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ORIGINAL ARTICLE

Community-Nurse Collaboration in Addressing Family Violence in Nigeria: An Evidence-Based Intervention Model

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Abstract

Background: Individuals affected by family violence (FV) face a range of physical, social, and psychological effects, disrupted family relationships, and mental health issues. In Nigeria, FV incidents are often kept silent due to cultural norms and social stigma, which prevent survivors from accessing essential care and support. Despite the significant impact of this problem, research on context-specific healthcare and support pathways remains limited.
Purpose: The study explored a nurse-led community-based approach to preventing and mitigating FV's impact.
Methods: The study employed an exploratory qualitative case study design using an intervention development model. Conducted in Ondo State, data were collected through semi-structured interviews (n=18) and focus group discussions (n=92) across three senatorial districts and were analysed using content and thematic analysis.
Results: The analysis led to the development of a three-component FV intervention consisting of (1) a training manual for nurses, (2) a clinical intervention pathway, and (3) management guidelines for nurses to identify and care for survivors.
Conclusion: The intervention offers a culturally appropriate, context-specific framework to strengthen nurses' capacity to address FV in Nigeria and may serve as a model for integrating FV management into primary healthcare practice.

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1. Introduction

Family violence is a complex, multi-layered issue that casts a long shadow over both direct victims and the family unit as a whole. Traditional interventions have often been piecemeal, targeting specific instances or types of abuse but falling short of comprehensive solutions. Research has demonstrated the significant role that the family of origin plays in the risk of perpetuating and experiencing violence, which raises questions about the cyclical nature of violence within family systems (Haj-Yahia et al., 2021; Wagers et al., 2021). According to family nursing principles, a family is a complex, interconnected system in which the impact of violence on one member reverberates throughout the unit, affecting its overall functioning (Southern & Sullivan, 2021).

The aftermath of family violence is devastating, with long-term ramifications that extend beyond immediate physical harm. Victims frequently suffer from a range of psychological issues, including but not limited to post-traumatic stress disorder (Rivara et al., 2019). More alarmingly, children who witness or experience family violence carry psychological scars that may manifest as behavioural problems and put them at a greater risk of either falling victim to or perpetrating violence in the future (Rasmussen, 2021). These observations make it clear that any intervention strategy must take into account the holistic needs of the family, aiming not just to mitigate but to prevent violence at its roots.

Interventions in the realm of family violence have often been coordinated through law enforcement agencies and judicial system referrals (Cordier et al., 2021; Johnson & Stylianou, 2022). However, in the Nigerian context, there exists a widespread societal belief that family issues should be kept within the family, making these external, authoritative approaches less effective or even stigmatizing. Alternative dispute resolution mechanisms such as informal justice, restorative justice, and mediation have begun to fill this gap, showing promising results in reducing family violence (Jeffries et al., 2021; Nettleton & Strang, 2018). Yet, these alternative approaches are often deployed informally and may lack the rigour and support of a more institutionalised system.

The healthcare system has emerged as a promising avenue for tackling family violence. According to existing studies, healthcare-based interventions have the potential to reduce the harm caused by family violence significantly (Barrett et al., 2024; Halliwell et al., 2019; Miller et al., 2021). Nurses, being frontline healthcare providers, occupy critical roles and can actively engage in the early detection, management, and even prevention of family violence. However, in Nigeria, the healthcare system is still grappling with how to address family violence systematically and effectively. This struggle continues despite the existence of the World Health Organization (WHO) standard protocols that guide healthcare providers in managing such cases (WHO, 2013).

There is an evident gap in the field: while interventions have traditionally focused on individual victims or perpetrators, they often overlook the broader family context in which violence occurs (Irinoye & Ogunlade, 2020). Women and children, who are disproportionately the victims of family violence, require specialised, context-sensitive approaches that consider the cultural shades and stigmas associated with violence in the family unit. In this regard, nurses are uniquely positioned to provide comprehensive and specialised care, particularly when properly trained and equipped within the Nigerian context.

Therefore, this study aimed to explore a nurse-led, community-based approach to preventing and mitigating the impact of family violence by addressing the needs of women and children within the broader family and sociocultural context. This study adopted the model for developing evidence-based nursing interventions proposed by Van Meijel et al. (2004). This framework outlines a systematic, theory-based approach that involves analyzing the problem, identifying target audiences, selecting relevant theories, designing interventions, and conducting pilot tests. The current study highlights the importance of engaging stakeholders, adapting to context, and refining strategies through iterative processes as key principles for tackling sensitive, culturally rooted issues such as family violence.

The nurse-led collaborative approach was built on a structured model that ensured the intervention was developed based on empirical evidence and was appropriate for the specific context. By combining healthcare expertise with cultural insights and engaging the community, the intervention addresses family violence not only from the victim's perspective but also within the larger family and community context. This framework positions nurses as active participants who not only respond to the aftermath of violence but also play a crucial role in prevention, advocacy, and collaboration across different sectors. As a result, the study outlined the creation and essential components of this tailored management strategy, offering a comprehensive response to family violence and serving as a potential model for implementation in similar cultural settings.

2. Methods

2.1. Research design

The study utilised the exploratory qualitative case study research design using the intervention development model proposed by Van Meijel et al. (2004), which is widely respected for its contribution to the development of evidence-based nursing interventions. The model is particularly unique for its holistic approach that integrates qualitative data collection throughout the developmental stage. This ensures that any interventions crafted align well with both the educational framework and the hands-on, practical requirements of community healthcare nurses, who are often the first medical professionals to interact with victims.

The model further considers the specific contexts in which data is gathered, providing an extra layer of scrutiny to gauge the possible acceptability and efficacy of the resulting interventions. This study delves into three pivotal facets: (1) Experiences of family violence from the perspective of couples; (2) The roles, responsibilities, and methods employed by community

and religious leaders in aiding victims, and (3) The practices employed by community healthcare nurses in meeting the needs of family violence victims.

2.2. Setting and samples

The study's geographical focus was six carefully selected communities within a state in southwest Nigeria. These communities are mainly Yoruba. When examining family structures, the study found that in addition to the traditional family unit of a father, mother, and children, polygyny is also common. This is significant because cultural context greatly influences how the community views family violence and the sacredness of family bonds.

The study employed a stratified purposive sampling method to gain a detailed and varied understanding of family violence. It involved 92 participants (48 women and 44 men) who took part in 12 gender-specific focus group discussions (FGDs), along with 18 individuals (community leaders, religious leaders, and nurses) who were interviewed using a semi-structured interview guide. Data collection took place over 12 weeks across the three senatorial districts of Ondo State. The inclusion criteria were adults aged 18 and above, residents of the selected communities for at least 1 year, and married or cohabiting individuals who may or may not live with their partners but are familiar with community expectations regarding marriage, which may not reflect their actual marital status. Those unable to participate due to health or communication issues were excluded. Participants were contacted through community gatekeepers who helped identify eligible individuals.

2.3. Data collection

Data collection involved focus group discussions (FGDs) and interviews to explore couples' experiences with family violence. The interview guides explored themes such as perceptions of cultural and religious norms around FV occurrence and disclosure, community and religious leaders' roles in preventing or responding to family violence, and the practices of nurses in supporting victims. The FGD guides examined community members' perceptions, experiences, and ways of managing, and suggested intervention strategies. Bilingual experts translated the guides into Yoruba to ensure cultural and language appropriateness. The data collection instruments were pretested for clarity, language appropriateness, and relevance of the questions. The FGD guide was pretested with two homogenous groups of Yoruba males and females, while the interview guides were pretested among community and religious leaders and nurses. The feedback necessitated adjustments to the questions for simplicity, restricting the sequence of the questions to improve the flow and participant understanding.

In this study, married males and females' FGDs explored patterns of family violence, victims' narratives, community perceptions, and support mechanisms, lasting 32 to 60 minutes. Community and religious leaders' interviews examined their roles in aiding victims and their preferred interventions, lasting 53 to 62 minutes. Meanwhile, nurses' interviews focused on how nurses identify and assist victims, extending their roles into the community. The participants completed demographic questionnaires, and field notes captured observational insights and potential research directions.

2.4. Data analysis

Data analysis was a dynamic and iterative process conducted concurrently with data collection, guided by the well-established principles of traditional content analysis as described by Hsieh and Shannon (2005) alongside the constant comparative method (Hewitt-Taylor, 2002). Interview transcripts were transcribed verbatim and imported into Atlas.Ti Software (version 13) to support systematic data organisation and management. Analysis commenced with repeated reading of transcripts to achieve immersion and an overall understanding of the data, followed by inductive open coding in which meaningful units of text were identified and labelled to capture participants perspectives. Codes were continuously compared within and across transcripts to identify similarities, differences, and emerging patterns, and conceptually related codes were clustered into subcategories and further abstracted into broader categories. Throughout the analytic process, earlier transcripts were revisited in light of newly developed codes to enhance consistency and analytic rigour, while analytic memos were maintained to document coding decisions and emerging insights. The final categories formed the basis of the study findings and were supported by illustrative participant quotations to enhance credibility.

2.5. Trustworthiness/rigor

Trustworthiness in this study was ensured by adhering to the principles of credibility, confirmability, and dependability (Korstjens & Moser, 2018). Credibility was established by validating the IDI and FGD guides with experts in sociology, family nursing, and public health nursing, to ensure content appropriateness, clarity, and alignment with study objectives. Feedback from experts was carefully reviewed, and adjustments were made. Participants voluntarily engaged in a supportive environment, and session summaries were reviewed with them to clarify and gather additional input.

Confirmability involves minimizing researchers' bias by clarifying it through the inclusion of verbatim participants' quotes to validate interpretations. Dependability was achieved by conducting FGDs and interviews in Yoruba, the participants' preferred language, and by having transcription and back-translation conducted by independent specialists to ensure accuracy and consistency. Sessions were audio-recorded and transcribed verbatim. The draft training package underwent item content validation (I-CVI) by a panel of three experts (2 nurses and 1 sociologist). Each item was reviewed and rated for relevance on a 4-point scale (1 = not relevant to 4 = very relevant). The I-CVI was calculated for the items' agreement among experts, and items with ≤ 0.78 were revised and restated as appropriate with their suggestions.

2.6. Ethical considerations

Ethical approval of this study was granted by the Research and Ethics Committee of the Ondo State Ministry of Health and the Ondo State Primary Healthcare Development Board (OSPHCDB/AD383/46). Community gatekeepers were identified and briefed on the study's purpose and process for consent. Participants were recruited after understanding the research goals and their right to withdraw without prejudice. Confidentiality was assured, and FGD participants were asked to maintain group confidentiality. Informed consent was obtained via signatures and thumbprints.

3. Results

The overview of findings from the qualitative case study (FGDs and interviews with religious and community leaders and nurses) that directly influenced the development of the family violence intervention is presented. The three intervention components were also described.

3.1. Participants' characteristics

Table 1 summarizes the socio-demographic characteristics of participants across 12 FGDs. The mean age was 45±12.9 years. One-fourth were traders, one-third artisans, and nearly half farmers, predominantly from rural areas. Almost half had primary or secondary education, while those with tertiary education were mostly artisans.

Table 1. Demographic characteristics of the focus group participants (n= 92)

Variables	Frequency (f)	Percentage (%)
Age in Years		
20-39	32	35.0
40-59	35	38.0
60-79	25	27.0
Gender		
Male	44	48.0
Female	48	52.0
Religion		
Christianity	52	57.0
Islam	40	43.0
Educational status		
No formal education	12	13.0
Primary	36	39.0
Secondary	38	41.0
Tertiary	6	7.0
Occupation		
Farming	38	41.0
Trading	24	26.0
Artisan	30	33.0

Table 2 presents the demographic characteristics of 18 interviewees (nurses, religious leaders, and community leaders). Participants had over five years of experience, with a mean age of 51±17.0. Nurses were recruited from primary health centres and held at least a General Nursing Certificate. Most community and religious leaders were elderly, with at least a primary education. Community leaders also engaged in teaching, trading, and farming, while Islamic leaders served as teachers in their roles as Imams.

Table 2. Socio-demographic profile of interviewees

Characteristics	Nurses (n=6)	Community Leaders (n=6)	Religious Leaders (n=6)
Age in Years			
24 – 44	4	1	1
45 – 65	2	1	4
66 and above	-	4	1
Gender			
Male	-	3	6
Female	6	3	-
Educational Status			
Primary	-	2	1
Secondary	-	2	4
Tertiary	6	2	1
Religion			
Christianity	6	5	3
Islam		1	3

3.2. Family violence occurrence: Couples' perspectives

3.2.1. Forms of family violence

The discussions highlighted family violence among couples, including physical acts like beating, slapping, and the use of weapons. Verbal abuse, especially from someone perceived as younger or of lower authority, was also noted as a violation. However, other forms, such as psychological violence, controlling behaviours, and sexual violence, were often normalized and not seen as harmful. Harshly spoken words by women were viewed as either acts of abuse towards husbands or as self-defence and retaliation, given the physical strength disparity (Table 3). This perspective is illustrated in one participant's response below:

> *If someone speaks to a woman, and the woman responds in an insulting tone, there are certain responses that* usually *dent the ego of the man and provoke him to respond with a slap or other forms of beating. (37-year-old male FGD participant)*

Controlling behaviours were predominantly exhibited by men, rooted in the patriarchal and religious beliefs of the study setting, which uphold male superiority and dominance over the family, including the wife. This regularisation undermines women's autonomy, reducing their individuality to their male partner's authority. This perspective is reflected in one participant's response below:

> *As for the husband to the wife, for now, our women keep saying that they have an equal right with their husbands at home. That is not true. Out of ten, the husband still has seven and two for the wife, and gives the remaining one to the children at home. (40-year-old female FGD participant)*

It was noted that either partner could dominate based on their authority and power at a given time. However, in rare cases where the woman is in control, it is perceived as a violation of the man's rights and considered absurd in the study setting, as exemplified below:

The one I heard about a while ago is the wife who sponsored the man, so in everything, the woman tried to control the man. (42-year-old female FGD participant)

Table 3. Theme and corresponding categories for forms of family violence

Theme	Category
Physical Violence	• Beating, slapping, punching • Use of weapons
Emotional Violence	• Abusive words that minimise and blame • The high tone of expression • Use of words perceived to be disrespectful in the indigenous language • Harshly spoken words
Controlling Behaviours	• Intimidation • Threat • Regulation of finances • Male sole decision-making capabilities for other members of the family
Economic Violence	• Occupation denial • Lack of resource control
Sexual Violence	• Sexual rejection • Forceful sexual intercourse • Sexual denial

Financial control, often perpetrated by men, manifests as occupation denial and lack of resource control (economic violence). Some men prevent their wives from working or take control of their earnings. A participant stated:

Another violence that I see is in the area of money; probably the woman is earning some amount of money, the man does not want her to spend this money the way she wants or do anything with the money despite the consent of the man, after all l am the man l got married to you, you belong to me everything about you belongs to me. That is another form of violence I have seen among couples as well. (30-year-old female FGD participant)

Responses revealed that forced sexual intercourse, often due to sexual rejection or denial by the wife, was viewed differently by male and female participants. Men saw it as non-violent, while women considered it a violation. Despite this, both parties agreed it was a violation, but neither condemned nor reported it, as it occurred within the conjugal relationship.

If a woman does not accept her husband's sexual demands easily, the man can force her, and she is his wife. If the woman has been complaining all the time that she is tired, she is tired, the man will use force on her. After all, she is the man's wife. If her husband rapes her, he rapes her. The man cannot go outside and rape another woman, and he will not be caught. However, for his wife, he has the right. (43-year-old female FGD participant).

Forcefully having sexual intercourse with the wife when she refuses sex is a form of family violence, but it is not a thing of pride for the man unless he is a hooligan. It will be between the couple, and it cannot be reported because they are married. (35-year-old male FGD participant).

Family violence can be perpetrated by either spouse, with participants noting that while men generally commit more violence (physical, sexual, and intimidation), women may engage in emotional violence and isolation. Economic violence was seen to depend on the spouse with higher socioeconomic status, while neglect of financial responsibility by the husband often led to psychological violence from the wife, triggering physical retaliation, as participants stated:

The husband perpetrates violence in most cases. (45-year-old female FGD participant)

It is the wife that usually starts it; the wife is having sharp tongue than her husband, you know when the tongue of the wife is sharper than her husbands, and the husband will want to tame the sharp tongue of the wife by responding with physical or other forms of violence. (60-year-old male FGD participant)

3.2.2. Victims of family violence

Participants highlighted that children are often the victims of family violence, with one participant noting that when parents fight, the children suffer. Violence may lead to one parent abandoning the relationship, leaving children without either a father or a mother, resulting in significant hardship for them.

It's the children who will bear it most, according to the adage 'where two elephants fight, the grasses beneath suffer it most' because the children are perceived to know nothing. For instance, a man may say he wants to punish his wife and, in a way, he will be punishing his children along. He may be giving them two hundred naira before, but because you want her to know that you are somebody, you will now reduce it to one hundred naira, and wives who have been sharing two hundred naira with children before, how would they now be able to share the one hundred naira, so it's the children that will suffer it most. (50-year-old Imam)

Likewise, the wives were identified as victims of violence in the home, especially the direct victims of their husbands. Women have been recognised to bear the burden of violence for the sake of the children.

The wife is the victim of direct violence from the husband in the home. The wives are also victims when violence is from other members of the family, except the children. (65-year-old male FGD participant)

Some male participants shared differing views, stating that in old age, men who previously perpetrated violence may become victims themselves. They noted that grown children, who had once supported their mother during violent times, would now ignore their father's requests for assistance.

If we give it a deeper thought, it is going to bounce back on the husband in old age when the children request the presence of their mother for support in child- rearing. (63-year-old female FGD participant)

3.2.3. Community-based family violence management strategies among couples

FGD participants suggested that fostering emotional bonds, good communication, and conflict resolution skills were key strategies to prevent and manage family violence. They also emphasized that divorce is uncommon in the study setting due to concerns for children, with women often staying in violent marriages for their sake. Therefore, interventions should focus on conflict resolution, strengthening emotional bonds, and improving overall family functioning.

3.3. Family violence occurrence and management: The community and religious leaders' perspectives

Community and religious leaders noted that family violence often arises from domestic disagreements, including wives' noncompliance, financial issues, sexual refusal, and external interventions. They highlighted that family violence is usually only recognized when it escalates to physical violence, causing injuries. A participant stated:

Violence between husband and wife can be referred to as a misunderstanding. When a spouse makes a statement, and the other makes theirs, there is a need for both to be patient and understand each other, but if we don't understand each other, there will be violence. By the time we understand each other, there will no longer be violence. Violence can occur

within a community as well as between husband and wife. (55-year-old Female Community Leader)

The management strategies for family violence, as identified by community and religious leaders, primarily involve mediation by extended family members, community leaders, and religious figures. This approach is used when couples are unable to resolve their relationship issues on their own.

Yes, very well. The chief imam and religious elders are saddled with this responsibility. People like us have also been called to settle the dispute in homes. So many countless cases have been settled in the past. (57-year-old Religious Leader)

In instances where violence leads to physical injuries or other health-related concerns, the healthcare system is engaged in necessary interventions. However, the involvement of law enforcement and legal professionals is usually reserved for situations where there is an imminent threat to life.

I could remember the case of a woman who ran to my house at night with bruises from a fight with her husband. The husband came while she was here and still threatened her. I asked the women to take the woman to the health centre for her wounds to be treated, while a delegate was sent to inform the police about the incident for intervention. (67-year-old Male Community Leader)

This perspective underscores a community-based approach to handling family violence, with a particular emphasis on mediation and the contribution of authoritative figures within the community and religious circles.

3.4. *Family violence occurrence and management: Nurses' perspectives and* practice *in managing family violence victims*

During data collection, nurses at health centres described their approaches to identifying and managing family violence victims. As the primary healthcare providers, nurses observed that family violence was common, with victims often seeking care for injuries from physical or help for sexual violence. However, they noted difficulty in identifying victims, as patients typically did not disclose the origin of their injuries during health history intake.

Recognising the victims of violence around here is pretty difficult; couples' quarrels and fights are not expressed, they are to be tolerated. Hence, physical and psychological trauma sustained in the course of these are termed insignificant or an accident with an undisclosed origin. (55-year-Old Female Nurse)

Nurses acknowledged differing opinions on marital sexual violence due to the perceived implicit sexual consent within marriage. While some couples discussed sexual issues if they felt the nurse was receptive, nurses reported limited focus on family violence during their training. In-service training primarily covered immunization and antenatal care, but none addressed identifying and managing family violence victims. There were no standardized methods for handling such cases, and identification relied on nurses' interpretation of verbal and non-verbal cues during patient history-taking, followed by further probing based on their assessments.

The local government organises workshops for healthcare workers at the health centres about other issues in the primary health centres, except for family violence identification and management. Probably because it is perceived to be in the law enforcement jurisdiction. Yet we see them here, and we do not have the requisite knowledge and skill to attend to them. (48-year-old Female Nurse)

The management strategies for family violence victims were determined by factors like the severity of injuries, frequency of incidents, and the victim's willingness to accept help. Nurses treated victims with care ranging from wound treatment to mediation, referring complex cases

for advanced care after first aid. Nurses' management approach was based on respect, responsibility, and relationship repair, engaging couples in dialogue with the nurse as a mediator. Nurses expressed the need for further training in assessing and supporting victims, recommending evidence-based interventions like motivational interviewing, risk assessment, and improved response protocols for better support.

3.5. Intervention development

The study synthesised data from two pivotal sources for the intervention development: (1) Qualitative data were harvested from the study's FGDs and interviews, which informed the actual content, structure, and nurse-training processes for the intervention, and (2) A comprehensive literature review of existing research provided the theoretical scaffolding for the intervention.

By integrating these two critical components, the study was committed to developing an intervention for family violence that is not just effective and evidence-based but is also deeply rooted in the cultural norms and conflict resolution frameworks prevalent in the studied communities. This approach ensures that the intervention is not only practically effective but also culturally acceptable and sustainable.

3.6. Intervention components

By integrating qualitative case study findings with theoretical and empirical literature, we developed a contextualized intervention for family violence. This intervention aims to empower nurses to identify and respond effectively to victims, with collaboration from families, religious leaders, and community structures. A central aspect is family-centred care, addressing the needs of children who witness violence and require proper support. The study introduced a comprehensive three-component intervention package, detailed as follows:

1. *Nurses' training package*: This component focuses on equipping nurses with the necessary skills and knowledge to identify and manage cases of family violence. The training enhances nurses' understanding of family dynamics and the various forms of violence, enabling them to offer effective support and care to victims.
2. *Clinical intervention pathway:* This pathway provides a structured approach for clinical interventions in cases of family violence. It outlines specific steps and procedures for nurses to follow when dealing with such cases, ensuring a systematic and thorough response to the needs of victims.
3. *Guidelines for management, follow-up, and referral strategies:* These guidelines offer a framework for the ongoing management of family violence cases, including follow-up care and referral processes. These guidelines ensure that victims receive continuous support and are directed to additional resources or higher levels of care when necessary.

This three-pronged intervention package aims to equip healthcare providers, particularly nurses, with the necessary tools to offer comprehensive and context-sensitive care to affected family members, addressing the multifaceted nature of family violence.

3.6.1. Nurses' training package

The nurses' training package was developed from three sources: qualitative data from FGDs, community and religious leaders; an analysis of nurses' current practices in identifying and managing family violence; and evidence from existing research. The training aims to increase nurses' knowledge and capacity for identifying, responding to, and intervening with family violence victims. It includes four modules: (i) family-centred nursing care, (ii) family violence overview, (iii) identifying family violence, and (iv) management strategies. These strategies cover safety assessment, relationship counselling, conflict resolution, and referral options. The content validation was done by three experts (2 nurses and 1 sociologist), with results shown in Table 4.

3.6.2. Clinical intervention pathway

The findings from the qualitative phase of this study and relevant evidence from the literature informed the development of this clinical pathway. The pathway consists of the route the nurse will take alongside the victim for support. It includes intervention strategies intended to guide healthcare workers in responding to identified victims of family violence and respecting the decision of victims to not disclose. This is shown in Figure 1.

3.6.3. Nurses' guidelines for family violence management, follow-up, and referral strategies

The intervention guidelines aim to support nurses in utilizing community resources, such as extended family, religious, and community leaders, to repair the harm suffered by victims and encourage perpetrators to acknowledge their actions and participate in reparation. The guidelines include mediation and conciliation to resolve issues with family members, while prioritizing the safety of the client. In cases of imminent risk to life, formal structures like the police are involved. The guidelines also focus on preventing and reducing the occurrence of family violence, as detailed in Table 5.

Table 4. Item content validation index (I-CVI) of the nurses' training package

Nurses Training Content	I-CVI
Module 1: Family-Centred Nursing Care	
Overview of family-centred nursing care	1
Module 2: Overview of Family Violence	
Overview of Family Violence (FV) to include major classification, forms, causes, and risk factors.	1
Overview of the cultural and social norms supporting different forms of family violence	1
Module 3: Identification of Victims of Family Violence	
Identifying victims of FV	1
Identifying indicators of FV	1
The use of expansive, precise, and straight questions to identify victims where there are suspicions of FV	1
Risk Assessment of the context of family violence	1
Safety Plan for the period of crisis	1
Module 4: Management of Family Violence	
Strategies for managing family violence	0.83
Offer specific support based on clients' needs	1
Counselling on healthy relationships targeting affected family members	1
Discuss issues that promote family functioning	1
Conflict resolution strategies	1
The mediation process	0.83

4. Discussion

The study developed a nurse-led collaborative intervention addressing family violence in Nigeria by integrating cultural considerations, healthcare expertise, and community engagement. The intervention was informed by insights from married individuals, community leaders, religious leaders, and nurses, ensuring that it was contextually relevant and culturally appropriate. Nurses were positioned at the core of the intervention, bridging community resources and healthcare systems. The process highlighted the importance of collaborative strategies to support victims, mitigate disparities in violence against women, and respond to the impact on child witnesses. By drawing on multidisciplinary expertise and community perspectives, the resulting intervention offers a comprehensive and sustainable model to strengthen the response to family violence in Nigeria.

The study highlights various forms of family violence, including physical, psychological, economic, sexual abuse, and controlling actions in marriage, which were normalised and overlooked. This mirrors national analyses showing high Intimate partner violence prevalence and underreporting in Nigeria (Banjo, 2025; Ikuteyijo et al., 2024). Similarly, studies have documented how cultural and religious norms minimize sexual autonomy and normalize coercive behaviours (Ezema et al., 2023; Oseni et al., 2022). These findings also highlight the cultural and societal barriers to family violence interventions (Green et al., 2023; Ikuteyijo et al., 2024).

Implementing interventions that are co-designed with participants can effectively challenge cultural narratives and societal norms regarding gender roles. This approach can lead to meaningful changes in attitudes and behaviours related to family violence (McLean et al., 2020; Stewart et al., 2021). This strategy aligns with the calls for culturally grounded approaches

(Mercier et al., 2024). The patriarchal norms deeply rooted in the stereotypical gender roles influenced the manifestation of family violence in the study setting. Men predominantly perpetuate violence, leveraging on societal expectations of male dominance in relationships, which are consistent with previous Nigerian and regional studies (Ogunbambi, 2025; Oluku & Abasiekong, 2024).

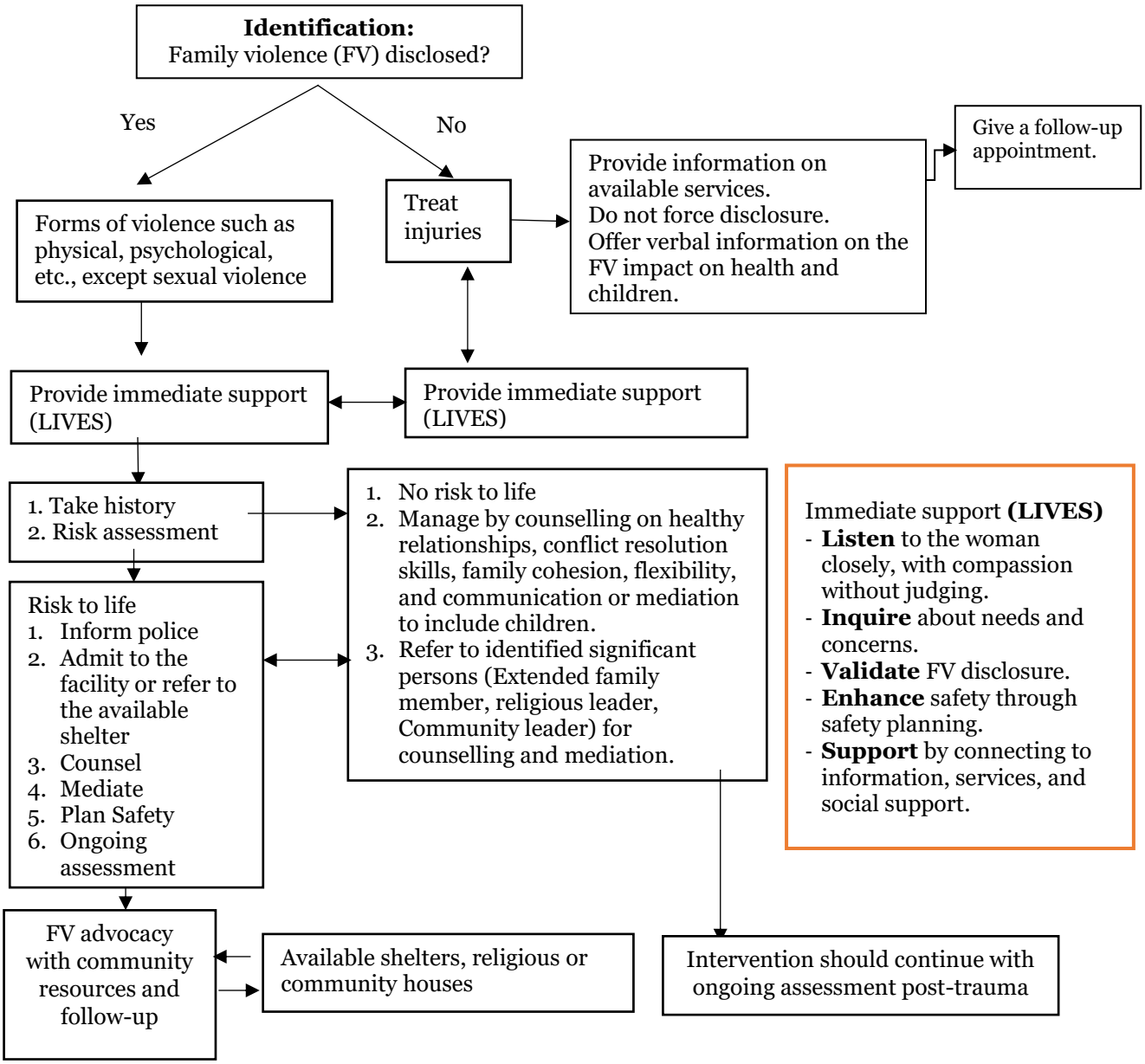

Figure 1. Clinical intervention pathway

Community and religious leaders mediate family violence cases, prioritising reconciliation over punitive measures, reflecting cultural values that may unintentionally sustain abuse cycles. Strengthening collaboration among community leaders, healthcare providers, and law enforcement could enhance accountability while respecting cultural sensitivities (Ezema et al., 2023; Oseni et al., 2022). Nurses address the consequences of violence responsively, but their role could expand to prevention, advocacy, and education in partnership with community stakeholders. Societal mistrust in formal legal systems favours community-based resolutions. The proposed intervention incorporates culturally adapted strategies, including conflict resolution, emotional bonding, communication training, and access to legal and healthcare support as needed.

Table 5. Nurses' guidelines for the management of family violence

No	Content of the guidelines for nurses to manage family violence victims
1	Welcome the client and establish rapport using motivational interviewing techniques.
2	Ensure consultation is conducted where other people cannot hear the discussions.
3	Gain the client's trust by being respectful and sensitive, listening actively, communicating belief, validating the feelings of the client, and stating that violence is unacceptable.
4	Ensure confidentiality by not divulging the client's information to anyone except with the client's permission, where necessary.
5	Take history for visiting the facility.
6	Note symptoms as stated by the client.
7	Assess for signs of physical injury and probe for unseen injuries.
8	Ask questions about happenings at home when there are suspicions of family violence, e.g.: "How are things at home?" "How are you and your spouse relating?" "Is there anything happening that might be affecting your health?" "Have you ever been horrified at home?"
9	Ask precise questions in relation to the client's health and actions in the family, if the client has a disposition to talk, e.g.: "When I see injuries like this, I wonder if someone could have hurt you." "You seem very anxious and nervous. Is everything all right at home?"
10	Ask straight questions about FV in relation to the client and children if the client is willing to discuss, e.g.: "Are you ever afraid of someone in your family or household? If so, who?" "Has someone in your family or household ever threatened to hurt you?" "Are you concerned about your safety or the safety of your children?"
11	Consider children's physical and psychological needs while asking about issues within the family.
12	Do a risk assessment to consider safety, to assess the nature, form, pattern, and degree of danger with or without family violence occurrence, and consider steps to prevent violence.
13	If there are safety issues, admit the client or arrange for safe housing as identified by the client.
14	Plan for client's safety in situations of sudden violence and serious risk by; i. Identifying a safe place to go (family, religious leader, dependable friends, and survivor shelter where available, or the health centre). ii. Plan the safety of children by getting a family member the perpetrator respects to stay over to look out for the children. iii. Assist the client in planning transportation. iv. Identify and pack essential items to take along. v. Cash, debit cards, important documents, and a small bag containing clothes and other daily needs. vi. Explore the access to money in cases of emergency (family, friends, religious leaders). vii. Explore possible support from someone close by (Neighbour, someone informed to be available at such times). viii. Counsel the client to discuss with the perpetrator in places with multiple exit routes that the client can use to leave easily. ix. Stay away from rooms that have weapons. x. Discuss the client's current needs for a safe and supportive environment and emotional and material support. xi. Identify with the client other sources of help (friends, family, religious leader, community leader, non-governmental organisation, etc.).
15	Identify with the client significant persons within the community that the couple or perpetrator will respect (Older family members, community/ religious leaders).
16	Offer to meet with the identified significant persons first before referring the client to them, in agreement with the client.
17	Give a follow-up appointment for ongoing assessment.
18	Respect the client's decision to remain non-disclosing, even after careful questioning.
19	Inform the client about other sources of help available, if needed, after acknowledging the client's response to the questions.
20	Document in detail the information generated from the interaction between the nurse and the client.
21	Plan termination with the client from the initial visit to avoid dependency by allowing the client to make informed decisions from the initial phase of the interactions.

The proposed intervention model concentrated on couples with children, shedding light on the unique dynamics and repercussions of violence occurring within such familial structures. A

recurring theme in contemporary interventions is the delineated focus on either the victim or the perpetrator, leading to a marked neglect of children who inadvertently become silent witnesses to these violent engagements (Travers et al., 2021; Wilson et al., 2021). The presence of children in these environments necessitates an expansive approach to intervention, inclusive of the diverse dimensions of family violence.

The strategies developed in this study were based on the principles of restorative justice (Barth & Jiranek, 2023; Brookes, 2019; Mills et al., 2019), emphasising the importance of fostering powerful, open, and facilitated dialogues to address deeply rooted relationship issues. These dialogues are strategic mechanisms for empowering victims and perpetrators, providing a structured platform for expressing narratives, promoting accountability, and resolving underlying conflicts (Jeffries et al., 2021). The integration of restorative justice principles with motivational interviewing techniques marks a paradigm shift, substantially reducing partner violence incidents by promoting mutual understanding and resolution.

The developed guidelines, deeply intertwined with community-based conflict resolution structures, emphasise nurturing healthy interpersonal relationships and the enhancement of familial cohesion and communication. The overarching goal is to enhance family health and reinforce familial ties through culturally grounded conflict-resolution mechanisms that firmly encourage marital resilience and stability. The future research trajectory is intricately designed to assess the pragmatic efficacy and applicability of the developed intervention package on a broader spectrum, with a particular focus on its adaptive integration within diverse Nigerian communities.

5. Implication and limitation

The results emphasize the need for specialized training and resources to enhance nurses' capacity to manage family violence effectively. Incorporating the intervention package into nursing education and professional development programs can help nurses identify, intervene, and support victims while respecting cultural differences. Healthcare organizations should establish policies with standardized clinical protocols and referral systems to improve case management. Nurses must also play active roles in community-based violence prevention, fostering collaboration with legal authorities and community leaders. This comprehensive approach can improve health outcomes and strengthen nursing's role in community health.

The proposed intervention can be viewed through the lens of family health nursing tasks, emphasising its potential not only to address violence but also to enhance the overall health-promoting capacity of families by recognising health issues related to violence and learning how to respond appropriately. It involves training nurses and engaging community and religious leaders to support families in making informed decisions about seeking help and pursuing safe options. Equipping nurses with guidelines for supportive care for affected family members, conflict resolution, and communication skills helps maintain a safe and supportive home environment. Including referral pathways to legal and healthcare services enables families to access health services more effectively.

However, the findings are context-specific and should be interpreted with caution, as cultural norms, social structures, and health system characteristics may differ across settings, thereby limiting their generalisability. In addition, self-reported data may introduce the possibility of recall and social desirability biases, which may have influenced participants' responses.

6. Conclusion

This study presents a three-component intervention to improve family violence management in healthcare, emphasizing nurse training, structured guidelines, and clinical pathways. It highlights nurses' vital role in identifying and addressing family violence, advocating for targeted training and curriculum integration. The findings also suggest that nurse-led, context-sensitive approaches can strengthen existing healthcare responses to family violence. Future research should assess the intervention's long-term impact, sustainability, and effectiveness in diverse contexts, focusing on victims' well-being and nurses' experiences to refine and enhance its relevance and application.

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Author contribution

OBO contributed to the conceptualization, data collection, analysis, interpretation of results, and drafting of the manuscript. CBB was responsible for data analysis, interpretation of findings, critical review, editing, and proofreading of the manuscript. OMA participated in the conceptualization, study design, data analysis, interpretation of results, and editing of the intellectual content. AEO was involved in conceptualization, interpretation of findings, and manuscript preparation. OI contributed to the conceptualization, study design, interpretation of results, and supervision of the study. All authors read and approved the final draft.

Conflict of interest

The authors declare no potential conflicts of interest concerning the research, authorship, and publication of this article.

Declaration of the use of Artificial Intelligence (AI)

AI-assisted tools were used to support language clarity during manuscript preparation. To the best of the authors knowledge, no artificial intelligence tools were used in the data collection, data analysis, coding, interpretation of findings, or decision-making processes. All analytic procedures, interpretations, and conclusions were conducted by the researchers, who retained full intellectual responsibility for the content, accuracy, and integrity of the manuscript. The use of AI did not replace scholarly judgment, compromise methodological rigour, or influence the study outcomes.

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