expect victims of IPV to bring up the issue of IPV for discussion. When this is not done, the midwives will not screen, even when there are obvious signs of abuse, this result in low statistics of IPV. In South Africa, similar practices are reported in the study of , who discover that routine screening for IPV is not being carried out by midwives. The midwives' attention is only drawn to those pregnant women with serious forms of bodily injuries, while those with slight forms of abuse are missed. They suggest that routine screening for IPV should be conducted alongside other antenatal routines on booking day to maximise the time spent attending to the pregnant women. They also suggest that pregnant women should be screened several times to gain the trust of the women, but did not specify the number of times that screening should be done in an index pregnancy.

The study by in Kenya is conducted in an emergency department with six nurses, four clinical officials and one doctor. He reveal that deliberate routine screening is not practiced, and rather, the medical personnel depend on history-taking and physical examination for confirming IPV . In Tanzania routine screening for IPV is also not practiced, although the screening intervention study by shows that there is a feasibility that routine screening will be practiced by the midwives in the near future.

In Nigeria, conduct a cross-sectional study on the extent and determinants of health professionals screening for IPV using the Domestic Violence Healthcare Provider Survey scale in Kano, Northern Nigeria. They submit that more than 74% of their respondents do not screen for IPV. This study is a quantitative research and conducted with other health professionals. Therefore, the findings cannot be generalized to midwives. This is because midwives have unique routine duties and work units which differ from other health professionals. To the best of our knowledge, there is no qualitative study on midwives screening practices in Nigeria, as such, this pioneer effort hopes to fill this vacuum. Hence, this study on

It has been shown that IPV exists in pregnancy and has an adverse effect on the maternal and perinatal mortality rate in Nigeria, which may indirectly affect the achievement of Goal Number Three of the Sustainable Development Goals (SDGs) on good health and wellbeing . Pregnant women from Northern Nigeria have a higher maternal mortality rate than those from the Southern part of the Country . This study is important because it will investigate the midwives screening practice to know if there is need for improvement of their practice and to draw their attention to IPV in pregnancy if they have neglected it too, so that women and their foetus will have healthy life and reduction of maternal and perinatal mortality rate too.

Objective of the study

To describe midwives' screening practice for intimate partner violence among pregnant women in a Northern Nigerian hospital.

METHODOLOGY

Study design: A qualitative descriptive design was used to explore and describe the midwives' screening practice of IPV among pregnant women attending the ANC between January 2017 to April 2017.

Study setting: study was conducted at the Antenatal clinic (ANC) in a tertiary hospital in northern Nigeria. The hospital has equipment and practices comparable to basic standards in other parts of the modern world. It enjoys high patient patronage and is a referral centre for patients from other hospitals from all over Nigeria, particularly northern Nigeria.

Sampling technique: A purposive sampling was used to select ten midwives who had worked in the ANC for more than three years and would be available for the duration of the study and were willing to participate in the study. The sample size was reached through data saturation. Data saturation is the point at which no new information can be obtained from participants, leading to redundancy .

Data collection: Two methods namely non-participant observation and Individual face-to-face interviews were used for data collection

(i) Non-Participant observation: To collect data, the first author conducted non-participant observation of the midwives' daily practice from first week of January to last week of February 2017. An observation checklist was developed based on the study objective to record all observed activities related to the midwives' screening of IPV. The researcher visited the ANC from Monday to Friday every week from 08h00 to 14h00 to observe all the participants when they were attending to pregnant women. The researcher observed all the activities of the participants during their interactions with pregnant women in the ANC using a checklist and took field notes.

(ii) Individual face-to-face interviews: The findings from the non-participant observations and the objectives of the study were used to develop the semi structured interview guide. This guide served as a tool for collecting data during the individual face to face interviews. The individual face-to-face interviews were conducted in English language with each of the ten participants in a private office within the ANC. Each interview session lasted for one hour and was audio-recorded with the participants' permission. Only one participant was interviewed per day due to the tight working schedule of the participants. The data were transcribed immediately after the interview session was over and preliminary data analysis was conducted, this helped towards data saturation and determination of sample size. Each participant's transcript was stored in a file according to the date of the interview. The data from non-participant observation was triangulated with the individual face-to-face interview's data.

Ethical considerations: Ethical clearance was obtained from the University's Human Research Ethics Committee (HREC REF:101/2016) and from the Health Research Ethics Committee (HREC/CL/05) of the research setting where the study was conducted. Informed Consent forms were signed by each participant before the commencement of the study. Informed consent was also obtained verbally from the pregnant women who may be observed while the midwives are attending to them, although they are not directly involved in the study. Other ethical principle such as confidentiality, privacy and justice were adhered to. Pseudonym names were allocated to participants, all transcript were stored under lock and key.

Data Analysis: Yin's five stages of data analysis was used to conduct thematic analysis . These are compiling, disassembling, reassembling, interpretation, and concluding. The researcher transcribed the data collected from the interviews and reread the transcripts again to enabled familiarisation

with the contents of the transcripts and noted some ideas. The transcripts were broken down into smaller fragments and codes assigned to each of the fragments. Then patterns were searched from the coded fragments and rearranged into themes. These was done severally until the coded data were subsumed under the appropriate themes. These were later interpreted and related the meaning to the subthemes and theme of the analysed data. An inter coder, a qualitative research expert was given the raw data to code and interpret independently. The inter coder agreed the meaning assigned to the themes by the researcher fit the extracts and the discrepancies were discussed and used in the final analysis. The inter coder agreement was 90% . The final analysis was shared with the second author, who confirmed the interpretation of the data. Thereafter, member checking was conducted with all participant to verify the interpreted data . They were all satisfied with the interpretation.

RESULT

Ten female registered midwives, age between 32 to 58 years participated in the study. Five of the participants had Bachelor degrees in Nursing Sciences (BNSc) and the other five had diploma qualifications. Their years in service ranged from 7 to 32 years. These prolonged years in service were an advantage to this study because the midwives were experienced in identifying, communicating and managing emotions of pregnant women who may have experience IPV.

Themes: two themes emerged from analysed and triangulated data

i). Selective screening for IPV; and

ii). Discriminatory screening of HIV-positive women for IPV.

i). **Selective Screening for IPV**: Triangulated data from non-participant observations and interviews regarding midwives' screening practices revealed that the midwives do not routinely screen pregnant women for IPV. This is demonstrated in the extracts below.

> *"we just have to be sensitive to women as we interact with them, once we sense they might be going through abuse in their home, we will ask them specific questions about abuse".* [Participant 3: 35years old with 7years in practice]

> *"it is not every pregnant woman that I meet whom I will ask direct questions about IPV, but if I sensed they might be experiencing abuse, I will pick them and ask direct question. That is what guides me".* [Participant 2: 36years old with 10years in practice]

> *"in the process of examining and palpating, we only ask questions if we find anything strange on the pregnant woman".*[Participant 4: 59 years old with 32years in practice]

The researcher observed that midwives do not routinely screen pregnant women for IPV and they do not talk about IPV during their health education discussion to pregnant women. This would have created awareness about IPV in pregnancy and the availability of the midwives to listen to pregnant women who might be experiencing IPV.

Data also revealed that midwives' screening of IPV was guided by the ability to identify the signs and symptoms of abuse, from the outward appearance or behaviours of some pregnant women as illustrated in the extracts below.

> *"From experience we know when we see intimate partner violence victims. They don't need to tell us because we can detect it from their mood that they are victims. That is how we identify them, then we proceed to ask further questions*." [Participant 7: 48years old with 23years in practice]

> *"sometimes on our own, when we* [midwives] *see the look in their faces, somehow we know what is going on at home and we might ask further questions on IPV".* [Participant 10: 52years old with 23years in practice]

> *"we will know as midwives if she is not happy then we will interview her in a polite manner, in a cool environment in another cubicle where there is nobody. She will be able to tell us what's in her mind".* [Participant 5: 52years old with 17years in practice]

> *"There are some women that by merely looking at their faces you can see that they are not happy. We can go close to*

such women and then ask 'What is happening? I was looking at you, you have not been talking since morning". [Participant 9: 58years old with 32years in practice]

"If we notice that the patient is not gaining weight as she is supposed to during pregnancy or her haemoglobin level has dropped due to poor nutrition ..., then we will know that something is happening to her. Maybe she is being abused, then we can ask her questions." [Participant 4: 59 years old with 32years in practice]

ii). Discriminatory Screening of HIV-Positive Women for IPV: This theme emerged from the data that showed that some midwives had biases towards HIV-positive pregnant women as the only ones who are at risk for IPV than HIV-negative pregnant women. They believe that HIV-positive pregnant women are more vulnerable to IPV, and therefore use this attribute as an identifying criterion for IPV in pregnant women, as demonstrated in the following extracts.

"However there are some [patients] *like this last example I gave you, the woman is coming from the PMTCT* [Prevention of Mother-to-Child Transmission of HIV] *clinic. If I am able to fish her out I will be comfortable to ask her anything because I want to go in depth to really know. There is no doubt in my mind about this patient. I know she is a victim of abuse."* [Participant 3: 35years old with 7years in practice]

"Majority of this violence comes with women that are HIV positives. That is why you will see such pregnant women always looking depressed. If I identify them, I will screen them." [Participant 6: 52years old with 27years in practice]

"HIV-positive status causes more violence in couples, especially when the wife is positive and the husband is negative. Therefore, whenever I find such woman, I will screen her." [Participant 7: 48years old with 23years in practice]

The first author observed the midwives giving forms to all new pregnant women that came for booking. Part of the forms was to screen for HIV but not IPV. After the HIV test, the pregnant women who were positive were sent to another clinic (HIV Clinic) for further test and counselling while the HIV negative pregnant women remained in the ANC clinic to continue with their antenatal.

DISCUSSION OF FINDINGS

The current study revealed that the midwives do not routinely screen pregnant women attending the ANC in Northern Nigeria. However, they employed selective screening, which is similar to case-finding methods to screen abused women. This was by seeing or sensing signs and symptoms of abuse, suspecting or thinking their patients might be abused by sensing their mood and interpreting the moody patients as possible victims and identifying patients at high risk of abuse, such as the HIV-positive patients. As such, the midwives missed the opportunity to screen, because not all victims of IPV present with physical symptoms of abuse. Similar findings have been reported in other African countries, including Zimbabwe, Kenya and South Africa. In Zimbabwe, found that the midwives do not screen all pregnant women for IPV but only screened when they recognised obvious signs of IPV such as physical injuries on the body parts. In Kenya reported that screening for IPV was only conducted on women with obvious signs of abuse such as bruises. In South Africa reported that midwives were likely to disregard subtle cases of IPV and to focus more on those pregnant women with obvious physical injuries. According to , IPV is a hidden problem, which supports the need for routine screening of IPV.

It is worrying that despite the high incidence of IPV in Africa, the African midwives including those from Zimbabwe, Kenya, Nigeria and South Africa do not practice routine screening as expected on global or internationally accepted standards. (Shamu, Abrahams, Temmerman, & Zarowsky, 2013).

The findings of this study showed that Nigerian midwives' screening for IPV practice is behind when compared to their counterparts from other countries. For instance, in Australia reported that routine screening for IPV was done for all women who presented in the ANC with or without signs of physical injuries, because all pregnant women were asked to complete an online form for IPV in the

clinic, thus ensuring that all women were screened. Nigeria is far from achieving this, and problems such as lack of a steady power supply and lack of internet connectivity may make it difficult to conduct online screening. Midwives in the USA have been reported to routinely screened for IPV in ANC at the initial visit of pregnant women, but on subsequent visits they used some clues which were prompted by their gut reactions, including behavioural and physical signs and symptoms and cultural clues, to screen pregnant women using a screening tool . In addition, they assessed for danger and assisted in planning for safety for the pregnant women in need of it and referred to other services . However, such screening practices were inconsistent with the recommendation of the ACOG for universal screening, which requires screening once every trimester and once postpartum, making a total of four times during pregnancy.

Other countries where midwives were reported to conduct routine screening for IPV among pregnant women include Belgium, Canada, United Kingdom, New Zealand and Sweden . This was further confirmed by , who reported that midwives do routinely screen pregnant women for IPV in developed countries, but the screening rate is low considering the level of awareness and availability of resources in such developed countries.

The current study revealed discriminatory screening of HIV-positive pregnant women for IPV by the midwives instead of routine screening. The reason stated by the midwives was that IPV is more common in HIV-positive than in HIV-negative women. This perception may sound discriminatory and stigmatizing to HIV-positive pregnant women, but there are links between IPV and HIV in pregnant women which have been reported. In Tanzania, reported that IPV was significantly increased in HIV-positive women compared with HIV-negative women. In Kenya and Uganda, it was reported that HIV testing of pregnant women during antenatal visits triggers violence against the women when their partners got to know of the test results. Others argued that been exposed to IPV may be the triggers for HIV risky behaviour among women. In South Africa, reported that women experiencing IPV were more at risk of having HIV because male partners that perpetrates IPV were more likely to also be practising HIV risky behaviour; such as having multiple sexual partners and having frequent sexual intercourse. They then introduce HIV to their wives, who may not be able to negotiate condom use to protect against HIV. In India, it was reported that women experiencing IPV were more prone to HIV than non-abused women, because their abusive husbands were more likely to have contracted HIV and transferred it to their wives . Furthermore, studies conducted in the USA have shown that, the fear of IPV by women affects effective communication with partners to negotiate condom use and discuss HIV status, leading to risk of contracting HIV .

Conclusion and Recommendations

The results of this study revealed the absence of routine screening for IPV in pregnant women presenting to health settings for antenatal care. This comes as no surprise because Nigeria is still lagging behind in achieving SDG 3, which targets the reduction of the maternal mortality ratio to 70 per 100,000 live births . Promoting routine screening for IPV in northern Nigeria may help in reducing the IPV and maternal mortality ratio.

We recommend training of midwives on IPV screening and development of policies that will promote routine screening in Nigeria and other countries with high maternal mortality rates. We further recommend studies to identify barriers that may influence midwives screening practice in Nigeria.

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