

Nurses' and midwives' awareness of intimate partner violence-related mental health care and associated factors in Tanzania

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Abstract

Although intimate partner violence (IPV) is a significant public health problem in Tanzania, the country's system to provide IPV-related mental health care is not sufficiently prepared to respond to IPV care needs. This study aimed to assess nurses' and midwives' awareness of IPV-related mental health care and associated factors to encourage care provision. A cross-sectional, anonymous, self-administered survey was conducted among nurses and midwives in health facilities in the Mbeya region, December 2018–January 2019. The questions gauged awareness of IPV-related mental disorders, availability of screening tools, confidence in providing IPV-related mental health care and presence of a mental health focal/resource person, in addition to socio-demographic and institutional characteristics. Of 1321 nurses and midwives in the region, 662 (50.1%) participated in the study, and the analysis included 568 (85.8%) responses without missing values. The median awareness score was 5 (range: 0–6), and 34.0% of the participants were aware of all six examined IPV-related mental health disorders. Separate logistic regression analyses were conducted for those working in hospitals and those working in health centres, assessing potential factors associated with nurses' and midwives' awareness of IPV-related mental disorders. Among nurses and midwives in hospitals, high professional education (adjusted odds ratio [AOR]: 1.479; 95% confidence interval [CI]: 1.009, 2.169; $P = 0.045$) and long work experience (AOR: 1.744; 95% CI: 1.161, 2.621; $P = 0.007$) were associated with high awareness of IPV-related mental disorders. For those in health centres, government ownership (AOR:

3.526; 95% CI: 1.082–11.489; $P = 0.037$) and having a mental health focal/resource person (AOR: 3.251; 95% CI: 1.184–8.932; $P = 0.022$) were associated with high awareness of IPV-related mental disorders. Appropriate distribution of mental health focal/resource persons is required for improving awareness of IPV-related mental health care provision among nurses and midwives in remote areas of Tanzania.

Keywords: mental health care, intimate partner violence, nurse, midwife, assessment tool, focal/resource person, Tanzania

What is known about this topic:

- Depression, anxiety, post-traumatic stress disorder, sleep disorders, substance abuse and suicidality and/or self-harm are common mental disorders related to intimate partner violence (IPV) that should be addressed by health care providers, including nurses and midwives at first-line health facilities.
- Because they constitute the largest health workforce, nurses and midwives have a role in addressing common IPV-related mental disorders, aided by brief screening tools, which are essential for improving mental health care in low- and middle-income countries.

What this paper adds:

- Nurses and midwives have insufficient awareness of common mental health problems associated with IPV and lack confidence in providing mental health care related to IPV.

- The current availability of screening tools for mental health problems/conditions and the presence of mental health focal/resource persons are insufficient for adequate mental health care provision in remote and resource-poor settings such as health centres in rural Tanzania.
- Increasing the availability of mental health focal/resource persons is necessary to improve IPV-related mental health care provision in first-line health care facilities, especially remote health centres.

Introduction

Worldwide, intimate partner violence (IPV) is a significant public health problem as well as a fundamental violation of human rights (World Health Organization/London School of Hygiene and Tropical Medicine, 2010; World Health Organization, 2013a). The consequences of IPV on the mental health of those affected have been well explored across the globe. Negative mental health effects are mostly experienced by women and those in low-income settings (Heise & Kotsadam, 2015); these effects include emotional distress, depression, anxiety, phobias, thoughts of suicide, suicide attempts and post-traumatic stress disorder (García-Moreno, 2005; Holden, McKenzie, Pruitt, Aaron, & Hall, 2012; Howard, Oram, Galley, Trevillion, & Feder, 2013; Mukanangana, Moyo, Zvoushe, & Rusinga, 2014; Rose et al., 2010). The impacts may also go beyond these mental health problems and can result in psychogenic non-epileptic seizures and psychotic disorders (Oram & Howard, 2013). Mental disorders are among the most significant causes of sickness, disability and mortality in low- and middle-income countries (LMICs), including Tanzania (Miranda & Patel, 2005).

Tanzania has a high prevalence of IPV: The national lifetime prevalence rate has been estimated at 50.2% (National Bureau of Statistics Tanzania & ICF Macro, 2011). The prevalence appears to be higher in rural settings than in urban areas. The lifetime IPV prevalence is 67.0% in Mbeya, whereas it is 47.2% in Dar es Salaam (National Bureau of Statistics Tanzania & ICF Macro, 2011). Sociocultural factors such as autonomy in decision making, cash or in-kind earnings, acceptance of justifications for wife-beating, exposure to parental IPV, educational attainment, having children and partner's alcohol consumption have been identified as key factors associated with IPV perpetration and

victimization in Tanzania (Reese, Chen, Nekkanti & Mulawa, 2017). Compared with men, women are much more affected by IPV, and victims of IPV are likely to not be taken seriously by health care providers when they present at health care facilities (Rodríguez, Valentine, Son, & Muhammad, 2009). Furthermore, in Tanzania, women may not be willing to disclose IPV because of sociocultural factors (Katiti, Sigalla, Rogathi, Manongi & Mushi, 2016). Although infrastructure and systems for reporting violence against women have been established in Tanzania, challenges remain. Through multi-sectoral approaches including not only the health sector and international agencies, but also community-based organisations, the country has struggled to strengthen the capacity of providers to deliver a package of essential services for violence protection and response for women and to build a robust referral network. For example, significant gaps remain in health care workers' capacity to provide quality and timely IPV health services. Problems with the response are often aggravated by judgemental or discriminatory attitudes towards survivors on the part of health care workers (PEPFAR, 2018).

The health sector has a role to play in a multi-sectoral response to gender-based violence (GBV), including IPV, in Tanzania (Kelsey, Mihyo & Messner, 2016). It must be noted, however, that the health sector's efforts to address IPV are relatively new. The national policy guidelines for the health sector's prevention and response to GBV and the guidelines for GBV management in Tanzania were first made available in 2011. Mental health care is part of the IPV services package that should be provided in health facilities, as stipulated in the national GBV management guidelines (United Republic of Tanzania, Ministry of Health and Social Services, 2011). Since the publication of these

guidelines, efforts have been made to integrate IPV into existing health facilities, but the desired outcomes are not being sufficiently realized (McCleary-Sills et al., 2013). This is probably explained by institutional and individual barriers such as a lack of IPV knowledge and training opportunities, negative attitudes towards IPV, a lack of case management protocols and time constraints in health care provision (Guruge, 2012; Sundborg, Saleh-Stattin, Wändell & Törnkvist, 2012; Hamberger, Rhodes & Brown, 2015). A previous study has shown that providing IPV services in health care facilities is feasible after the institutional and individual barriers are addressed (Laisser, Nyström, Lindmark, Lugina & Emmelin, 2011).

Mental health services in general are often neglected and not prioritized within health systems—not only in Tanzania, but also in other LMICs (Kutcher et al., 2017; Sweetland et al., 2014). Hence, there is also a danger of neglecting the mental health care needs of women experiencing IPV who present at health care facilities. The World Health Organization's (WHO) 2010 Mental Health Gap Action Programme intervention guide recommends mental health care for people experiencing IPV. These guidelines also emphasise that mental health care services should be delivered by health care professionals with an appropriate understanding of violence against women (World Health Organization, 2013b), an approach that has been adopted by the government of Tanzania in health facilities (MoHSW, 2011). Assessing mental health status is part of the first-line support that individuals experiencing IPV need to receive from care providers. The WHO lists depression, anxiety, post-traumatic stress disorder, sleep disorders, substance abuse, and suicidality and/or self-harm as common IPV-related mental disorders that should be included in the assessment (World Health Organization,

2013b). Nurses and midwives have a unique role in addressing IPV and its effects among those who have experienced IPV, such as caring for their physical needs, attending to their safety, providing support and advice, and making referrals (Guruge, 2012). Partly because they constitute the largest health workforce (Exavery et al., 2013; World Health Organization, 2016a), nurses and midwives can play a critical role in delivering mental health services in health facilities to individuals who have experienced IPV (Sloan, 2011). In Tanzania, 0.14 doctors and 5.84 nurses and midwives serve each 10,000 people (World Health Organization, 2016b), meaning that there are approximately 42 times more nurses than doctors. This situation has led to the development of a task-sharing policy that allows nurses and midwives to perform additional roles such as diagnosing mental disorders and prescribing medications, especially at lower-level health facilities such as health centres (HCs) and in remote settings (Tanzania Nursing and Midwifery Council, 2014; Technical Support Services Project, 2019).

There is growing evidence that mental health interventions may help to prevent or reduce IPV in LMICs (Tol et al., 2019). Hindrances and facilitators to the integration of mental health services into health care, especially at the primary health care level, have also been well studied in LMICs. The inadequacy of capabilities in terms of knowledge about mental disorders, a lack of trained mental health specialists or professionals experienced in mental health consultation, the absence of clinical guidelines, conflicting priorities and a lack of regulatory measures to encourage mental health screening have been associated with difficulties in providing mental health services (Wakida et al.,

2018). Brief screening tools have been determined to be essential for improving mental health care in LMICs, and screening is an important first step in the integration of care for common mental disorders into health care services (Ali, Ryan, & De Silva, 2016; Vythilingum et al., 2013). Mental health screening is likely to have maximal benefit in contexts where a clear referral system (i.e. the availability of a mental health resource person) exists for persons who screen positive for common mental disorders (Kagee, Tsai, Lund, & Tomlinson, 2013). A previous study on the obstacles faced by nurses and midwives in providing mental health care identified organisational and practitioner-related barriers, including a lack of mental health services, the absence of care pathways, heavy workload, a lack of time, a lack of privacy and a lack of knowledge and skills to respond to mental health and cultural issues (Higgins et al., 2018). In Tanzania in particular, the pre-service training received by most nurses and midwives already employed in health facilities lacked content on IPV. This is because IPV content was absent in the basic nursing and midwifery curricula such as the National Technical Awards system. IPV content was first introduced in these curricula in 2018. Inadequate training to provide GBV-related education among teachers in the country presents an additional challenge.

It is imperative to assess nurses' and midwives' capacity to respond to IPV-related mental health problems because they frequently encounter women in health facilities (Mezey, Bacchus, Haworth, & Bewley, 2003; Santos, Matos, & Machado, 2016; World Health Organisation, 2011). Understanding this capacity can contribute to better knowledge of the challenges nurses and midwives experience and the development of

better ways to address these challenges. However, little is currently known regarding the capacity to provide IPV-related mental health care among nurses and midwives working in health facilities in Tanzania. Thus, this study's objective was to assess the current condition regarding nurses' and midwives' awareness related to providing mental health care to individuals experiencing IPV and to identify the factors associated with this awareness in a remote area of Tanzania.

Methods

A cross-sectional survey was administered anonymously from December 2018 to January 2019 among nurses and midwives in the seven districts of Tanzania's Mbeya region, which has a population of approximately three million. This region was selected as a study area because of a high lifetime IPV prevalence, which was 67.0%, compared with the national average of 50.2% (National Bureau of Statistics Tanzania and ICF Macro, 2011). All hospitals and HCs in the region were used as the settings for data collection. A few hospitals such as the regional hospital were located in a town, but most health facilities, especially the HCs, were located in remote areas. Different types of health facilities—government, private, and faith-based establishments—were included in the study. In conducting research in Tanzania, agreement to collaborate in the research from the authority of the institution or other setting of data collection is essential. Therefore, institutional agreements on data collection were obtained from the regional and district medical offices before conducting the data collection, in addition to obtaining academic ethical clearance. All nurses and midwives from different departments of the health facilities who were available during the time of data collection and who provided consent were recruited into the study.

In Tanzania, nurses and midwives are divided into two levels based on years of professional training. The first level is ‘enrolled nurses/midwives’, who have 2 years of training and have been awarded a certificate. The second level is ‘registered nurses’, who have 3 or more years of professional training and have been awarded either a diploma or a bachelor’s degree. In this study, nurses were categorized into these two levels according to their years of professional training. Common mental health disorders and basic mental health care provision are included in the nursing pre-service education programme. However, IPV-related mental health disorders and care provision for these cases, as mentioned above, have only recently been included in the pre-service education programme. There is a lack of nursing teachers with sufficient training on IPV, and specialists/supervisors in mental health care including IPV-related care are unevenly distributed in remote areas. Therefore, although nurses who work in first-line health facilities are expected to be aware of common mental disorders that IPV clients experience, they may not know how to properly assess and deal with these clients.

In addition to socio-demographic information, an anonymous, self-administered, structured questionnaire was used to collect data on awareness of IPV-related mental health care. The questionnaire was developed based on the 2013 WHO IPV Clinical and Policy Guidelines (World Health Organization, 2013) and the Mental Health Gap Action Programme Guideline for Mental, Neurological and Substance Use Disorders (Health & Action, 2015), which stipulate the mental health services that should be provided to victims of IPV. The questionnaire used in this study consisted of questions on awareness of IPV-related mental disorders, the availability of screening tools for

these mental disorders in the health facility, confidence in explaining symptoms of IPV-related mental disorders, confidence in providing IPV-related first-line mental health care and the availability of a mental health focal/resource person at the facility. Awareness of common IPV-related mental disorders was evaluated using six items; a score of 1 was assigned when the participant was aware of the disorder, and a score of 0 was assigned when they were not. The maximum score on awareness was 6. Similarly, the availability of screening tools for IPV-related mental health problems at the health facility was evaluated by considering each common mental disorder, again with a maximum score of 6. The questionnaire was originally developed in English and translated into Swahili, the common language in Tanzania with which most people are comfortable. To ensure the accuracy and quality of the translation, back-translation was performed by two authors with ability in both languages. The Swahili questionnaire was then pre-tested among 12 nurses and midwives in two health facilities located outside the Mbeya region, and feedback from the pre-test on aspects such as the clarity, sequence and organization of questions, as well as the time required, were considered to improve the questionnaire before beginning the data collection for this study.

Data collection was conducted by the authors and two research assistants. The research assistants received 2 days of training to acquaint them with the questionnaire and data collection logistics and procedure. To avoid interfering with their work, the nurses and midwives completed the questionnaire at the end of their shift in a room provided by the health facility. Confidentiality was guaranteed by ensuring participants' anonymity. Written informed consent was obtained from all participants, participation was voluntary and withdrawal from the study was allowed at any time. An author or

research assistant was present in case of any requests for clarification, and the questionnaire took 20 to 30 minutes to complete. At the end of the day, one of the authors was responsible for keeping the completed questionnaires secure until they could be stored in a locked cabinet. To avoid errors, the data were double entered into a computer by two research assistants. The data were then analysed by the authors. Only the authors had access to the data after they were entered into the computer.

In addition to analysing the nurses' and midwives' demographic characteristics, we used the chi-square test in bivariate analyses to examine other factors related to awareness of IPV-related disorders, the availability of screening tools for these disorders, level of confidence in explaining the signs of these mental health problems and level of confidence in providing IPV-related first-line mental health care. These analyses were followed by logistic regression analyses. All analyses were conducted using IBM SPSS, Version 20, and frequency tables and percentages were used to summarise the data. A *P*-value of < 0.05 was used to indicate statistical significance in all analyses.

Results

Forty health facilities (15 hospitals and 25 HCs) in the Mbeya region were visited for data collection. Of a total of 1321 nurses and midwives employed in the health facilities at the time of data collection, 662 (50.1%) nurses working the day shift in hospitals or HCs on the day of data collection were invited to participate in the study. A total of 568

(85.8%) completed the questionnaire without missing data on the variables included in this analysis.

Table 1 shows demographic characteristics and level of confidence in mental health care provision among the participants by type of health facility. Regarding the level of professional nursing education, registered nurses/midwives were more likely to work in hospitals than in HCs (53.8% vs. 42.4%, chi-square test, $P = 0.045$). There was a statistically significant difference in having a mental health focal/resource person between hospitals and HCs (90.8% vs. 72.8%, chi-square test, $P < 0.001$).

The median IPV-related mental health disorder awareness score was 5 (range: 0–6), and 34.0% of the participants were aware of all six examined IPV-related mental health problems/conditions. Scores of 4 or lower were categorized as low awareness, and scores of 5 or higher were categorized as high awareness. A total of 323 (56.9%) participants showed high awareness. The IPV-related mental health disorder awareness questionnaire was tested for internal consistency reliability, and Cronbach's alpha was 0.538. Table 2 summarises the participants' awareness of IPV-related mental disorders by individual and organisational characteristics. There were statistically significant differences in awareness of IPV-related mental disorders by work experience (chi-square test, $P = 0.001$).

The nurses' and midwives' reported levels of confidence in explaining the signs of IPV-related mental disorders and in providing IPV-related first-line mental health care are shown by organisational and individual characteristics in Table 3. There were 165

(29.0%) nurses and midwives with high confidence in explaining the signs and symptoms of IPV-related mental health disorders, and 114 (20.1%) had high confidence in providing IPV-related first-line mental health care. There were statistically significant differences in confidence in explaining mental health disorders by sex (chi-square test, $P = 0.001$) and by access to a mental health focal/resource person (chi-square test, $P = 0.046$). For level of confidence in providing IPV-related first-line mental health care, there were statistically significant differences by facility ownership (chi-square test, $P = 0.002$), sex (chi-square test, $P < 0.001$), work experience (chi-square test, $P = 0.001$), and having a mental health focal/resource person (chi-square test, $P = 0.028$). Spearman's rank correlation coefficient (ρ) between level of confidence in explaining the signs of IPV-related mental disorders and level of confidence in providing IPV-related first-line mental health care was 0.621 ($P < 0.001$).

Table 4 presents the factors associated with nurses' and midwives' awareness of IPV-related mental disorders. Facility ownership, sex, level of professional education, work experience and availability of a mental health focal/resource person were included as independent variables in separate logistic regression analyses for those working in hospitals and for those working in HCs. Among nurses and midwives in hospitals, high professional education (adjusted odds ratio [AOR]: 1.479; 95% confidence interval [CI]:1.009, 2.169; $P = 0.045$) and long work experience (AOR: 1.744; 95% CI: 1.161, 2.621; $P = 0.007$) were associated with high awareness of IPV-related mental disorders. For those working in HCs, government ownership (AOR: 3.526; 95% CI: 1.082–11.489; $P = 0.022$) and having a mental health focal/resource person (AOR: 3.251; 95%

CI: 1.184–8.932; $P = 0.036$) were associated with high awareness of IPV-related mental disorders.

Discussion

IPV-related mental health care provision is especially challenging in LMICs, including Tanzania (Colombini, Mayhew, & Watts, 2008). In addition to finding that nurses and midwives had insufficient capacities on IPV-related mental health care provision, this study identified inadequate facility-based conditions, such as the availability of mental health screening tools and access to a focal/resource person as a supervisor for mental health care provision, especially in HCs. A previous study in Malawi reported that health care providers felt inadequately prepared to handle the psychosocial and mental health consequences of IPV (Chepuka et al., 2014). In view of our findings and those of previous research, increased efforts should be directed towards improving the IPV-related mental health care provided by nurses and midwives in health facilities by addressing both individual and facility-related factors (Lovero et al., 2019).

The level of awareness of the six examined IPV-related mental health problems found among the participants in this study was not sufficient because nurses and midwives are expected to be aware of all these conditions. This finding is consistent with a study in Uganda, which found an inadequate level of knowledge about mental disorders among primary care providers, most of whom were nurses and midwives (Wakida et al., 2018). This low awareness may be attributed to a lack of IPV training among nurses and midwives (Alotaby, Alkandari, Alshamali, Kamel, & El-shazly, 2013). In Tanzania, this

lack of training is found because of the lack of IPV content in the basic pre-service nursing and midwifery curricula before 2018. It may also be related to the challenge of making national IPV guidelines available at lower-level health facilities, such as HCs.

We found that having more than 5 years of work experience and a high level of professional education predicted higher awareness of IPV-related mental health problems/conditions, at least in hospitals. This finding might be explained by the possibility of encountering learning opportunities increasing with longer work experience (Skår, 2010) and by a higher level of professional education among those with more work experience. In contrast, for those working in HCs, government facility ownership and the availability of a mental health focal/resource person were associated with higher awareness, regardless of professional education and work experience. Compared with hospitals, HCs have a smaller number of medical staff members; therefore, in HC contexts, nurses and midwives are likely to encounter clients with diverse health problems, including mental health disorders, because of the task-sharing policy in Tanzania, as mentioned in the ‘Introduction’ section (Tanzania Nursing and Midwifery Council, 2014; Technical Support Services Project, 2019). In remote areas, HCs with government ownership might be more likely than non-governmental HCs to be able to obtain essential resources for health care provision, including care manuals and guidelines, and nurses and midwives can be expected to use such materials as much as possible in caring for patients.

In this study, in the bivariate analysis, being a man was associated with higher levels of confidence in explaining the signs of IPV-related mental health problems and in

providing IPV-related mental health care. A possible explanation for this discrepancy involves broader sex differences in self-reported confidence levels. In general, women tend to report lacking confidence even when they are equally or more skilled, compared with their male colleagues (Gneezy, Niederle, & Rustichini, 2003). This difference is thought to be caused by stereotypical gender roles and socially endorsed values that conflict with women's professional identities and competitiveness (Cadsby, Servátka, & Song, 2013). In Tanzania, nursing and midwifery are female-dominated professions, regardless of the level of the health facility, with female personnel making up 86% of the workforce (Exavery et al., 2013), but the proportion nursing personnel who are men may be greater in Tanzania than in high-income countries. For example, men make up only 9% of the total nursing personnel in the United States (United States Census Bureau, 2013), 11.4% of registered nurses in the United Kingdom (Williams, 2017) and 6.6% of registered nurses in Canada (Canadian Institute for Health Information, 2012).

In the bivariate analysis, we also found that having fewer years of work experience predicted a higher level of confidence in providing IPV-related first-line mental health care. This difference may be explained by nurses and midwives with shorter work experience potentially having a more optimistic attitude because they learned more contemporary knowledge and skills in their pre-service training. However, participants' capacity and quality of care provision were not evaluated in real-life settings in this study. In general, previous work has found that professional confidence increases with more work experience (Makarem et al., 2019). Further study is needed to assess nurses' and midwives' confidence in providing IPV-related mental health care, as well as the quality of their care provision.

Validated screening tools for common mental disorders are available for LMICs (Ali et al., 2016), including Tanzania. However, most nurses and midwives in this study worked in environments without these screening tools. In addition, in this study, HCs were less likely than hospitals to have screening tools and a focal/resource person for mental health. This finding is consistent with a previous study in South Africa, where less than half of nurses reported using a specific screening tool for mental disorders (Lovero et al., 2019). These findings imply that emphasis should be placed not only on screening women for IPV-related mental disorders (Holden et al., 2012), but also on ensuring that the appropriate screening tools are available in health facilities. Although it seems that, in the study setting, better care for IPV was provided in hospitals, care in hospitals is associated with high costs that most people cannot afford (Boex, Fuller & Malik, 2015). Therefore, it is important to make high-quality IPV-related services available at lower-level health facilities that are located closer to most people, facilitating access to these services (Kelsey, Mihyo & Messner, 2016). Several HCs included in this study were located in extremely remote areas, but they nevertheless had mobile phone service. Because digital technology holds promise for improving access to and quality of mental health care in LMICs (Naslund et al., 2017), the use of mobile phone technology to provide IPV-related services, including mental health services, should be considered in Tanzania.

Nurses and midwives are important stakeholders who should be actively involved in the development of nursing resources for mental health (World Health Organization, 2007). These individuals perform a variety of mental health interventions such as counselling

and advising patients on medication, but they have minimal confidence in their skill level. Nurses' and midwives' expressed learning needs include education on many mental health conditions including IPV-related mental health problems, such as suicidal ideation, depression and bipolar disorders, as well as skills in therapies such as cognitive behavioural therapy and family therapy (Prince & Nelson, 2011). Therefore, to improve their capacity to provide IPV-related mental health care, training measures should be considered to increase knowledge and to facilitate the use of certain management skills—especially systematic strategies to effect change (Willettts & Leff, 2003). IPV-related training may instil skills and confidence in ability to detect IPV and take proper steps to care for survivors (Rodríguez, Valentine, Son, & Muhammad, 2009), and thus it is important to provide such training in addition to improving the distribution of the necessary instruments for care provision and of appropriate supervisors and/or consulting systems, even in resource-poor settings.

This study had several limitations. First, awareness of IPV-related mental disorders among nurses and midwives was assessed by asking participants to check off disorders listed in the questionnaire. A detailed assessment of awareness for each IPV-related mental disorder might yield a more realistic view of the situation. Second, the availability of screening tools for IPV-related mental health problems in health facilities was assessed using written responses, and these reports were not physically confirmed. Third, other important factors in mental health services such as coordination and supervision were not explored, and these factors may also affect IPV-related mental health care in health facilities. Fourth, social desirability could be a limitation because participants' responses may have been influenced by the desire to please the researchers.

Despite these limitations, this study has provided a better understanding of the current situation regarding IPV-related mental health care provision by nurses and midwives in a remote area of Tanzania.

Conclusion

This study identified several gaps in IPV-related mental health care in health facilities. Individual-level gaps included insufficient awareness of IPV-related mental health problems and a lack of confidence in providing IPV-related mental health care. A lack of screening tools and the absence of a focal/resource person for mental health care provision were the main facility-based factors, especially at lower-level health facilities such as HCs. There is a need to facilitate nurses' and midwives' capacity to provide IPV-related mental health care by improving their awareness of IPV-related mental health problems through in-service training and through strengthening pre-service training.

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Table 1. Demographic characteristics and level of confidence in IPV-related mental health care provision among nurses and midwives (N = 568)

	Hospital (n = 476)		Health centre (n = 92)		P-value
	n	%	n	%	
Facility ownership					
Government	308	64.7	76	82.6	0.001
Non-government	168	35.3	16	17.4	
Sex					
Male	126	26.5	23	25.0	0.769
Female	350	73.5	69	75.0	
Level of professional education					
Enrolled nurse/midwife	220	46.2	53	57.6	0.045
Registered nurse/midwife	256	53.8	39	42.4	
Work experience					
≤ 5 years	183	38.4	33	35.9	0.641
> 5 years	293	61.6	59	64.1	
Availability of mental health screening tools					
Depression	215	45.2	20	21.7	< 0.001
Anxiety	179	37.6	18	19.6	0.001
Post-traumatic stress disorder	101	21.2	14	15.2	0.190
Sleep disorders	91	19.1	11	12.0	0.101
Substance abuse	124	26.1	14	15.2	0.027
Self-harm	120	25.2	18	19.6	0.248
Level of confidence in explaining the signs of IPV-related mental health disorders					
Somehow confident/Not confident	336	70.6	67	72.8	0.665
Very confident	140	29.4	25	27.2	
Level of confidence in providing IPV-related first-line mental health care					
Somehow confident/Not confident	381	80.0	73	79.3	0.879
Very confident	95	20.0	19	20.7	
Availability of a mental health focal/resource person					
No	44	9.2	25	27.2	< 0.001
Yes	432	90.8	67	72.8	

Chi-square tests were performed. IPV: intimate partner violence

Table 2. Nurses' and midwives' awareness of IPV-related mental disorders (N = 568)

	Low awareness (≤ 4)		High awareness (≥ 5)		<i>P</i> -value
	n	%	n	%	
Type of health facility					
Hospital	209	43.9	267	56.1	0.397
Health centre	36	39.1	56	60.9	
Facility ownership					
Government	159	41.1	225	58.6	0.230
Non-government	86	46.7	98	53.3	
Sex					
Male	67	45.0	82	55.0	0.599
Female	178	42.5	241	57.5	
Level of professional education					
Enrolled nurse/midwife	128	46.9	145	53.1	0.082
Registered nurse/midwife	117	39.7	178	60.3	
Work experience					
≤ 5 years	112	51.9	104	48.1	0.001
> 5 years	133	37.8	219	62.2	
Level of confidence in explaining the signs of IPV-related mental health disorders					
Somehow confident/Not confident	184	45.7	219	54.6	0.058
Very confident	61	37.0	104	63.0	
Level of confidence in providing IPV-related first-line mental health care					
Somehow confident/Not confident	198	43.6	256	56.4	0.646
Very confident	47	41.2	67	58.8	
Availability of a mental health focal/resource person					
No	36	52.2	33	47.8	0.106
Yes	209	41.9	209	58.1	

Chi-square tests were performed. IPV: intimate partner violence

Table 3. Nurses' and midwives' levels of confidence in explaining the signs of IPV-related mental health disorders and in providing IPV-related first-line mental health care (N = 568)

	High confidence in explaining signs		<i>P</i> -value	High confidence in providing care		<i>P</i> -value
	n	%		n	%	
Type of health facility						
Hospital	140	29.4	0.665	95	20.0	0.879
Health centre	25	27.2		19	20.7	
Facility ownership						
Government	104	27.1	0.136	63	16.4	0.002
Non-Government	61	33.2		51	27.7	
Sex						
Male	59	39.6	0.001	49	32.9	< 0.001
Female	106	25.3		65	15.5	
Level of professional education						
Enrolled nurse/midwife	76	27.8	0.541	56	20.5	0.800
Registered nurse/midwife	89	30.2		58	19.7	
Work experience						
≤ 5 years	70	32.4	0.167	59	27.3	0.001
> 5 years	95	27.0		55	15.6	
Availability of a mental health focal/resource person						
No	13	18.8	0.046	7	10.1	0.028
Yes	152	30.5		107	21.4	

Chi-square tests were performed. IPV: intimate partner violence

Table 4. Relationship of organisational and individual factors with nurses' and midwives' awareness of IPV-related mental disorders (N = 602)

	Hospital (n = 476)			Health centre (n = 92)		
	AOR	95% CI	P-value	AOR	95% CI	P-value
Facility ownership (ref: Government)						
Non-government	1.207	0.787–1.852	0.389	0.284	0.087–0.924	0.037
Sex (ref: Male)						
Female	0.992	0.640–1.537	0.971	0.499	0.162–1.535	0.225
Level of professional education (ref: Enrolled nurse/midwife)						
Registered nurse/midwife	1.479	1.009–2.169	0.045	0.632	0.253–1.579	0.326
Work experience (ref : ≤ 5 years)						
> 5 years	1.744	1.161–2.621	0.007	1.937	0.728–5.148	0.185
Availability of a mental health focal/resource person (ref: No)						
Yes	1.312	0.686–2.507	0.412	3.251	1.184–8.932	0.022

Logistic regression analysis was performed. IPV: intimate partner violence; AOR: adjusted odds ratio; CI: confidence interval