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The value of screening and intervening for intimate partner violence in South African primary care: Project evaluation

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Abstract

Objectives

Intimate partner violence (IPV) is an important contributor to the burden of disease in South Africa. Evidence-based approaches to IPV in primary care are lacking. This study evaluated a project that implemented a South African protocol for screening and managing IPV. This article reports on the benefits, and harms, of this intervention from the perspective of the women IPV survivors.

Design

This was a project evaluation involving two urban and three rural primary care facilities. Over 4-8 weeks primary care providers screened all adult women for a history of IPV within the previous 24 months and offered referral to the study nurse. The study nurse assessed and managed the women according to the protocol. Researchers interviewed the women 1-month later to ascertain their adherence to the management plan and views on the intervention.

Results

In total 168 women were managed and 124 (73.8%) returned for follow up. Emotional (139, 82.7%), physical (115, 68.5%), sexual (72, 42.9%) and financial abuse (72, 42.9%) were common and 114 (67.9%) were at high/severe risk of harm. Adherence to the management plan ranged from testing for syphilis 10/25 (40.0%) to consulting a psychiatric nurse 28/58 (48.3%) to obtaining a protection order 28/28 (100.0%). More than 75% perceived all aspects of their care as helpful, except for legal advice from a non-profit organisation.

Women reported significant benefits to their mental health, reduced alcohol abuse, improved relationships, increased self-efficacy and reduced abusive behavior. Two characteristics seemed particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Conclusion

Female IPV survivors in primary care experience benefit from an empathic, comprehensive approach to assessing and managing the clinical, mental, social and legal aspects. Primary care managers should find ways to integrate this into primary care services and evaluate it further.

ARTICLE SUMMARY

ARTICLE FOCUS

- Did women experiencing IPV find assessment and management in primary care beneficial?
- What aspects of the management plan did they adhere to?
- What aspects of the management plan did they find most helpful?

KEY MESSAGES

- Women diagnosed with IPV in primary care perceive benefit from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to the clinical, mental, social and legal aspects.
- Women reported benefits to their mental health, alcohol use, relationships, and experience of abusive behaviour.
- IPV survivors were most proactive about securing protection orders, laying criminal charges, and testing for pregnancy post-intervention.

STRENGTHS AND LIMITATIONS

- A comprehensive biopsychosocial and forensic intervention in primary care was tested, securing follow-up which revealed its value.
- The study was conducted under usual working conditions and resource availability making the findings applicable to the primary care context.
- Although the study only involved five purposely selected facilities, the rural/urban mix makes it likely that these are fairly typical.
- Obsequiousness bias was reduced by different researchers conducting the follow up interviews.
- Follow up after one month is too short to predict the longer term consequences of the intervention.
- The study did not measure the effect of the intervention on the abuse, but relied on the women's perceptions and self-reports.

Introduction

Interpersonal violence is the second highest contributor to the burden of disease after HIV and AIDS, with intimate partner violence (IPV) accounting for 62.4% of the total burden in females.[1] South African women are killed by their intimate partners more often than in most other countries.[2] IPV appears to be twice as common in rural South African settings compared to urban, with a complex interplay of racial, gender and economic forces, maintaining women in abusive situations.[3] The use of violence to maintain dominance in interpersonal relationships forms a cross-cultural cornerstone of masculinity in South Africa.[4] For these reasons, it is crucial that healthcare providers attend to IPV survivors' needs comprehensively.

South African laws and policy on violence against women acknowledge it to be a significant human rights and public health issue. South Africa's Domestic Violence Act (116 of 1998) includes a definition of domestic violence so comprehensive that marks it as a legislative standard bearer internationally.[5] An inexpensive and unsophisticated civil procedure for obtaining a protection order clearly demarcates the duties of the police.[6] Unfortunately, specific responsibilities for healthcare providers are not outlined and a gulf exists between the contents of the Act and its practical implementation.

The WHO now positions IPV as an urgent public health priority.[7] Internationally, evidence-based interventions in primary care settings are lacking.[8,9] A systematic review on screening for IPV in primary care concludes that while "domestic violence is a common problem with major health consequences for women, implementation of screening programmes cannot be justified."[10] They call for evidence of the benefit of specific interventions and lack of harm from screening.

Paradoxically, universal screening for IPV in health care settings is commonly endorsed by international guidelines.[11] However, in poorly resourced contexts such as South Africa the use of case finding, based on the presentation of specific signs or symptoms of abuse, is recommended.[12] This focuses healthcare resources and providers' time on those needing immediate healthcare.

In South African primary care, case finding is not practiced routinely and IPV remains hidden beneath other diagnoses. Health providers are mostly reluctant to ask about

IPV and patients rarely disclose the problem spontaneously. Providers are also unsure how to manage IPV as it has complex clinical, mental, social and legal implications. They tend not to accept that IPV is a health problem and in a system already over burdened by other diseases, may be unwilling to legitimise IPV as part of their work.

Evaluations of initiatives addressing IPV are lacking, and frequently focus on the criminal justice system.[13] However lack of evidence should not be equated with lack of effectiveness.[14] Inquiry about IPV offers a way of "uncovering and reframing a hidden stigma" to provide benefit, even if no action follows forthwith.[15]

This study evaluated the implementation of a South African protocol for screening and managing women living with IPV in local primary healthcare settings.[16] This article reports on the benefits, and harms, of this intervention from the participants' perspective.

Methods

Study design

Evaluation of a project in South African primary care which implemented a protocol for the recognition, assessment and management of women with IPV.

Study setting

Two urban and three rural health care facilities were purposefully selected in the Western Cape. Selection was based on their willingness to participate, availability of a psychiatric nurse and a private space for the study nurse. Otherwise facilities were typical of primary care in the Western Cape. Patients in ambulatory primary care were usually seen by a nurse practitioner.

The two urban community health centres were situated in formerly designated "black" and "coloured" townships in Cape Town. One rural site was a community health centre in a large rural town and in a former "coloured group area". The other two rural sites were remote, smaller clinics in farming communities. All these public sector facilities served low socio-economic groups who were not medically insured.

Selection of women

All primary care providers at the facilities were asked to screen all female patients, of 18 years and older, for a history of IPV during the previous 24 months. Facilities agreed to screen women for 4-8 weeks.

In-service training of the health care practitioners was given by the researchers and they were provided with a prompt tool that listed the questions, such as, “How are things going in your relationship?” or “In this clinic we ask all women patients if they have ever experienced any form of abuse. Have you ever experienced abuse by your partner?” Women identified as having experienced IPV were offered a referral to the study nurse.

Intervention

The authors recruited and trained two nurse practitioners to provide the intervention. These study nurses, including principal author, then obtained consent and built rapport with the women before proceeding with the comprehensive assessment and management plan described below. The screening and management protocol tested in this study was developed in Cape Town by the Consortium on Violence Against Women with the help of Canadian activists.[16] The suggested assessment and management plan included the following:

- A systematic history of type and frequency of abuse.
- A comprehensive medico-legal history including previous HIV tests, sexually transmitted infections, risk of pregnancy, previous attempts to enlist assistance from police or law courts and forensic documentation of injuries. If necessary the woman was offered further testing or treatment.
- The original protocol neglected aspects of mental health. Therefore a locally adapted version of the World Health Organisation’s toolkit for the recognition, diagnosis and treatment of mental disorders in primary care was added.[17] If a mental problem was suspected the participant was referred to the psychiatric nurse.
- A safety assessment tool intended to ascertain the woman’s risk of serious injury. Discussion of a safety plan then followed with referral to other health, social, legal or police services.

Before leaving, women were given an appointment for a follow-up interview 1-month later.

Data collection

Data was extracted from the record of the initial consultation to give a profile of the management plans. The intended management plan was available to the researcher at the follow up interview.

A different researcher conducted the follow-up interviews. A semi-structured questionnaire explored adherence to, and perceptions of, the care planned during the initial consultation. Participants reflected on how useful this had been, how they felt about their IPV situation now, and whether they had acted upon their intended plans. This researcher either made detailed notes or recorded key responses verbatim.

Data analysis

The quantitative data was analysed by Stellenbosch University's Centre for Statistical Consultation in terms of simple frequency tables. The qualitative data was coded and analysed according to the framework method to understand how participants experienced the intervention.[18]

Findings

Profile of the women

Participants comprised 168 females with 56 (33.3%) from urban and 112 (66.6%) from rural facilities. Table I describes the frequency and range of abuse. Over the 2 years preceding this study, 96 (57%) participants admitted to being abused more than twenty times, 27(16%) between eleven and twenty times and 45 (27%) had been abused ten or less times. Each woman experienced on average eight forms of abuse over extended periods. Emotional abuse was commonest and ranged from verbal abuse, to restricted contact with family and friends, to control of the woman's freedom to pursue activities. Physical abuse came a close second, with 115 (68%) having experienced beatings, 82 (50%) kicked, and alarmingly 55 (34%) had been choked.

Table II describes their degree of risk according to the safety scores and shows that 114 (67.9%) were at high or severe risk. The fact that 77 (45.8%) believed he was capable of killing indicates the atmosphere of fear pervading the households. Apart from the danger to the woman herself, 91 (54.2%) admitted that their partners had threatened to kill their children.

Value of different aspects of the intervention

Out of the 168 women 124 (73.8%) returned for the follow up interview. Table III shows key elements of the management plan and the extent to which women acted on these plans. Significantly, 28/28 (100%) of women followed through on applying for a protection order, 16/19 (84.2%) proceeded to lay a charge and 23/24 (95.8%) saw the social worker.

Table IV shows the perceived usefulness of different aspects of the intervention. No respondents reported the intervention as harmful. Over 75% found all elements of their suggested management plans useful, apart from referral to local non-profit organisations for legal advice.

Therapeutic effect of empathic listening

Participants explained that telling their story and feeling understood was in itself beneficial.

"… found the intervention interesting … felt that … she could talk to someone and they actually heard her. She also felt that she could trust the study nurse. She described the social worker and psychiatric nurse and how they just said, 'yes, yes' and never really understand. The study nurse gave her advice and told her what she could do."

Being able to be honest in a supportive and non-judgmental interaction was helpful:

"No one had ever spoken to her openly before and it was the first time she was able to be completely honest about everything. She does not want to give up on her marriage and feels it would be best if she and her husband received counselling together."

The style of interaction was different from usual and facilitated honest reflection on the situation:

"Doctor had asked her before why she was so stressed but was too embarrassed to tell him. But she was able to talk to (the study nurse) and felt it was good to have evaluated her situation."

Value of clinical care

Participants appreciated having their overall health as women taken seriously, particularly since many aspects were examined, which were not usually dealt with. Many felt relieved to be tested for HIV or assessed for sexually transmitted infections. Adherence to other ongoing clinical care, such as antiretroviral treatment, appeared to also improve:

> "When patient first came she describes herself as tense and hysterical. While talking to the study nurse she experienced a change inside…hope…Before she met her she never thought she could reach the place she is now…(decreased CD4 count, attending ARV clinic, has gained weight)."

Safety Assessment and Planning

The safety assessment was found to be useful for the following range of reasons:

"… made her feel better after hearing that it was wrong to be forced to have sex";
"… opened her eyes as she learnt that he should not hurt her like that";
"… saw how dangerous her situation was and decided to get help (an interdict");
"… made her aware of her own faults as well".

Participants cited many reasons why they found the safety plan useful:

> "She is very afraid as feels he could kill her. Good to discuss what to do and make a plan – not tell him anything. Just leave."
> "In the past always had to scramble around and look for things in an emergency but now all her things are in one place."

Referral to other resources

Knowing about the available resources and being offered referral was appreciated:

"The intervention helped a lot. She did not know that there were so many people to help her. She had been to social workers before, but it is not the same. She now does not feel alone anymore."

The referral letter had helped to access services required:

"…before "x" court had refused to help her, but with letter they gave her a protection order. Now she feels happy."

Many participants expressed relief at discovering they have rights, and where to find help when they need it. Many expressed that the questions and information opened up a new world, linking them to resources and showing ways to change their circumstances.

Problems with police

Most complaints referred to unsympathetic, impersonal, indiscreet or corrupt police. One participant's partner had paid the police off while another's recurrently abusive behavior continued despite her protection order. Another explained when she had applied for a protection order she was not given a copy of the temporary order. When she laid a charge, she received a case number, but no copy of the statement or medical report. This was failure of authorities to provide copies was commonly reported by participants.

Negative reactions to the intervention

Digging up the past had upset a participant. Another complained that she felt very frightened after the interview. One said that things were worse at home because when informed of the pending divorce, he threatened to take the children and jump under a train.

Suggestions to improve the help offered

A strong theme was the need for a support group:

"She would like to talk to other women who have been through the same situations. She would like to make friends and learn from other people."

A professional rural woman desired referral to services outside her community as she felt too exposed to access services within it. Another would only see a female counsellor. Some wanted their partner to be "spoken to" or couple counselling to prevent the impression that only women need help. Some resented a perceived onus on women to resolve problems rather than zero tolerance for men's abusive behaviour and proactive efforts to get functional interventions in place. Other participants requested practical assistance such as written advice or help with

completing protection order application. One woman expressed a need for solitude and space to reflect.

Impact of the intervention on the women and their situations

Improved mental state

Multiple participants reported improved mood, sociability and sense of well-being as well as decreased anxiety, suicidal ideation and alcohol abuse. Enhanced parenting emerged frequently as a theme.

“I used to feel sad all the time. I used to feel useless but now I feel responsible. I can take care of my children now. When I was drinking every day I would take them to a woman to look after them. Now I enjoy my kids and my life more … since I went to press charges we have not been together and he has not hurt me either.”

“I was a wreck, but when I left her office I could face the world squarely again. She taught me things about myself I did not know. My problems were not solved then and there but I can now notice what I did not before and I feel better about myself as a person.”

Reduced isolation

Some participants found that the intervention encouraged them to reduce their isolation by reconnecting with trustworthy friends or family members in a more open and honest way:

“Communication … has improved. It is easier for her to disagree and she feels more independent, like she could manage without him. She had isolated herself quite a bit, but is now starting to reach out to her friends again.’

More aware of their rights

Women described no longer “feeling lost” since they learnt about potentially helpful resources:

“For the first time in two years, she phoned the police and used her protection order. She appeared in front of the magistrate and since then he has lived with his family.”

Many discussed a notable improvement in the partners' behaviour in response to a letter the researcher had written to the police and/or magistrates' court. Women reported that obtaining a protection order from the court was more effective than laying a charge at the police station. In most cases where the criminal justice system was effectively engaged the abusive behaviour stopped completely, usually due to fear of jail.

Taking action

On follow-up, some reported having taken action to enhance the quality of their lives.

"…after interview she got a protection order and ended her relationship with her gangster boyfriend who uses tic" (metamphetamine)."

Improved relationships

Many participants described improvement in their family relationships:

"I went to a support group for abused women. A lot changed inside myself, like now I know how to talk to my husband. I was always angry and shouting at him, now we communicate better. I am much kinder to the kids. I feel happy now. Before I felt sad, wanted to cry and stay alone."

"Before I met the researcher, I always felt alone. Secondly when I'm talking to my kids I'm always fighting because I think I am somebody useless. After I talk with her I do not fight so much. I try not to be aggressive. I try to sit down and talk with my children. At least they listen to me – they appreciate me being kind. Also, I have stopped shouting at my baby, now 18 months, because I love her so much and show her that in a kind way ... the last three weeks I feel more normal, like myself."

Change in own behaviour

Many participants described how the intervention had motivated change in their own behavior. Reduced alcohol abuse was a particularly frequent effect, with enhanced parenting an attendant theme.

"Our relationship is going much better than before. I discussed certain things with him and he understood me. I am drinking much less than before and going to evening songs again. I never wanted to work on Saturdays but now I am".

"It made her realise that she can no longer continue to use alcohol because it's detrimental to her baby. She feels she can talk about things easier and that she came out a stronger person, able to take a stand."

"Yes, I am different inside. When he tries to provoke me with verbal abuse when drunk, I don't allow him to make me angry. He doesn't even listen to me, but I take me seriously."

Change in partners' behaviour

Change in partners' behaviour was also reported:

"There has been great change in her life. The intervention was very useful because the results have made her feel very happy. The situation at home has improved very much. Her husband has even been working in their garden and helping the children with homework - never before."

"She found the whole experience useful because she got a protection order and there is now someone to stop him. Even though he was famous for his actions locally and people were aware of his behaviour, nothing was ever done. The protection order however has changed his behaviour."

No real change

Some participants reported that the process had been useful, even though neither his behaviour nor her circumstances had altered. A few participants found no improvement or only felt better temporarily. The intractable challenges that pervaded these responses often involved alcoholism in either or both partners, financial constraints, HIV infection as well as participants' inertia to follow up on referrals made.

"No real change – he continues to withhold pay while expecting money from her with which to buy alcohol. Locked her and kids out of home while he was away drinking, very abusive on return. She wants a divorce."

A common refrain was, "When he is not drunk, he is such a nice guy."

Another trap was expressed as follows:

"She needs the money that he provides … a protection order will make him angry and he will not be able to work if he is in jail. She is still very scared of him but he gets angry if she addresses his behavior. He must always be right."

Discussion

Women were suffering simultaneously from multiple types of abuse and were mostly at high or severe risk of injury and death. Women showed strong adherence to the components of the management plan and described all aspects of the intervention as helpful. Women reported significant benefits to their mental health, reduced alcohol abuse, improved relationships, increased self-efficacy and reduced abusive behavior.

Two characteristics of the intervention appeared particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Being encouraged to tell their story and being listened to with genuine interest and care emerged as key features of the interview which participants valued. This echoes other studies which speak of IPV survivors' need for compassionate, uninterrupted listening.[19,20] Clearly indicating to patients that violence is not a taboo topic, is in itself a vital therapeutic component of any intervention.[21] The safety assessment provided feedback on how the situation is perceived relative to a different norm, thus enhancing the discrepancy between 'normalcy' and their current situation. Our findings of the significance of empathic, non-judgmental interaction is supported.[22,23,24]

This study addresses a key gap in the literature since it provides evidence of the benefits of a comprehensive intervention for IPV.[8,9,10] In order to be comprehensive, assessment and management should include clinical, psychological, social, legal and advocacy components. Clinical aspects include the risk of pregnancy, sexually transmitted infections and HIV testing. Psychological aspects include identifying potential mental health problems. Social includes possible referral to support groups, social workers and safety planning. Legal includes referral for a protection order, which was found more effective than laying a criminal charge. Information about rights and local resources was important.

Advocacy and referral to relevant resources has the potential to interrupt and prevent recurrent IPV and associated trauma while enhancing IPV survivors' quality of life.[8] Six months of advocacy has been found to improve emotional health, personal

safety, health care and the ability to get medication or treatment while decreasing unhealthy coping behaviours.[25]

The intervention occasionally led to separation, but more often to improvement in the relationship with the partner. Contrary to popular belief, most IPV survivors want the violence, not the relationship, to end.[26]

Strengths and limitations

The mixed methods facilitated in depth understanding of how women experienced the intervention. Follow up however was limited to 1-month so the study cannot determine if changes were sustained or if additional changes occurred subsequently. A longitudinal evaluation measuring the effect of the intervention on the abuse could provide further evidence of effectiveness. Fewer women than expected were identified and referred to the study and the issues related to screening are presented elsewhere.[12]

Implications and recommendation

The study provides evidence that the intervention was perceived as useful by most participants. Implementation in primary care will require attention to enabling an empathic communication style and a comprehensive assessment and management plan. A proposed model of how the intervention can be integrated into local primary care is described elsewhere.[27] The evaluation of this protocol has provided sufficient evidence to the Department of Health to implement the model in the Western Cape.

The communication style mirrors that of motivational interviewing which helps people make difficult decisions about behavior change.[28] Characterised by empathy, clear direction, collaboration, evocation of the client's perspective and solutions, its approach respects autonomy. Training in motivational interviewing as well as the conceptualisation of IPV as a chronic rather than an acute condition should be considered in the roll-out of this model.

Conclusion

Women diagnosed with IPV in primary care perceive clear benefit, at least in the short term, from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to assessing and managing the clinical,

mental, social and legal aspects. District managers should integrate this approach into primary care services and evaluate it further.

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Table I: Prevalence of different types of abuse

Abuse behavior	n = 168	%
Emotional		
Shouting	139	82.7
Name calling	136	81.0
Threatening	94	56.0
Restricting contact	84	50.0
Controlling activities	63	37.5
Accusations	19	11.3
Other	16	9.5
Physical		
Hit	115	68.5
Pushed	90	53.6
Kicked	82	48.8
Use of weapon	69	41.1
Choked	57	33.9
Burnt	8	4.8
Hair pulled	2	1.2
Sexual		
Infidelity	72	42.9
Sexual coercion	55	32.7
Unwanted touching	41	24.4
Sexually transmitted infections	41	24.4
Other	6	3.6

Table I: Prevalence of different types of abuse

Financial		
Withholding money	72	42.9
Controlling decisions	25	14.9
Taking money	23	13.7
Other	6	3.6
Total reports of an incidence of abuse	**1 315**	

Table II: Safety assessment score

	n = 168	%
Safety assessment score		
Not done	3	1.8
Caution (0–3)	50	29.8
High risk (4–7)	87	51.8
Severe risk (8–11)	27	16.1
Safety assessment fields		
Threatened with physical violence?	125	74.4
Threatened children with violence?	109	64.9
Firearm in house?	102	60.7
Made a death threat?	92	54.8
Threatened to kill children?	91	54.2
Capable of killing?	77	45.8
Substance use prior to last abuse?	62	36.9
Police intervention necessary?	54	32.1
Is he in the house?	41	24.4
Has abuse escalated in severity?	35	20.8
Received medical treatment for injuries?	33	19.6

Table III: Adherence of women to plans made by 1-month follow up (N=124)

	Management plan		Action		Adherence
	N	%	n	%	n/N %
Wants HIV test	56	45.2	31	25.0	55.4
Wants rapid plasma reagin test	25	20.2	10	8.1	40.0
Wants pregnancy test	6	4.8	10	8.1	100.0
Intends to obtain a protection order	28	22.6	28	22.6	100.0
Intends to lay a charge	19	15.3	16	12.9	84.2
Referral to NPO for legal support	15	12.1	7	5.6	46.7
Referral to NPO counselling	32	25.8	12	9.7	37.5
Referral to psychiatric nurse	58	46.8	28	22.6	48.3
Referral to social worker	24	19.4	23	18.5	95.8

NPO=Non profit organisation

Table IV Perceived usefulness of different aspects of the intervention

Intervention		Very helpful		Helpful		Unhelpful		Don't know	
	N	n	%	n	%	n	%	n	%
Safety assessment	106	31	29.2	54	50.9	6	5.7	15	14.2
Safety plan	102	33	32.4	44	43.1	9	8.8	16	15.7
Protection order	28	14	50.0	9	32.1	4	14.3	1	3.6
Going to NPO for legal advice	7	2	28.6	2	28.6	1	14.3	2	28.6
Going to NPO for counselling	12	5	41.7	4	33.3	1	8.3	2	16.7
Going to psychiatric nurse	28	13	46.4	13	46.4	2	7.1	0	0.0
Going to social worker	23	6	26.1	10	43.5	3	13.0	4	17.4
Laying criminal charge	16	5	31.3	10	62.5	1	6.3	0	0.0

NPO=Non profit organisation

Acknowledgements:

Thanks are due first and foremost to all the IPV survivors, health care providers, health system managers, key informants, co-researchers, supervisors and referral resources who participated in this study, thereby making it possible. Thanks also to Julia Blitz for her critical review

Competing Interests:

The authors declare no conflict of interests.

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Contributor Statement

Conception and design: K Joyner and R Mash

Data collection: K Joyner, N Bakumeni, M Abrahams, L Le Roux, K Thomson
Analysis of the data: K Joyner, M Kidd (statistician)
Interpretation of the data: K Joyner, R Mash
Drafting of the article: K Joyner and R Mash
Critical revision of the article for important intellectual content: K Joyner, R Mash and J Blitz
Final approval of the article: K Joyner and R Mash

COREQ 32-ITEM CHECKLIST (Tong, Sainsbury & Craig, 2007)

Domain 1: Research team and reflexivity

Personal characteristics

1. **Interviewer/Facilitator**

   Kate Joyner: conducted first and follow-up interviews and focus groups

2. **Credentials** *M.Soc. Sc; Advanced Diploma in Psychiatric Nursing; Diploma in General, Community and Psychiatric Nursing and Midwifery.*

3. **Occupation** Programme coordinator: Mental Health and Gender-Based Violence Nursing, StellenboschUniversity; doctoral student.

4. **Gender** Female

5. **Research experience**
   Conceptualised and supervised a student project which subsequently won the DumoBaqwa award for best original research article in South African Journal of Family Practice 2007: Joyner K. et al. Emergency care provision for, and psychological distress in, survivors of domestic violence. SA FamPract 2007;49(3).
   Training

   Active in the NGO sector since 1985

   Three social science degrees at UCT, was busy doing a doctorate in Social Science Research Methodology.

   Seven years of integrating how to provide care for those affected by gender-based violence into all undergraduate, postgraduate and non-degree purpose training at Stellenbosch University.

   Organised and participated in all cooperative inquiry group meetings.

1. **Facilitator**

   Robert Mash: conducted a focus group, and facilitated all cooperative inquiry group meetings

2. **Credentials** *PhD; MBChB; MRCGP; DCH; CRCOG*

3. **Occupation** Assoc. Professor in Family Medicine and Primary Care, StellenboschUniversity

4. **Gender** Male

5. **Research experience and training** Research projects currently focus on chronic diseases (diabetes, asthma), training of family physicians; defining

family medicine in Sub-Saharan Africa, motivational interviewing, a survey for reasons for encounter and diagnoses in South African primary care.

Supervisor of 30 Masters and 7 Doctoral students at StellenboschUniversity.

1. **Interviewer/Facilitator**

Maggie Abrahams: conducted first and follow up interviews and a focus group

2. **Credentials** *Diploma in Community Health Science and Administration,Registration as Midwife and Psychiatric Professional Nurse*
3. **Occupation** Research assistant/study nurse; Masters student.
4. **Gender** Female
5. **Experience** No former research experience, three decades of nursing experience in the clinical field.

Training Three day training before beginning data collection and participated in five cooperative inquiry group meetings.

1. **Interviewer**

NobuhleBakumeni: conducted first interviews

2. **Credentials***Diploma in General Nursing Science and Midwifery; Certificate in Advanced Health Management Programme*
3. **Occupation** Nurse clinician at HIV/ARV clinics in Eastern Cape; Masters student.
4. **Gender** Female
5. **Research experience** Worked as research assistant and facilitator to improve water sanitation in East London for 9 months on a Water Commission research project.

Training Two day training before beginning data collection and one cooperative inquiry group meeting during her involvement in the research process. Principal author also met with Nobuhle twice a week during data collection process to provide supervision (support).

1. **Interviewer**

Liezel Le Roux: conducted follow-up interviews

2. **Credentials** *B Cur; Registration as General, Community and Psychiatric Professional Nurse and Midwife*

3. **Occupation** Research assistant at Medical Research Council's Unit for Anxiety and Stress Disorders.

4. **Gender** Female

5. **Research experience**

Student research project supervised by Joyner and subsequent employment as research assistant, see occupation above.

Training

Two day training before data collection began.

1. **Interviewer**

Kirsten Thomson: conducted follow-up interviews

2. **Credentials** *Bachelor of Arts*

3. **Occupation** Research assistant;Honours degree in History student

4. **Gender** Female

5. **Research experience**

Kirsten was working as a research assistant on the Groote Schuur History project. She had participated in 19 interviews and was coordinating the study.

Training Training discussions in meetings with Kate, and participated in three cooperative inquiry group meetings.

Relationship with participants

6. **Relationship established**

Most participants had no prior relationship with interviewers, except in case of Maggie Abrahams who was the full time study nurse in the region she had grown up in.

7. **Participant knowledge of the interviewer**

Participants were informed that she was the study nurse, and that her role was to provide comprehensive assistance to them. Participants were informed that the role of the follow-up interviewer was to understand whether the intervention (1st interview) had been of use to them.

8. Interviewer characteristics

Participants only had positive things to say about all interviewers. Their experience of the intervention was surprisingly satisfactory – perhaps due to the historical and continuing neglect of intimate partner violence as a legitimate, important health concern.

Significantly also, all first interviewers had left or were living in abusive relationships. Out of 11 potential interviewers, these three committed to participating in the project and from participant's feedback it is clear that their approach was a non-judgmental one of insight, compassion and respect .

Domain 2: study design

Theoretical framework

9. Methodological orientation and Theory

Professional action research framework for a mixed method intervention study

Participant selection

10. Sampling	168 participants choose to participate in the intervention
11. Method of approach	Female patients, 18 and older, were screened during their healthcare consultation
12. Sample size	168 women, 18 and older.
13. Non-participation	No idea because it wasn't a feature of the methodology

Setting

14. Setting of data collection	Primary health care facilities (CHCs)

15. **Presence of non-participants** Occasionally the participant's child was present.

16. **Description of sample** The sample consisted primarily of poor, relatively uneducated, African women and women of mixed origin.

Data Collection

17. Interview guide

The first interview involved piloting a protocol for the screening and management of intimate partner violence (Martin L, Jacobs T. Screening for Domestic Violence: A Policy and Management Framework for the Health Sector. Cape Town: Institute of Criminology, University of Cape Town, 2003.). Professional action research methodology enabled us to modify it for use in the primary health care sector.

The research team compiled the follow-up interview tool to assess participant's experience of the intervention and what action they had subsequently taken to address the care plan she had formulated with the study nurse/researcher.

18. Repeat interviews

Nil

19. Audio/visual recording

Focus groups were audio recorded with a digital device.

First and follow-up interviews were manually transcribed.

20. Field notes

Field notes were made and analysed as part of the bigger study.

21. Duration

First interview (intervention): 60 – 90 minutes

Follow-up interview: 30 minutes

Focus groups: 60 minutes

22. Data saturation

Yes, discussed in supervision with Prof Mash and cooperative inquiry group meetings.

23. Transcripts returned

No

Domain 3: analysis and findings

24. Number of data coders

Coded by principal author and verified by three co-researchers.

25. Description of the coding tree

Evident from results

26. Derivation of themes

Derived from the data

27. Software

SPSS for quantitative data

Manual coding of qualitative data according to Framework Method.

28. Participant checking

Yes, that was the purpose of the follow-up interview and is reported on in the article submitted.

Reporting

29. Quotations presented

Multiple participants' quotations are presented to illustrate themes.

30. Data and findings consistent

Yes

31. Clarity of major themes

Yes, major themes are clearly presented in the findings.

32. Clarity of minor themes

Yes, there is a discussion of minor themes

BMJ open

The value of intervening for intimate partner violence in South African primary care: Project evaluation

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2011-000254.R1
Article Type:	Research
Date Submitted by the Author:	02-Sep-2011
Complete List of Authors:	Joyner, Kate; Stellenbosch University, Division of Nursing Mash, Robert; Stellenbosch University, Division of Family Medicine and Primary Care
Primary Subject Heading:	Evidence-based practice
Keywords:	MEDICAL EDUCATION & TRAINING, PRIMARY CARE, MENTAL HEALTH

The value of intervening for intimate partner violence in South African primary care: Project evaluation

Abstract

Objectives

Intimate partner violence (IPV) is an important contributor to the burden of disease in South Africa. Evidence-based approaches to IPV in primary care are lacking. This study evaluated a project that implemented a South African protocol for screening and managing IPV. This article reports primarily on the benefits of this intervention from the perspective of the women IPV survivors.

Design

This was a project evaluation involving two urban and three rural primary care facilities. Over 4-8 weeks primary care providers screened adult women for a history of IPV within the previous 24 months and offered referral to the study nurse. The study nurse assessed and managed the women according to the protocol. Researchers interviewed the participants 1-month later to ascertain adherence to their care plan and their views on the intervention.

Results

In total 168 women were assisted and 124 (73.8%) returned for follow up. Emotional (139, 82.7%), physical (115, 68.5%), sexual (72, 42.9%) and financial abuse (72, 42.9%) were common and 114 (67.9%) were at high/severe risk of harm. Adherence to the management plan ranged from testing for syphilis 10/25 (40.0%) to consulting a psychiatric nurse 28/58 (48.3%) to obtaining a protection order 28/28 (100.0%). Over 75% perceived all aspects of their care as helpful.

Women reported significant benefits to their mental health, reduced alcohol abuse, improved relationships, increased self-efficacy and reduced abusive behavior. Two characteristics seemed particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Conclusion

Female IPV survivors in primary care experience benefit from an empathic, comprehensive approach to assessing and assisting with the clinical, mental, social and legal aspects. Primary care managers should find ways to integrate this into primary care services and evaluate it further.

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ARTICLE SUMMARY

ARTICLE FOCUS

- Did women experiencing IPV find assessment and management in primary care beneficial?
- What aspects of their care plan did they adhere to?
- What aspects of their care plan did they find most helpful?

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KEY MESSAGES

- Women diagnosed with IPV in primary care perceive benefit from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to the clinical, mental, social and legal aspects.
- Women reported benefits to their mental health, alcohol use, relationships, and experience of abusive behaviour.
- IPV survivors were most proactive about securing protection orders, laying criminal charges, and testing for pregnancy post-intervention.

STRENGTHS AND LIMITATIONS

- A comprehensive biopsychosocial and forensic intervention in primary care was tested, securing follow-up which revealed its value.
- The study was conducted under usual working conditions and resource availability making the findings applicable to the primary care context.
- Although the study only involved five purposely selected facilities, the rural/urban mix makes it likely that these are fairly typical.
- Obsequiousness bias was reduced by different researchers conducting the follow up interviews.
- Follow up after one month is too short to predict the longer term consequences of the intervention.
- The study measured the effect of the intervention on the abuse indirectly via participants' self-reports.

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Introduction

Interpersonal violence is the second highest contributor to the burden of disease after HIV and AIDS, with intimate partner violence (IPV) accounting for 62.4% of the total burden in females.[1] South Africa's intimate femicide rate is the highest globally.[2] IPV appears to be twice as common in rural South African settings compared to urban, with a complex interplay of racial, gender and economic forces, maintaining women in abusive situations.[3] The use of violence to maintain dominance in interpersonal relationships forms a cross-cultural cornerstone of masculinity in South Africa.[4] For these reasons, it is crucial that healthcare providers attend to IPV survivors' needs comprehensively.

Gender-based violence is an umbrella term for forms of interpersonal violence characterised by gendered power imbalances. Fitting within this, IPV refers to emotional, physical, sexual or financial abuse between intimates. It also fits within broader sub-categories of gender-based violence, namely family and domestic violence.

South African laws and policy on violence against women acknowledge it to be a significant human rights and public health issue yet extreme levels of gender-based violence, poverty and HIV infection among women reveal a chasm between the daily lives of female citizens and apparent gains in the public sphere.[5] South Africa's Domestic Violence Act (116 of 1998) includes a definition of domestic violence so comprehensive it is a legislative standard bearer internationally.[6] An inexpensive and unsophisticated civil procedure for obtaining a protection order clearly demarcates the duties of the police.[7] Unfortunately, specific responsibilities for healthcare providers are not outlined and a gulf exists between the contents of the Act and its practical implementation.

The World Health Organization (WHO) now positions IPV as an urgent public health priority.[8] Internationally, evidence-based interventions in primary care settings are lacking.[9,10] A systematic review on screening for IPV in primary care concludes that while "domestic violence is a common problem with major health consequences for women, implementation of screening programmes cannot be justified."[11] They

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call for evidence of the benefit of specific interventions and lack of harm from screening.

Paradoxically, universal screening for IPV in health care settings is commonly endorsed by international guidelines.[12] However, in poorly resourced contexts such as South Africa the use of case finding, based on the presentation of specific signs or symptoms of abuse, is recommended.[13] This focuses healthcare resources and providers' time on those needing immediate healthcare.

In South African primary care, case finding is not practiced routinely and IPV remains hidden beneath other diagnoses. Health providers are mostly reluctant to ask about IPV and patients rarely disclose the problem spontaneously. Providers are also unsure how to manage IPV as it has complex clinical, mental, social and legal implications. They tend not to accept that IPV is a health problem and in a system already over burdened by other challenges, may be unwilling to legitimise IPV as part of their work.[13]

Evaluations of initiatives addressing IPV are lacking, and frequently focus on the criminal justice system.[14] However lack of evidence should not be equated with lack of effectiveness.[15] Inquiry about IPV offers a way of "uncovering and reframing a hidden stigma" to provide benefit, even if no action follows forthwith.[16]

This study implemented and evaluated a South African protocol for screening and managing women living with IPV in local primary healthcare settings.[17] This article reports primarily on the benefits of this intervention from the participants' perspective.

Methods

Study design

This article presents part of a larger study for which the overall study design was action-research. The action or project was the implementation of a protocol for the screening and management of IPV in primary care. The research, by a co-operative inquiry group, evaluated the experience of the primary care staff and women survivors of IPV and reflected on their own experience of using the protocol. This article presents quantitative and qualitative data that was collected 1-month after the initial screening and use of the protocol and which was designed to obtain feedback

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from the women on their experience and response to the intervention. For the purposes of this article we have described this as project evaluation.

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Study setting

Two urban and three rural health care facilities were purposefully selected in the Western Cape. Selection was based on their willingness to participate, availability of a psychiatric nurse and a private space for the study nurse. Otherwise facilities were typical of primary care in the Western Cape. Patients in ambulatory primary care were usually seen by a nurse practitioner.

The two urban community health centres were situated in formerly designated "black" and "coloured" townships in Cape Town. One rural site was a community health centre in a large rural town and in a former "coloured group area". The other two rural sites were remote, smaller clinics in farming communities. All these public sector facilities served low socio-economic groups who were not medically insured.

Ethical considerations

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Guided by the ethical considerations and research solutions recommended to the WHO by the International Research Network on Violence Against Women [18], the following issues were prioritised:

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- The safety of respondents and research team was paramount and infused all project decisions.
- Study nurses received specialized training and ongoing support. During the research process regular debriefing enabled the study nurses to discuss the challenges and feelings raised. Consultations with a psychologist were also made available if wanted. This accorded with the ethical responsibility to reduce work stress and avert negative consequences.
- Interviews were conducted privately and confidentially by members of the research team, and anonymity was assured.
- Participants provided informed, written consent and could withdraw or reschedule at their will.

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Selection of women

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As part of a larger study, all primary care providers at the facilities were asked to screen all female patients, of 18 years and older, for a history of IPV during the previous 24 months. Facility managers agreed to screen women for 4-8 weeks.

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However many providers were resistant and uncooperative with our request for universal screening.

In-service training of the health care practitioners was given by the researchers and they were provided with a prompt tool that listed the questions, such as, “How are things going in your relationship?” or “In this clinic we ask all women patients if they have ever experienced any form of abuse. Have you ever experienced abuse by your partner?” Women identified as having experienced IPV were offered a referral to the study nurse.

Intervention

The authors recruited and trained two nurse practitioners to provide the intervention. These study nurses, including principal author, then obtained consent and built rapport with the women before proceeding with the comprehensive assessment and management plan described below (see appendix A). The protocol tested in this study was developed in Cape Town by the Consortium on Violence Against Women with the help of Canadian specialists in IPV.[17] The suggested assessment and management plan included the following:

- A systematic history of type and frequency of abuse specifying particular aspects of emotional, sexual, financial and physical abuse.
- A comprehensive medico-legal history including previous HIV tests, sexually transmitted infections, risk of pregnancy, previous attempts to enlist assistance from police or law courts and forensic documentation of injuries. If necessary the woman was offered further testing or treatment.
- The original protocol neglected aspects of mental health. Therefore a locally adapted version of the WHO’s toolkit for the recognition, diagnosis and treatment of mental disorders in primary care was added.[19] If a mental problem was suspected the participant was referred to the psychiatric nurse.
- A safety assessment tool intended to ascertain the woman’s risk of serious injury. Discussion of a safety plan then followed with referral to other health, social, legal or police services.

Before leaving, women were given an appointment for a follow-up interview 1-month later.

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Data collection

Data was extracted from the record of the initial consultation to give a profile of the management plans. The intended management plan was available to the researcher at the follow up interview.

A different researcher conducted the follow-up interviews. A semi-structured questionnaire explored adherence to, and perceptions of, the care planned during the initial consultation (see appendix B). Participants reflected on how useful this had been, how they felt about their IPV situation now, and whether they had acted upon their intended plans. This data is based on the detailed notes of the researcher who recorded participants' responses to the open questions. All data was collected in the same way. Sometimes narratives were recorded verbatim in the first person and sometimes paraphrased in the third person.

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Data analysis

The quantitative data was analysed by Stellenbosch University's Centre for Statistical Consultation in terms of simple frequency tables. The qualitative data was coded and analysed according to the framework method to understand how participants experienced the intervention.[20]

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Findings

Profile of the women

Participants comprised 168 females with 56 (33.3%) from urban and 112 (66.6%) from rural facilities. Overall the mean age was 36.7 years and there was no significant difference between those who did (36.9 years) and did not (36.0 years) attend follow up (p=0.59). Women were mostly married (82, 48.8%), cohabiting (36, 21.4%) or currently single (35, 20.8%), and had a mean of 2.5 children (range 0-6 children).

Table I describes the frequency and range of abuse. Over the 2 years preceding this study, 96 (57%) participants admitted to being abused more than twenty times, 27(16%) between eleven and twenty times and 45 (27%) had been abused ten or less times. Each woman experienced on average eight forms of abuse over extended periods. Emotional abuse was commonest and ranged from verbal abuse, to restricted contact with family and friends, to control of the woman's freedom to

pursue activities. Physical abuse came a close second, with 115 (68%) having experienced beatings, 82 (50%) kicked, and alarmingly 55 (34%) had been choked. There was no difference in the types of abuse between the women who did and did not attend follow up.

Table II describes their degree of risk according to the safety scores and shows that 114 (67.9%) were at high or severe risk. The fact that 77 (45.8%) believed he was capable of killing indicates the atmosphere of fear pervading the households. Apart from the danger to the woman herself, 91 (54.2%) admitted that their partners had threatened to kill their children. Overall the mean safety assessment score was 4.85 and there was also no significant difference between those who did (4.81) and did not (4.96) attend follow up (p=0.75).

Table III shows the high levels of suspected mental problems amongst the women and how many were referred for further assessment. More than two thirds of women were suspected of having depression or anxiety disorders, and a third were specifically suspected of post traumatic stress disorder (PTSD). A quarter of women were suspected to have problems with substance abuse, most commonly alcohol. There was no difference in the mental health profile of the women who did and did not attend for follow up.

Impact and value of different aspects of the intervention

Out of the 168 women 124 (73.8%) returned for the follow up interview. Table IV shows key elements of the management plan and the extent to which women acted on these plans. Significantly, 28/28 (100%) of women followed through on applying for a protection order, 16/19 (84.2%) proceeded to lay a charge and 23/24 (95.8%) saw the social worker.

Table V shows the perceived usefulness of different aspects of the intervention. Over 75% found all elements of their suggested management plans useful.

Therapeutic effect of empathic listening

Participants explained that telling their story and feeling understood was in itself beneficial.

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Deleted: No respondents reported the intervention as harmful.

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"… found the intervention interesting … felt that … she could talk to someone and they actually heard her. She also felt that she could trust the study nurse. She described the social worker and psychiatric nurse and how they just said, 'yes, yes' and never really understand. The study nurse gave her advice and told her what she could do." (036)

Being able to be honest in a supportive and non-judgmental interaction was helpful:

"No one had ever spoken to her openly before and it was the first time she was able to be completely honest about everything. She does not want to give up on her marriage and feels it would be best if she and her husband received counselling together." (122)

The style of interaction was different from usual and facilitated honest reflection on the situation:

"Doctor had asked her before why she was so stressed but was too embarrassed to tell him. But she was able to talk to (the study nurse) and felt it was good to have evaluated her situation." (154)

Value of clinical care

Participants appreciated having their overall health as women taken seriously, particularly since many aspects were examined, which were not usually dealt with. Many felt relieved to be tested for HIV or assessed for sexually transmitted infections. Adherence to other ongoing clinical care, such as antiretroviral treatment, appeared to also improve:

> "When patient first came she describes herself as tense and hysterical. While talking to the study nurse she experienced a change inside…hope…Before she met her she never thought she could reach the place she is now", (decreased CD4 count, attending ARV clinic, has gained weight). (048)

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Safety assessment and planning

The safety assessment was found to be useful for the following range of reasons:

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"… made her feel better after hearing that it was wrong to be forced to have sex" (149);

"… opened her eyes as she learnt that he should not hurt her like that" (138);
"… saw how dangerous her situation was and decided to get help (an interdict) (097);
"… made her aware of her own faults as well" (082).

Participants cited many reasons why they found the safety plan useful:

"She is very afraid as feels he could kill her. Good to discuss what to do and make a plan – not tell him anything. Just leave." (156)
"In the past always had to scramble around and look for things in an emergency but now all her things are in one place." (123)

Referral to other resources

Knowing about the available resources and being offered referral was appreciated:

"The intervention helped a lot. She did not know that there were so many people to help her. She had been to social workers before, but it is not the same. She now does not feel alone anymore." (025)

The referral letter had helped to access services required:

"…before "x" court had refused to help her, but with letter they gave her a protection order. Now she feels happy." (053)

Many participants expressed relief at discovering they have rights, and where to find help when they need it. Many expressed that the questions and information opened up a new world, linking them to resources and showing ways to change their circumstances.

Problems with police

Most complaints referred to unsympathetic, impersonal, indiscreet or corrupt police. One participant's partner had paid the police off while another's recurrently abusive behavior continued despite her protection order. Another explained when she had applied for a protection order she was not given a copy of the temporary order. When she laid a charge, she received a case number, but no copy of the statement or medical report. This failure of authorities to provide copies was commonly reported by participants.

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Negative reactions to the intervention

Digging up the past had upset a participant. Another complained that she felt very frightened after the interview. One said that things were worse at home because following the intervention she informed her husband that she intended to divorce him and he threatened to take the children and jump under a train.

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Suggestions to improve the help offered

A strong theme was the need for a support group:

"She would like to talk to other women who have been through the same situations. She would like to make friends and learn from other people." (083)

A professional rural woman desired referral to services outside her community as she felt too exposed to access services within it. Another would only see a female counsellor. Some wanted their partner to be "spoken to" or couple counselling to prevent the impression that only women need help. Some resented a perceived onus on women to resolve problems rather than zero tolerance for men's abusive behaviour and proactive efforts to get functional interventions in place. Other participants requested practical assistance such as written advice or help with completing protection order application. One woman expressed a need for solitude and space to reflect.

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Impact of the intervention on the women and their situations
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Improved mental state

Thirty nine of the participants reported an improved mental state in terms of their mood, sociability or sense of well-being as well as decreased anxiety, suicidal ideation and alcohol abuse. Enhanced parenting emerged frequently as a theme.

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"I used to feel sad all the time. I used to feel useless but now I feel responsible. I can take care of my children now. When I was drinking every day I would take them to a woman to look after them. Now I enjoy my kids and my life more … since I went to press charges we have not been together and he has not hurt me either." (047)

"I was a wreck, but when I left her office I could face the world squarely again. She taught me things about myself I did not know. My problems were not solved then and there but I can now notice what I did not before and I feel better about myself as a person." (166)

Reduced isolation

Some participants found that the intervention encouraged them to reduce their isolation by reconnecting with trustworthy friends or family members in a more open and honest way:

"Communication … has improved. It is easier for her to disagree and she feels more independent, like she could manage without him. She had isolated herself quite a bit, but is now starting to reach out to her friends again." (026)

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More aware of their rights

Women described no longer "feeling lost" since they learnt about potentially helpful resources:

"For the first time in two years, she phoned the police and used her protection order. She appeared in front of the magistrate and since then he has lived with his family." (021)

Many discussed a notable improvement in the partners' behaviour in response to a letter the researcher had written to the police and/or magistrates' court. In most cases where the criminal justice system was effectively engaged the abusive behaviour stopped completely, usually due to fear of jail.

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Taking action

On follow-up, some reported having taken action to enhance the quality of their lives. Eleven women ended the relationship after the intervention and reported at follow-up how relieved they felt.

"…after interview she got a protection order and ended her relationship with her gangster boyfriend who uses tic" (metamphetamine). (104)

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Improved relationships

Many participants described improvement in their family relationships:

"I went to a support group for abused women. A lot changed inside myself, like now I know how to talk to my husband. I was always angry and shouting at him, now we

communicate better. I am much kinder to the kids. I feel happy now. Before I felt sad, wanted to cry and stay alone." (016)

Change in own behaviour

Many participants described how the intervention had motivated change in their own behavior. Reduced alcohol abuse was a particularly frequent effect, with enhanced parenting an attendant theme.

"Our relationship is going much better than before. I discussed certain things with him and he understood me. I am drinking much less than before and going to evening songs again. I never wanted to work on Saturdays but now I am". (164)

"It made her realise that she can no longer continue to use alcohol because it's detrimental to her baby. She feels she can talk about things easier and that she came out a stronger person, able to take a stand." (166)

"Yes, I am different inside. When he tries to provoke me with verbal abuse when drunk, I don't allow him to make me angry. He doesn't even listen to me, but I take me seriously." (007)

Change in partners' behaviour

Change in partners' behaviour was also reported and 56 reported an improved relationship with their partner;

"There has been great change in her life. The intervention was very useful because the results have made her feel very happy. The situation at home has improved very much. Her husband has even been working in their garden and helping the children with homework - never before." (065)

"She found the whole experience useful because she got a protection order and there is now someone to stop him. Even though he was famous for his actions locally and people were aware of his behaviour, nothing was ever done. The protection order however has changed his behaviour." (078)

No real change

Thirty nine participants reported that there had been no real change. The intractable challenges that pervaded these responses often involved alcoholism in either or both partners, financial constraints, HIV infection as well as participants' inertia to follow

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up on referrals made. Even so, some reported that they had found the process useful.

"No real change – he continues to withhold pay while expecting money from her with which to buy alcohol. Locked her and kids out of home while he was away drinking, very abusive on return. She wants a divorce." (133)

A common refrain was, "When he is not drunk, he is such a nice guy."

Another trap was expressed as follows:

"She needs the money that he provides … a protection order will make him angry and he will not be able to work if he is in jail. She is still very scared of him but he gets angry if she addresses his behavior. He must always be right." (156)

Discussion

Women were suffering simultaneously from multiple types of abuse and were mostly at high or severe risk of injury and death. Women showed strong adherence to the components of their care plan and described all aspects of the intervention as helpful. Women reported significant benefits to their mental health, reduced alcohol abuse, improved relationships, increased self-efficacy and reduced abusive behavior. Referral to the psychiatric nurse and how this was valued speaks to the impact of psychosocial stressors which characterise our context. Indeed, South African society is so fraught with trauma and violence, that care from a psychiatric nurse is seen to provide a vital safety net, rather than as grounds for declaring someone mentally unfit.

Two characteristics of the intervention appeared particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Being encouraged to tell their story and being listened to with genuine interest and care emerged as key features of the interview which participants valued. This echoes other studies which speak of IPV survivors' need for compassionate, uninterrupted listening.[21,22] Clearly indicating to patients that violence is not a taboo topic, is in itself a vital therapeutic component of any intervention.[23] The safety assessment provided feedback on how the situation is perceived relative to a different norm, thus enhancing the discrepancy between 'normalcy' and their current situation. Our

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findings are congruent with other studies that emphasise the value of empathic, non-judgmental interaction.[24,25,26]

This study addresses a key gap in the literature since it provides evidence of the benefits of a comprehensive intervention for IPV.[9,10,11] In order to be comprehensive, assessment and management should include clinical, psychological, social, legal and advocacy components. Clinical aspects include preventing unwanted pregnancy, sexually transmitted infections and HIV testing. Psychological refers to identification of, and care for, potential mental health problems. Social encompasses referral to support groups, social workers and safety planning. Legal includes referral for a protection order, which was found more effective than laying a criminal charge. Information about rights and local resources was important.

Advocacy and referral to relevant resources has the potential to interrupt and prevent recurrent IPV and associated trauma while enhancing IPV survivors' quality of life.[9] Six months of advocacy has been found to improve emotional health, personal safety, health care and the ability to get medication or treatment while decreasing unhealthy coping behaviours.[27]

For eleven participants, the intervention led to termination of the abusive relationship much to their expressed relief. However in almost half of the sample, 56 (45%), it resulted in improved relationships with partners. Contrary to popular belief, most IPV survivors want the violence, not the relationship, to end.[28]

Strengths and limitations

The mixed methods facilitated in depth understanding of how women experienced the intervention. Follow up however was limited to 1-month so the study cannot determine if changes were sustained or if additional changes occurred subsequently. A longitudinal evaluation measuring the effect of the intervention on the abuse could provide further evidence of effectiveness. Fewer women than expected were identified and referred to the study and the issues related to screening are presented elsewhere.[13]

Another limitation of the study was the safety assessment, which seems to have been formulated on the assumption that she would present with a serious injury, that her abuser would be living with her and that he might kill her if/when she gets home, or soon thereafter. The predictive value of the assessment needs to be further evaluated in relation to a specific outcome such as frequency of abuse or likelihood

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of being killed in the immediate future. How accurately the tool represents the most important risk factors in the South African setting needs further study. All risk factor counted equally, for example "Has he threatened to kill you?" scores the same as "Is he presently at home?", and yet factors may have different weighting in terms of the risk that they represent. Assessment of risk may also be more valuable in a setting where resources are available to offer the women choices. Nevertheless, participants seemed to find it valuable to receive feedback on their risk from an apparently objective measure.

Implications and recommendation

The study provides evidence that the intervention was perceived as useful by most participants. Implementation in primary care will require attention to enabling an empathic communication style and a comprehensive assessment and care plan. A proposed model of how the intervention can be integrated into local primary care is described elsewhere.[29] The evaluation of this protocol has provided sufficient evidence to the Department of Health to pilot the model in the Western Cape. While this intervention focuses on women, future research should include working with men.

The communication style mirrors that of motivational interviewing which helps people make difficult decisions about behavior change.[30] Characterised by empathy, clear direction, collaboration, evocation of the client's perspective and solutions, its approach respects autonomy. Training in motivational interviewing as well as the conceptualisation of IPV as a chronic rather than an acute condition should be considered in the roll-out of this model.

Conclusion

Women diagnosed with IPV in primary care perceive clear benefit, at least in the short term, from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to assessing and managing the clinical, mental, social and legal aspects. District managers should integrate this approach into primary care services and evaluate it further.

Reference List

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Also, what is the reason for doing it? Is one assessing whether the woman is at risk of being repeatedly assaulted? Or is one attempting to identify whether the woman could be killed?¶
And a further difficulty, what does it help a woman who has nowhere to go to be told she is at severe risk? It is different to do it in a first world context where more resources exist.

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Table I: Prevalence of different types of abuse

Abuse behaviour	All N = 168 n (%)	Follow up N=124 n (%)	No follow up N=44 n (%)	P value
Emotional				
Shouting	139 (82.7)	105 (84.7)	34 (77.3)	0.27
Name calling	136 (81.0)	102 (82.3)	34 (77.3)	0.47
Threatening	94 (56.0)	69 (55.6)	25 (56.8)	0.89
Restricting contact	84 (50.0)	64 (51.6)	20 (45.4)	0.48
Controlling activities	63 (37.5)	47 (37.9)	16 (36.4)	0.86
Accusations	19 (11.3)	17 (13.7)	2 (4.5)	0.07
Physical				
Hit	115 (68.5)	86 (69.3)	29 (65.9)	0.67
Pushed	90 (53.6)	56 (45.2)	26 (59.1)	0.11
Kicked	82 (48.8)	46 (37.1)	23 (52.3)	0.08
Use of weapon	69 (41.1)	65 (52.4)	25 (56.8)	0.61
Choked	57 (33.9)	41 (33.1)	16 (36.4)	0.69
Burnt	8 (4.8)	5 (4.0)	3 (6.8)	0.47
Hair pulled	2 (1.2)	2 (1.6)	0 (0.0)	0.27

Table I: Prevalence of different types of abuse

Sexual				
Infidelity	72 (42.9)	53 (42.7)	19 (43.2)	0.96
Sexual coercion	55 (32.7)	42 (33.9)	13 (29.5)	0.60
Unwanted touching	41 (24.4)	34 (27.4)	7 (15.9)	0.11
STIs	41 (24.4)	32 (25.8)	9 (20.4)	0.47
Financial				
Withholding money	72 (42.9)	55 (44.3)	17 (38.6)	0.51
Controlling decisions	25 (14.9)	19 (15.3)	6 (13.6)	0.78
Taking money	23 (13.7)	19 (15.3)	4 (9.1)	0.28

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Table II: Safety assessment score

	n = 168	%
Safety assessment score		
Not done	3	1.8
Caution (0–3)	50	29.8
High risk (4–7)	87	51.8
Severe risk (8–11)	27	16.1
Safety assessment fields		
Threatened with physical violence?	125	74.4
Threatened children with violence?	109	64.9
Firearm in house?	102	60.7
Made a death threat?	92	54.8
Threatened to kill children?	91	54.2
Capable of killing?	77	45.8
Substance use prior to last abuse?	62	36.9
Police intervention necessary?	54	32.1
Is he in the house?	41	24.4
Has abuse escalated in severity?	35	20.8
Received medical treatment for injuries?	33	19.6

Table III: Referred for assessment of mental health problems

Referred for further assessment for:	All N = 168 n (%)	Follow up N=124 n (%)	No follow up N=44 n (%)	P value
Depression	110 (65.5)	79 (64.7)	31 (72.1)	0.37
PTSD	65 (38.7)	44 (35.5)	21 (48.8)	0.12
Anxiety	121 (72.0)	91 (74.6)	30 (69.8)	0.24
Substance abuse	42 (25.0)	31 (25.0)	11 (25.6)	0.13

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Table IV: Adherence of women to plans made by 1-month follow up (N=124)

	Management plan		Action		Adherence
	N	%	n	%	n/N %
Wants HIV test	56	45.2	31	25.0	55.4
Wants rapid plasma reagin test	25	20.2	10	8.1	40.0
Wants pregnancy test	6	4.8	10	8.1	100.0
Intends to obtain a protection order	28	22.6	28	22.6	100.0
Intends to lay a charge	19	15.3	16	12.9	84.2
Referral to NPO for legal support	15	12.1	7	5.6	46.7
Referral to NPO counselling	32	25.8	12	9.7	37.5
Referral to psychiatric nurse	58	46.8	28	22.6	48.3
Referral to social worker	24	19.4	23	18.5	95.8

NPO=Non profit organisation

Table V Perceived usefulness of different aspects of the intervention

Intervention		Very helpful		Helpful		Unhelpful		Harmful		Don't know	
	N	n	%	n	%	n	%	n	%	n	%
Safety assessment	106	31	29.2	54	50.9	6	5.7	0	0.0	15	14.2
Safety plan	102	33	32.4	44	43.1	9	8.8	0	0.0	16	15.7
Protection order	28	14	50.0	9	32.1	4	14.3	0	0.0	1	3.6
Going to NPO for legal advice	7	2	28.6	2	28.6	1	14.3	0	0.0	2	28.6
Going to NPO for counselling	12	5	41.7	4	33.3	1	8.3	0	0.0	2	16.7
Going to psychiatric nurse	28	13	46.4	13	46.4	2	7.1	0	0.0	0	0.0
Going to social worker	23	6	26.1	10	43.5	3	13.0	0	0.0	4	17.4
Laying criminal charge	16	5	31.3	10	62.5	1	6.3	0	0.0	0	0.0

NPO=Non profit organisation

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Contributor Statement

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Data collection: K Joyner, N Bakumeni, M Abrahams, L Le Roux, K Thomson
Analysis of the data: K Joyner, M Kidd (statistician)
Interpretation of the data: K Joyner, R Mash
Drafting of the article: K Joyner and R Mash
Critical revision of the article for important intellectual content: K Joyner, R Mash and J Blitz
Final approval of the article: K Joyner and R Mash

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Table I: Prevalence of different types of abuse

Abuse behavior	n = 168	%
Emotional		
Shouting	139	82.7
Name calling	136	81.0
Threatening	94	56.0
Restricting contact	84	50.0
Controlling activities	63	37.5
Accusations	19	11.3
Other	16	9.5
Physical		
Hit	115	68.5
Pushed	90	53.6
Kicked	82	48.8
Use of weapon	69	41.1
Choked	57	33.9
Burnt	8	4.8
Hair pulled	2	1.2
Sexual		
Infidelity	72	42.9
Sexual coercion	55	32.7
Unwanted touching	41	24.4
Sexually transmitted infections	41	24.4
Other	6	3.6

Table I: Prevalence of different types of abuse

Financial		
Withholding money	72	42.9
Controlling decisions	25	14.9
Taking money	23	13.7
Other	6	3.6
Total reports of an incidence of abuse	**1 315**	

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Table VI: Referred for assessment of mental health problems

Referred for further assessment for:	**All N = 168 n (%)**	**Follow up N=124 n (%)**	**No follow up N=44 n (%)**	**P value**
Depression	110 (65.5)	79 (64.7)	31 (72.1)	0.37
PTSD	65 (38.7)	44 (35.5)	21 (48.8)	0.12
Anxiety	121 (72.0)	91 (74.6)	30 (69.8)	0.24
Substance abuse	42 (25.0)	31 (25.0)	11 (25.6)	0.13

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Intervention		**Very helpful**		**Helpful**		**Unhelpful**		**Don't know**	
	N	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**

Safety assessment	106	31	29.2	54	50.9	6	5.7	15	14.2
Safety plan	102	33	32.4	44	43.1	9	8.8	16	15.7
Protection order	28	14	50.0	9	32.1	4	14.3	1	3.6
Going to NPO for legal advice	7	2	28.6	2	28.6	1	14.3	2	28.6
Going to NPO for counselling	12	5	41.7	4	33.3	1	8.3	2	16.7
Going to psychiatric nurse	28	13	46.4	13	46.4	2	7.1	0	0.0
Going to social worker	23	6	26.1	10	43.5	3	13.0	4	17.4
Laying criminal charge	16	5	31.3	10	62.5	1	6.3	0	0.0

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Table V: Prevalence of different types of abuse

Abuse behaviour	All N = 168 n (%)	Follow up N=124 n (%)	No follow up N=44 n (%)	P value
Emotional				
Shouting	139 (82.7)	105 (84.7)	34 (77.3)	0.27
Name calling	136 (81.0)	102 (82.3)	34 (77.3)	0.47
Threatening	94 (56.0)	69 (55.6)	25 (56.8)	0.89
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Controlling activities	63 (37.5)	47 (37.9)	16 (36.4)	0.86
Accusations	19 (11.3)	17 (13.7)	2 (4.5)	0.07
Physical				
Hit	115 (68.5)	86 (69.3)	29 (65.9)	0.67
Pushed	90 (53.6)	56 (45.2)	26 (59.1)	0.11
Kicked	82 (48.8)	46 (37.1)	23 (52.3)	0.08
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Choked	57 (33.9)	41 (33.1)	16 (36.4)	0.69
Burnt	8 (4.8)	5 (4.0)	3 (6.8)	0.47
Hair pulled	2 (1.2)	2 (1.6)	0 (0.0)	0.27

Table V: Prevalence of different types of abuse

Sexual				
Infidelity	72 (42.9)	53 (42.7)	19 (43.2)	0.96
Sexual coercion	55 (32.7)	42 (33.9)	13 (29.5)	0.60
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Financial				
Withholding money	72 (42.9)	55 (44.3)	17 (38.6)	0.51
Controlling decisions	25 (14.9)	19 (15.3)	6 (13.6)	0.78
Taking money	23 (13.7)	19 (15.3)	4 (9.1)	0.28

COREQ 32-ITEM CHECKLIST (Tong, Sainsbury & Craig, 2007)

Domain 1: Research team and reflexivity

Personal characteristics

1. **Interviewer/Facilitator**
   Kate Joyner: conducted first and follow-up interviews and focus groups
2. **Credentials** *M.Soc. Sc; Advanced Diploma in Psychiatric Nursing; Diploma in General, Community and Psychiatric Nursing and Midwifery.*
3. **Occupation** Programme coordinator: Mental Health and Gender-Based Violence Nursing, Stellenbosch University; doctoral student.
4. **Gender** Female
5. **Research experience**
   Conceptualised and supervised a student project which subsequently won the Dumo Baqwa award for best original research article in South African Journal of Family Practice 2007: Joyner K. et al. Emergency care provision for, and psychological distress in, survivors of domestic violence. SA Fam Pract 2007;49(3).
   Training

   Active in the NGO sector since 1985

   Three social science degrees at UCT, was busy doing a doctorate in Social Science Research Methodology.

   Seven years of integrating how to provide care for those affected by gender-based violence into all undergraduate, postgraduate and non-degree purpose training at Stellenbosch University.

   Organised and participated in all cooperative inquiry group meetings.

1. **Facilitator**
   Robert Mash: conducted a focus group, and facilitated all cooperative inquiry group meetings
2. **Credentials** *PhD; MBChB; MRCGP; DCH; CRCOG*
3. **Occupation** Assoc. Professor in Family Medicine and Primary Care, Stellenbosch University
4. **Gender** Male
5. **Research experience and training** Research projects currently focus on chronic diseases (diabetes, asthma), training of family physicians; defining family medicine in Sub-Saharan Africa, motivational interviewing, a survey for reasons for encounter and diagnoses in South African primary care. Supervisor of 30 Masters and 7 Doctoral students at Stellenbosch University.

1. **Interviewer/Facilitator**
   Maggie Abrahams: conducted first and follow up interviews and a focus group
2. **Credentials** *Diploma in Community Health Science and*

Administration,Registration as Midwife and Psychiatric Professional Nurse

3. **Occupation** Research assistant/study nurse; Masters student.
4. **Gender** Female
5. **Experience** No former research experience, three decades of nursing experience in the clinical field.

   Training Three day training before beginning data collection and participated in five cooperative inquiry group meetings.

1. **Interviewer**
   Nobuhle Bakumeni: conducted first interviews
2. **Credentials** *Diploma in General Nursing Science and Midwifery; Certificate in Advanced Health Management Programme*
3. **Occupation** Nurse clinician at HIV/ARV clinics in Eastern Cape; Masters student.
4. **Gender** Female
5. **Research experience** Worked as research assistant and facilitator to improve water sanitation in East London for 9 months on a Water Commission research project.
   Training Two day training before beginning data collection and one cooperative inquiry group meeting during her involvement in the research process. Principal author also met with Nobuhle twice a week during data collection process to provide supervision (support).

1. **Interviewer**
   Liezel Le Roux: conducted follow-up interviews
2. **Credentials** *B Cur; Registration as General, Community and Psychiatric Professional Nurse and Midwife*
3. **Occupation** Research assistant at Medical Research Council's Unit for Anxiety and Stress Disorders.
4. **Gender** Female
5. **Research experience**
   Student research project supervised by Joyner and subsequent employment as research assistant, see occupation above.
   Training
   Two day training before data collection began.

1. **Interviewer**
   Kirsten Thomson: conducted follow-up interviews
2. **Credentials** *Bachelor of Arts*
3. **Occupation** Research assistant; Honours degree in History student
4. **Gender** Female
5. **Research experience**
   Kirsten was working as a research assistant on the Groote Schuur History project. She had participated in 19 interviews and was coordinating the study.

Training Training discussions in meetings with Kate, and participated in three cooperative inquiry group meetings.

Relationship with participants

6. **Relationship established**
   Most participants had no prior relationship with interviewers, except in case of Maggie Abrahams who was the full time study nurse in the region she had grown up in.

7. **Participant knowledge of the interviewer**
   Participants were informed that she was the study nurse, and that her role was to provide comprehensive assistance to them. Participants were informed that the role of the follow-up interviewer was to understand whether the intervention (1st interview) had been of use to them.

8. **Interviewer characteristics**
   Participants only had positive things to say about all interviewers. Their experience of the intervention was surprisingly satisfactory – perhaps due to the historical and continuing neglect of intimate partner violence as a legitimate, important health concern.
   Significantly also, all first interviewers had left or were living in abusive relationships. Out of 11 potential interviewers, these three committed to participating in the project and from participant's feedback it is clear that their approach was a non-judgmental one of insight, compassion and respect .

Domain 2: study design

Theoretical framework

9. **Methodological orientation and Theory**
   Professional action research framework for a mixed method intervention study

Participant selection

10. Sampling	168 participants choose to participate in the intervention
11. Method of approach	Female patients, 18 and older, were screened during their healthcare consultation
12. Sample size	168 women, 18 and older.

13. Non-participation No idea because it wasn't a feature of the methodology

Setting

14. Setting of data collection Primary health care facilities (CHCs)

15. Presence of non-participants Occasionally the participant's child was present.

16. Description of sample The sample consisted primarily of poor, relatively uneducated, African women and women of mixed origin.

Data Collection

17. Interview guide

The first interview involved piloting a protocol for the screening and management of intimate partner violence (Martin L, Jacobs T. Screening for Domestic Violence: A Policy and Management Framework for the Health Sector. Cape Town: Institute of Criminology, University of Cape Town, 2003.). Professional action research methodology enabled us to modify it for use in the primary health care sector.

The research team compiled the follow-up interview tool to assess participant's experience of the intervention and what action they had subsequently taken to address the care plan she had formulated with the study nurse/researcher.

18. Repeat interviews

Nil

19. Audio/visual recording

Focus groups were audio recorded with a digital device.

First and follow-up interviews were manually transcribed.

20. Field notes

Field notes were made and analysed as part of the bigger study.

21. Duration

First interview (intervention): 60 – 90 minutes

Follow-up interview: 30 minutes

Focus groups: 60 minutes

22. Data saturation

Yes, discussed in supervision with Prof Mash and cooperative inquiry group meetings.

23. Transcripts returned

No

Domain 3: analysis and findings

24. Number of data coders

Coded by principal author and verified by three co-researchers.

25. Description of the coding tree

Evident from results

26. Derivation of themes

Derived from the data

27. Software

SPSS for quantitative data

Manual coding of qualitative data according to Framework Method.

28. Participant checking

Yes, that was the purpose of the follow-up interview and is reported on in the article submitted.

Reporting

29. Quotations presented

Multiple participants' quotations are presented to illustrate themes.

30. Data and findings consistent

Yes

31. Clarity of major themes

Yes, major themes are clearly presented in the findings.

32. Clarity of minor themes

Yes, there is a discussion of minor themes

The value of intervening for intimate partner violence in South African primary care: Project evaluation

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Manuscript ID:	bmjopen-2011-000254.R2
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Date Submitted by the Author:	30-Sep-2011
Complete List of Authors:	Joyner, Kate; Stellenbosch University, Division of Nursing Mash, Robert; Stellenbosch University, Division of Family Medicine and Primary Care
Primary Subject Heading:	Evidence-based practice
Keywords:	MEDICAL EDUCATION & TRAINING, PRIMARY CARE, MENTAL HEALTH

The value of intervening for intimate partner violence in South African primary care: Project evaluation

Abstract

Objectives

Intimate partner violence (IPV) is an important contributor to the burden of disease in South Africa. Evidence-based approaches to IPV in primary care are lacking. This study evaluated a project that implemented a South African protocol for screening and managing IPV. This article reports primarily on the benefits of this intervention from the perspective of the women IPV survivors.

Design

This was a project evaluation involving two urban and three rural primary care facilities. Over 4-8 weeks primary care providers screened adult women for a history of IPV within the previous 24 months and offered referral to the study nurse. The study nurse assessed and managed the women according to the protocol. Researchers interviewed the participants 1-month later to ascertain adherence to their care plan and their views on the intervention.

Results

In total 168 women were assisted and 124 (73.8%) returned for follow up. Emotional (139, 82.7%), physical (115, 68.5%), sexual (72, 42.9%) and financial abuse (72, 42.9%) were common and 114 (67.9%) were at high/severe risk of harm. Adherence to the management plan ranged from testing for syphilis 10/25 (40.0%) to consulting a psychiatric nurse 28/58 (48.3%) to obtaining a protection order 28/28 (100.0%). Over 75% perceived all aspects of their care as helpful, except for legal advice from a non-profit organisation.

Women reported significant benefits to their mental health, reduced alcohol abuse, improved relationships, increased self-efficacy and reduced abusive behavior. Two characteristics seemed particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Conclusion

Female IPV survivors in primary care experience benefit from an empathic, comprehensive approach to assessing and assisting with the clinical, mental, social and legal aspects. Primary care managers should find ways to integrate this into primary care services and evaluate it further.

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ARTICLE SUMMARY

ARTICLE FOCUS

- Did women experiencing IPV find assessment and management in primary care beneficial?
- What aspects of their care plan did they adhere to?
- What aspects of their care plan did they find most helpful?

KEY MESSAGES

- Women diagnosed with IPV in primary care perceive benefit from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to the clinical, mental, social and legal aspects.
- Women reported benefits to their mental health, alcohol use, relationships, and experience of abusive behaviour.
- IPV survivors were most proactive about securing protection orders, laying criminal charges, and testing for pregnancy post-intervention.

STRENGTHS AND LIMITATIONS

- A comprehensive biopsychosocial and forensic intervention in primary care was tested, securing follow-up which revealed its value.
- The study was conducted under usual working conditions and resource availability making the findings applicable to the primary care context.
- Although the study only involved five purposely selected facilities, the rural/urban mix makes it likely that these are fairly typical.
- Obsequiousness bias was reduced by different researchers conducting the follow up interviews.
- Follow up after one month is too short to predict the longer term consequences of the intervention.
- The study measured the effect of the intervention on the abuse indirectly via participants' self-reports.

Introduction

Interpersonal violence is the second highest contributor to the burden of disease after HIV and AIDS, with intimate partner violence (IPV) accounting for 62.4% of the total burden in females.[1] South Africa's intimate femicide rate is the highest globally.[2] IPV appears to be twice as common in rural South African settings compared to

urban, with a complex interplay of racial, gender and economic forces, maintaining women in abusive situations.[3] The use of violence to maintain dominance in interpersonal relationships forms a cross-cultural cornerstone of masculinity in South Africa.[4] For these reasons, it is crucial that healthcare providers attend to IPV survivors' needs comprehensively.

Gender-based violence is an umbrella term for forms of interpersonal violence characterized by gendered power imbalances. Fitting within this, IPV refers to emotional, physical, sexual or financial abuse between intimates. It also fits within broader sub-categories of gender-based violence, namely family and domestic violence.

South African laws and policy on violence against women acknowledge it to be a significant human rights and public health issue yet extreme levels of gender-based violence, poverty and HIV infection among women reveal a chasm between the daily lives of female citizens and apparent gains in the public sphere.[5] South Africa's Domestic Violence Act (116 of 1998) includes a definition of domestic violence so comprehensive it is a legislative standard bearer internationally.[6] An inexpensive and unsophisticated civil procedure for obtaining a protection order clearly demarcates the duties of the police.[7] Unfortunately, specific responsibilities for healthcare providers are not outlined and a gulf exists between the contents of the Act and its practical implementation.

The World Health Organization (WHO) now positions IPV as an urgent public health priority.[8] Internationally, evidence-based interventions in primary care settings are lacking.[9,10] A systematic review on screening for IPV in primary care concludes that while "domestic violence is a common problem with major health consequences for women, implementation of screening programmes cannot be justified."[11] They call for evidence of the benefit of specific interventions and lack of harm from screening.

Paradoxically, universal screening for IPV in health care settings is commonly endorsed by international guidelines.[12] However, in poorly resourced contexts such as South Africa the use of case finding based on the presentation of specific signs or symptoms of abuse, is recommended.[13] This focuses healthcare resources and providers' time on those needing immediate healthcare.

In South African primary care, case finding is not practiced routinely and IPV remains hidden beneath other diagnoses. Health providers are mostly reluctant to ask about IPV and patients rarely disclose the problem spontaneously. Providers are also unsure how to manage IPV as it has complex clinical, mental, social and legal implications. They tend not to accept that IPV is a health problem and in a system already overburdened by other challenges, may be unwilling to legitimise IPV as part of their work.[14]

Evaluations of initiatives addressing IPV are lacking, and frequently focus on the criminal justice system.[15] However lack of evidence should not be equated with lack of effectiveness.[16] Inquiry about IPV offers a way of "uncovering and reframing a hidden stigma" to provide benefit, even if no action follows forthwith.[17]

This article presents part of a larger study that implemented and evaluated a South African protocol for screening and managing women living with IPV in local primary healthcare settings.[18] This article reports on how acceptable this protocol was to the women and what they perceived as its benefits.

Methods

Study design

The overall design for the larger study was action-research. The action or project was the implementation of a protocol for the screening and management of IPV in primary care. The research, by a co-operative inquiry group, evaluated the experience of the primary care staff and women survivors of IPV and reflected on their own experience of using the protocol. This article presents quantitative and qualitative data that was collected 1-month after the initial screening and use of the protocol and which was designed to obtain feedback from the women on their experience and response to the intervention. For the purposes of this article we have described this as project evaluation.

Study setting

Two urban and three rural health care facilities were purposefully selected in the Western Cape. Selection was based on their willingness to participate, availability of a psychiatric nurse and a private space for the study nurse. Otherwise facilities were typical of primary care in the Western Cape. Patients in ambulatory primary care were usually seen by a nurse practitioner.

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The two urban community health centres were situated in formerly designated "black" and "coloured" townships in Cape Town. One rural site was a community health centre in a large rural town and in a former "coloured group area". The other two rural sites were remote, smaller clinics in farming communities. All these public sector facilities served low socio-economic groups who were not medically insured.

Ethical considerations

Guided by the ethical considerations and research solutions recommended to the WHO by the International Research Network on Violence Against Women [19], the following issues were prioritised:

- The safety of respondents and research team was paramount and infused all project decisions.
- Study nurses received specialized training and ongoing support. During the research process regular debriefing enabled the study nurses to discuss the challenges and feelings raised. Consultations with a psychologist were also made available if wanted. This accorded with the ethical responsibility to reduce work stress and avert negative consequences.
- Interviews were conducted privately and confidentially by members of the research team, and anonymity was assured.
- Participants provided informed, written consent and could withdraw or reschedule at their will. Ethics approval was given by the Health Research Ethics Committee at Stellenbosch University (Reference No 6/10/216).

Selection of women

As part of a larger study, all primary care providers at the facilities were asked to screen all female patients, of 18 years and older, for a history of IPV during the previous 24 months. Facility managers agreed to screen women for 4-8 weeks. However many providers were resistant and uncooperative with our request for universal screening.

In-service training of the health care practitioners was given by the researchers and they were provided with a prompt tool that listed the questions, such as, "How are things going in your relationship?" or "In this clinic we ask all women patients if they have ever experienced any form of abuse. Have you ever experienced abuse by your partner?" Women identified as having experienced IPV were offered a referral to the study nurse.

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Intervention

The authors recruited and trained two nurse practitioners to provide the intervention. These study nurses, including principal author, then obtained consent and built rapport with the women before proceeding with the comprehensive assessment and management plan described below (see appendix A). The protocol tested in this study was developed in Cape Town by the Consortium on Violence Against Women with the help of Canadian specialists in IPV.[18] The suggested assessment and management plan included the following:

- A systematic history of type and frequency of abuse specifying particular aspects of emotional, sexual, financial and physical abuse.
- A comprehensive medico-legal history including previous HIV tests, sexually transmitted infections, risk of pregnancy, previous attempts to enlist assistance from police or law courts and forensic documentation of injuries. If necessary the woman was offered further testing or treatment.
- The original protocol neglected aspects of mental health. Nine questions to screen for mental health problems were added from a locally adapted version of the WHO's toolkit for the recognition, diagnosis and treatment of mental disorders in primary care.[20] Each question was designed to increase the likelihood of either depression, anxiety disorders, post traumatic stress disorder or substance abuse. If as a result of this screening tool a mental problem was suspected then the participant was referred to the psychiatric nurse for a full assessment.
- A safety assessment tool intended to ascertain the woman's risk of serious injury. Discussion of a safety plan then followed with referral to other health, social, legal or police services.

The safety assessment tool used in the protocol appeared to have been formulated on the assumption that women would present with a serious injury, that her abuser would be living with her and that he might kill her if/when she gets home, or soon thereafter. The predictive value of the assessment needs to be further evaluated in relation to a specific outcome such as frequency of abuse or likelihood of being killed in the immediate future. How accurately the tool represents the most important risk factors in the South African setting needs further study. All risk factor counted equally, for example "Has he threatened to kill you?" scores the same as "Is he

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presently at home?", and yet factors may have different weighting in terms of the risk that they represent.

Before leaving, women were given an appointment for a follow-up interview 1-month later.

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Data collection

Data was extracted from the record of the initial consultation to give a profile of the management plans. The intended management plan was available to the researcher at the follow up interview.

A different researcher conducted the follow-up interviews. A semi-structured questionnaire explored adherence to, and perceptions of, the care planned during the initial consultation (see appendix B). Participants reflected on how useful this had been, how they felt about their IPV situation now, and whether they had acted upon their intended plans. This data is based on the detailed notes of the researcher who recorded participants' responses to the open questions. All data was collected in the same way. Sometimes narratives were recorded verbatim in the first person and sometimes paraphrased in the third person.

Data analysis

The quantitative data was analysed by Stellenbosch University's Centre for Statistical Consultation in terms of simple frequency tables. The qualitative data was coded and analysed according to the framework method to understand how participants experienced the intervention.[21]

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Findings

Profile of the women

Participants comprised 168 females with 56 (33.3%) from urban and 112 (66.6%) from rural facilities. Overall the mean age was 36.7 years and there was no significant difference between those who did (36.9 years) and did not (36.0 years) attend follow up (p=0.59). Women were mostly married (82, 48.8%), cohabiting (36, 21.4%) or currently single (35, 20.8%), and had a mean of 2.5 children (range 0-6 children).

Table I describes the frequency and range of abuse. Over the 2 years preceding this study, 96 (57%) participants admitted to being abused more than twenty times, 27(16%) between eleven and twenty times and 45 (27%) had been abused ten or less times. Each woman experienced on average eight forms of abuse over extended periods. Emotional abuse was commonest and ranged from verbal abuse, to restricted contact with family and friends, to control of the woman's freedom to pursue activities. Physical abuse came a close second, with 115 (68%) having experienced beatings, 82 (50%) kicked, and alarmingly 55 (34%) had been choked. There was no difference in the types of abuse between the women who did and did not attend follow up.

Table II describes their degree of risk according to the safety scores and shows that 114 (67.9%) were at high or severe risk. The fact that 77 (45.8%) believed he was capable of killing indicates the atmosphere of fear pervading the households. Apart from the danger to the woman herself, 91 (54.2%) admitted that their partners had threatened to kill their children. Overall the mean safety assessment score was 4.85 and there was also no significant difference between those who did (4.81) and did not (4.96) attend follow up (p=0.75).

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Table III shows the high levels of suspected mental problems amongst the women and how many were referred for further assessment. More than two thirds of women were suspected of having depression or anxiety disorders, and a third were specifically suspected of post traumatic stress disorder (PTSD). A quarter of women were suspected to have problems with substance abuse, most commonly alcohol. There was no difference in the mental health profile of the women who did and did not attend for follow up.

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Impact and value of different aspects of the intervention

Out of the 168 women 124 (73.8%) returned for the follow up interview. Table IV shows key elements of the management plan and the extent to which women acted on these plans. Significantly, 28/28 (100%) of women followed through on applying for a protection order, 16/19 (84.2%) proceeded to lay a charge and 23/24 (95.8%) saw the social worker.

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Table V shows the perceived usefulness of different aspects of the intervention. Over 75% of women found counselling from a NPO, safety assessment and planning, referral to the psychiatric nurse, applying for a protection order and laying a criminal charge useful, when it was part of their management plan.

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Therapeutic effect of empathic listening

Participants explained that telling their story and feeling understood was in itself beneficial.

"… found the intervention interesting … felt that … she could talk to someone and they actually heard her. She also felt that she could trust the study nurse. She described the social worker and psychiatric nurse and how they just said, 'yes, yes' and never really understand. The study nurse gave her advice and told her what she could do." (036)

Being able to be honest in a supportive and non-judgmental interaction was helpful:

"No one had ever spoken to her openly before and it was the first time she was able to be completely honest about everything. She does not want to give up on her marriage and feels it would be best if she and her husband received counselling together." (122)

The style of interaction was different from usual and facilitated honest reflection on the situation:

"Doctor had asked her before why she was so stressed but was too embarrassed to tell him. But she was able to talk to (the study nurse) and felt it was good to have evaluated her situation." (154)

Value of clinical care

Participants appreciated having their overall health as women taken seriously, particularly since many aspects were examined, which were not usually dealt with. Many felt relieved to be tested for HIV or assessed for sexually transmitted infections. Adherence to other ongoing clinical care, such as antiretroviral treatment, appeared to also improve:

"When patient first came she describes herself as tense and hysterical. While talking to the study nurse she experienced a change inside…hope…Before she met her she

never thought she could reach the place she is now…(decreased CD4 count, attending ARV clinic, has gained weight).” (048)

Safety assessment and planning

The safety assessment was found to be useful for the following range of reasons:

“… made her feel better after hearing that it was wrong to be forced to have sex” (149);
“… opened her eyes as she learnt that he should not hurt her like that” (138);
“… saw how dangerous her situation was and decided to get help (a protection order) (097);
“… made her aware of her own faults as well” (082).

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Participants cited many reasons why they found the safety plan useful:

> “She is very afraid as feels he could kill her. Good to discuss what to do and make a plan – not tell him anything. Just leave.” (156)
> “In the past always had to scramble around and look for things in an emergency but now all her things are in one place.” (123)

Referral to other resources

Knowing about the available resources and being offered referral was appreciated:

“The intervention helped a lot. She did not know that there were so many people to help her. She had been to social workers before, but it is not the same. She now does not feel alone anymore.” (025)

The referral letter had helped to access services required:

“…before “x” court had refused to help her, but with letter they gave her a protection order. Now she feels happy.” (053)

Many participants expressed relief at discovering they have rights, and where to find help when they need it. Many expressed that the questions and information opened

up a new world, linking them to resources and showing ways to change their circumstances.

Problems with police

Most complaints referred to unsympathetic, impersonal, indiscreet or corrupt police. One participant's partner had paid the police off while another's recurrently abusive behavior continued despite her protection order. Another explained when she had applied for a protection order she was not given a copy of the temporary order. When she laid a charge, she received a case number, but no copy of the statement or medical report. This failure of authorities to provide copies was commonly reported by participants.

Negative reactions to the intervention

Digging up the past had upset a participant. Another complained that she felt very frightened after the interview. One said that things were worse at home because following the intervention she informed her husband that she intended to divorce him and he threatened to take the children and jump under a train.

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Suggestions to improve the help offered

A strong theme was the need for a support group:

"She would like to talk to other women who have been through the same situations. She would like to make friends and learn from other people." (083)

A professional rural woman desired referral to services outside her community as she felt too exposed to access services within it. Another would only see a female counsellor. Some wanted their partner to be "spoken to" or couple counselling to prevent the impression that only women need help. Some resented a perceived onus on women to resolve problems rather than zero tolerance for men's abusive behaviour and proactive efforts to get functional interventions in place. Other participants requested practical assistance such as written advice or help with completing protection order application. One woman expressed a need for solitude and space to reflect.

Improved mental state

At least thirty five of the participants reported an improved mental state in terms of their mood, sociability or sense of well-being as well as decreased anxiety, suicidal ideation and alcohol abuse. Enhanced parenting emerged frequently as a theme.

"I used to feel sad all the time. I used to feel useless but now I feel responsible. I can take care of my children now. When I was drinking every day I would take them to a woman to look after them. Now I enjoy my kids and my life more … since I went to press charges we have not been together and he has not hurt me either." (047)

"I was a wreck, but when I left her office I could face the world squarely again. She taught me things about myself I did not know. My problems were not solved then and there but I can now notice what I did not before and I feel better about myself as a person." (166)

Reduced isolation

Some participants found that the intervention encouraged them to reduce their isolation by reconnecting with trustworthy friends or family members in a more open and honest way:

"Communication … has improved. It is easier for her to disagree and she feels more independent, like she could manage without him. She had isolated herself quite a bit, but is now starting to reach out to her friends again." (026)

More aware of their rights

Women described no longer "feeling lost" since they learnt about potentially helpful resources:

"For the first time in two years, she phoned the police and used her protection order. She appeared in front of the magistrate and since then he has lived with his family." (021)

Many discussed a notable improvement in the partners' behaviour in response to a letter the researcher had written to the police and/or magistrates' court. In most cases where the criminal justice system was effectively engaged the abusive behaviour stopped completely, usually due to fear of jail.

Taking action

On follow-up, some reported having taken action to enhance the quality of their lives. Eleven women ended the relationship after the intervention and reported at follow-up how relieved they felt.

"…after interview she got a protection order and ended her relationship with her gangster boyfriend who uses tic" (metamphetamine). (104)

Improved relationships

Many participants described improvement in their family relationships:

"I went to a support group for abused women. A lot changed inside myself, like now I know how to talk to my husband. I was always angry and shouting at him, now we communicate better. I am much kinder to the kids. I feel happy now. Before I felt sad, wanted to cry and stay alone." (016)

Change in own behaviour

Many participants described how the intervention had motivated change in their own behavior. Reduced alcohol abuse was a particularly frequent effect, with enhanced parenting an attendant theme.

"Our relationship is going much better than before. I discussed certain things with him and he understood me. I am drinking much less than before and going to evening songs again. I never wanted to work on Saturdays but now I am". (164)

"It made her realise that she can no longer continue to use alcohol because it's detrimental to her baby. She feels she can talk about things easier and that she came out a stronger person, able to take a stand." (166)

"Yes, I am different inside. When he tries to provoke me with verbal abuse when drunk, I don't allow him to make me angry. He doesn't even listen to me, but I take me seriously." (007)

Change in partners' behaviour

Change in partners' behaviour was also reported and 56 reported an improved relationship with their partner:

"There has been great change in her life. The intervention was very useful because the results have made her feel very happy. The situation at home has improved very

much. Her husband has even been working in their garden and helping the children with homework - never before." (065)

"She found the whole experience useful because she got a protection order and there is now someone to stop him. Even though he was famous for his actions locally and people were aware of his behaviour, nothing was ever done. The protection order however has changed his behaviour." (078)

No real change

Thirty nine participants reported that there had been no real change. The intractable challenges that pervaded these responses often involved alcoholism in either or both partners, financial constraints, HIV infection as well as participants' inertia to follow up on referrals made. Even so, some reported that they had found the process useful.

"No real change – he continues to withhold pay while expecting money from her with which to buy alcohol. Locked her and kids out of home while he was away drinking, very abusive on return. She wants a divorce." (133)

A common refrain was, "When he is not drunk, he is such a nice guy."

Another trap was expressed as follows:

"She needs the money that he provides … a protection order will make him angry and he will not be able to work if he is in jail. She is still very scared of him but he gets angry if she addresses his behavior. He must always be right." (156)

Discussion

Women were suffering simultaneously from multiple types of abuse and were mostly at high or severe risk of injury and death. Women showed strong adherence to the components of their care plan, particularly applying for a protection order, laying a charge, referral to a social worker and obtaining a pregnancy test. Women described all aspects of the intervention as helpful, particularly counselling from a NPO, the safety assessment and planning, applying for a protection order, laying a criminal charge and seeing the psychiatric nurse.

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Overall 11 (9%) women reported that they had ended their relationship, 56 (45%) that their relationship had improved and 39 (31%) that there was no change. These

findings are congruent with previous work that suggests that most IPV survivors want the violence, not the relationship, to end.[22] Women reported significant benefits to their mental health, reduced alcohol abuse, increased self-efficacy and reduced abusive behavior.

Two characteristics of the intervention appeared particularly important: the style of interaction with the nurse and the comprehensive nature of the assessment.

Being encouraged to tell their story and being listened to with genuine interest and care emerged as key features of the interview which participants valued. This echoes other studies which speak of IPV survivors' need for compassionate, uninterrupted listening.[23,24] Clearly indicating to patients that violence is not a taboo topic, is in itself a vital therapeutic component of any intervention.[25] The safety assessment provided feedback on how the situation is perceived relative to a different norm, thus enhancing the discrepancy between 'normalcy' and their current situation. Our findings are congruent with other studies that emphasise the value of empathic, non-judgmental interaction.[26,27,28]

This study addresses a key gap in the literature since it provides evidence of the benefits of a comprehensive intervention for IPV.[9,10,11] In order to be comprehensive, assessment and care should include clinical, psychological, social, legal and advocacy components. Clinical aspects include preventing unwanted pregnancy, sexually transmitted infections and HIV testing. Psychological refers to identification and treatment of potential mental health problems. Social encompasses referral to support groups, social workers and safety planning. Legal includes referral for a protection order, which was found more effective than laying a criminal charge. Information about rights and local resources was important.

Advocacy and referral to relevant resources has the potential to interrupt and prevent recurrent IPV and associated trauma while enhancing IPV survivors' quality of life.[9] Six months of advocacy has been found to improve emotional health, personal safety, health care and the ability to get medication or treatment while decreasing unhealthy coping behaviours.[29]

Strengths and limitations

The hidden nature of IPV and the study design make it impossible to determine what proportion of women suffering from IPV in these communities attended the primary care facilities. It is also not possible to determine what proportion of women who did

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Deleted: Referral to the psychiatric nurse and how this was valued speaks to the enormity of the psychosocial stressors characterising our context. Indeed, South African society is so fraught with trauma and violence, that care from a psychiatric nurse is understood to provide a vital safety net, rather than as grounds for declaring someone mentally unfit. ¶

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Deleted: For eleven participants, the intervention led to termination of the abusive relationship much to their expressed relief. However in almost one half of the sample (56, 45%) it resulted in improved relationships with partners. Contrary to popular belief, most IPV survivors want the violence, not the relationship, to end.[28]¶

attend were identified. Fewer women than expected were identified and referred to the study and the issues related to screening are presented elsewhere.[13] It is possible that those women who disclosed were suffering from more severe forms of IPV and therefore more likely to seek help.

The mixed methods facilitated in depth understanding of how women experienced the intervention. Follow up however was limited to 1-month so the study cannot determine if changes were sustained or if additional changes occurred subsequently. A longitudinal evaluation measuring the effect of the intervention on the abuse could provide further evidence of effectiveness.

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Deleted: Another limitation of the study was the safety assessment, which seems to have been formulated on the assumption that she would present with a serious injury, that her abuser would be living with her and that he might kill her if/when she gets home, or soon thereafter. The predictive value of the assessment needs to be further evaluated in relation to a specific outcome such as frequency of abuse or likelihood of being killed in the immediate future. How accurately the tool represents the most important risk factors in the South African setting needs further study. All risk factor counted equally, for example "Has he threatened to kill you?" scores the same as "Is he presently at home?", and yet factors may have different weighting in terms of the risk that they represent. Assessment of risk may also be more valuable in a setting where resources are available to offer the women choices. Nevertheless, participants seemed to find it valuable to receive feedback on their risk from an apparently objective measure.

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Implications and recommendation

The study provides evidence that the intervention was perceived as useful by most participants. Implementation in primary care will require attention to enabling an empathic communication style and a comprehensive assessment and care plan. A proposed model of how the intervention can be integrated into local primary care is described elsewhere.[30]

The evaluation of this protocol has provided sufficient evidence to the Department of Health to pilot the model in the Western Cape. While this intervention focuses on women, future research should include working with men. As the model is implemented further research should monitor the identification of women via case finding in primary care compared to the expected prevalence in the community served, explore which women disclose to and take up services initiated by health professionals and evaluate benefits in the longer term. It may also be useful to relate the introduction of the model to outcomes such as mortality from inter-personal violence amongst women at the sub-district level.

The communication style mirrors that of motivational interviewing which helps people make difficult decisions about behavior change.[31] Characterised by empathy, clear direction, collaboration, evocation of the client's perspective and solutions, its approach respects autonomy. Training in motivational interviewing as well as the conceptualisation of IPV as a chronic rather than an acute condition should be considered in the roll-out of this model.

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Conclusion

Women diagnosed with IPV in primary care perceive clear benefit, at least in the short term, from an intervention characterised by both empathic, non-judgmental listening and a comprehensive approach to assessing and managing the clinical, mental, social and legal aspects. District managers should integrate this approach into primary care services and evaluate it further.

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Table I: Prevalence of different types of abuse

Abuse behaviour	All N = 168 n (%)	Follow up N=124 n (%)	No follow up N=44 n (%)	P value
Emotional				
Shouting	139 (82.7)	105 (84.7)	34 (77.3)	0.27
Name calling	136 (81.0)	102 (82.3)	34 (77.3)	0.47
Threatening	94 (56.0)	69 (55.6)	25 (56.8)	0.89
Restricting contact	84 (50.0)	64 (51.6)	20 (45.4)	0.48
Controlling activities	63 (37.5)	47 (37.9)	16 (36.4)	0.86
Accusations	19 (11.3)	17 (13.7)	2 (4.5)	0.07
Physical				
Hit	115 (68.5)	86 (69.3)	29 (65.9)	0.67
Pushed	90 (53.6)	56 (45.2)	26 (59.1)	0.11
Kicked	82 (48.8)	46 (37.1)	23 (52.3)	0.08
Use of weapon	69 (41.1)	65 (52.4)	25 (56.8)	0.61
Choked	57 (33.9)	41 (33.1)	16 (36.4)	0.69
Burnt	8 (4.8)	5 (4.0)	3 (6.8)	0.47
Hair pulled	2 (1.2)	2 (1.6)	0 (0.0)	0.27

Table I: Prevalence of different types of abuse

Sexual				
Infidelity	72 (42.9)	53 (42.7)	19 (43.2)	0.96
Sexual coercion	55 (32.7)	42 (33.9)	13 (29.5)	0.60
Unwanted touching	41 (24.4)	34 (27.4)	7 (15.9)	0.11
STIs	41 (24.4)	32 (25.8)	9 (20.4)	0.47
Financial				
Withholding money	72 (42.9)	55 (44.3)	17 (38.6)	0.51
Controlling decisions	25 (14.9)	19 (15.3)	6 (13.6)	0.78
Taking money	23 (13.7)	19 (15.3)	4 (9.1)	0.28

Table II: Safety assessment score

	n = 168	%
Safety assessment score		
Not done	3	1.8
Caution (0–3)	50	29.8
High risk (4–7)	87	51.8
Severe risk (8–11)	27	16.1
Safety assessment fields		
Threatened with physical violence?	125	74.4
Threatened children with violence?	109	64.9
Firearm in house?	102	60.7
Made a death threat?	92	54.8
Threatened to kill children?	91	54.2
Capable of killing?	77	45.8
Substance use prior to last abuse?	62	36.9
Police intervention necessary?	54	32.1
Is he in the house?	41	24.4
Has abuse escalated in severity?	35	20.8
Received medical treatment for injuries?	33	19.6

Table III: Referred for assessment of mental health problems

Referred for further assessment for:	All N = 168 n (%)	Follow up N=124 n (%)	No follow up N=44 n (%)	P value
Depression	110 (65.5)	79 (64.7)	31 (72.1)	0.37
PTSD	65 (38.7)	44 (35.5)	21 (48.8)	0.12
Anxiety	121 (72.0)	91 (74.6)	30 (69.8)	0.24
Substance abuse	42 (25.0)	31 (25.0)	11 (25.6)	0.13

Table IV: Adherence of women to plans made by 1-month follow up (N=124)

	Management plan		Action		Adherence
	N	%	n	%	n/N %
Wants HIV test	56	45.2	31	25.0	55.4
Wants rapid plasma reagin test	25	20.2	10	8.1	40.0
Wants pregnancy test	6	4.8	10	8.1	100.0
Intends to obtain a protection order	28	22.6	28	22.6	100.0
Intends to lay a charge	19	15.3	16	12.9	84.2
Referral to NPO for legal support	15	12.1	7	5.6	46.7
Referral to NPO counselling	32	25.8	12	9.7	37.5
Referral to psychiatric nurse	58	46.8	28	22.6	48.3
Referral to social worker	24	19.4	23	18.5	95.8

NPO=Non profit organisation

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Table V Perceived usefulness of different aspects of the intervention

Intervention		Very helpful / helpful		Don't know		Unhelpful	
	N	n	%	n	%	n	%
Going to NPO for legal advice	7	4	57.2	2	28.6	1	14.3
Going to social worker	23	16	69.6	4	17.4	3	13
Going to NPO for counselling	12	9	75.0	2	16.7	1	8.3
Safety plan	102	77	75.5	16	15.7	9	8.8
Safety assessment	106	85	80.1	15	14.2	6	5.7
Protection order	28	23	82.1	1	3.6	4	14.3
Going to psychiatric nurse	28	26	92.8	0	0	2	7.1
Laying criminal charge	16	15	93.8	0	0	1	6.3

NPO=Non profit organisation

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Competing Interests:

The authors declare no conflict of interests.

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Contributor Statement

Conception and design: K Joyner and R Mash
Data collection: K Joyner, N Bakumeni, M Abrahams, L Le Roux, K Thomson
Analysis of the data: K Joyner, M Kidd (statistician)
Interpretation of the data: K Joyner, R Mash
Drafting of the article: K Joyner and R Mash
Critical revision of the article for important intellectual content: K Joyner, R Mash and J Blitz

Final approval of the article: K Joyner and R Mash

COREQ 32-ITEM CHECKLIST (Tong, Sainsbury & Craig, 2007)

Domain 1: Research team and reflexivity

Personal characteristics

1. **Interviewer/Facilitator**
   Kate Joyner: conducted first and follow-up interviews and focus groups
2. **Credentials** *M.Soc. Sc; Advanced Diploma in Psychiatric Nursing; Diploma in General, Community and Psychiatric Nursing and Midwifery.*
3. **Occupation** Programme coordinator: Mental Health and Gender-Based Violence Nursing, Stellenbosch University; doctoral student.
4. **Gender** Female
5. **Research experience**
   Conceptualised and supervised a student project which subsequently won the Dumo Baqwa award for best original research article in South African Journal of Family Practice 2007: Joyner K. et al. Emergency care provision for, and psychological distress in, survivors of domestic violence. SA Fam Pract 2007;49(3).
   Training

   Active in the NGO sector since 1985

   Three social science degrees at UCT, was busy doing a doctorate in Social Science Research Methodology.

   Seven years of integrating how to provide care for those affected by gender-based violence into all undergraduate, postgraduate and non-degree purpose training at Stellenbosch University.

   Organised and participated in all cooperative inquiry group meetings.

1. **Facilitator**
   Robert Mash: conducted a focus group, and facilitated all cooperative inquiry group meetings
2. **Credentials** *PhD; MBChB; MRCGP; DCH; CRCOG*
3. **Occupation** Assoc. Professor in Family Medicine and Primary Care, Stellenbosch University
4. **Gender** Male
5. **Research experience and training** Research projects currently focus on chronic diseases (diabetes, asthma), training of family physicians; defining family medicine in Sub-Saharan Africa, motivational interviewing, a survey for reasons for encounter and diagnoses in South African primary care. Supervisor of 30 Masters and 7 Doctoral students at Stellenbosch University.

1. **Interviewer/Facilitator**
   Maggie Abrahams: conducted first and follow up interviews and a focus group
2. **Credentials** *Diploma in Community Health Science and*

Administration,Registration as Midwife and Psychiatric Professional Nurse

3. **Occupation** Research assistant/study nurse; Masters student.
4. **Gender** Female
5. **Experience** No former research experience, three decades of nursing experience in the clinical field.

Training Three day training before beginning data collection and participated in five cooperative inquiry group meetings.

1. **Interviewer**
   Nobuhle Bakumeni: conducted first interviews
2. **Credentials** *Diploma in General Nursing Science and Midwifery; Certificate in Advanced Health Management Programme*
3. **Occupation** Nurse clinician at HIV/ARV clinics in Eastern Cape; Masters student.
4. **Gender** Female
5. **Research experience** Worked as research assistant and facilitator to improve water sanitation in East London for 9 months on a Water Commission research project.
   Training Two day training before beginning data collection and one cooperative inquiry group meeting during her involvement in the research process. Principal author also met with Nobuhle twice a week during data collection process to provide supervision (support).

1. **Interviewer**
   Liezel Le Roux: conducted follow-up interviews
2. **Credentials** *B Cur; Registration as General, Community and Psychiatric Professional Nurse and Midwife*
3. **Occupation** Research assistant at Medical Research Council's Unit for Anxiety and Stress Disorders.
4. **Gender** Female
5. **Research experience**
   Student research project supervised by Joyner and subsequent employment as research assistant, see occupation above.
   Training
   Two day training before data collection began.

1. **Interviewer**
   Kirsten Thomson: conducted follow-up interviews
2. **Credentials** *Bachelor of Arts*
3. **Occupation** Research assistant; Honours degree in History student
4. **Gender** Female
5. **Research experience**
   Kirsten was working as a research assistant on the Groote Schuur History project. She had participated in 19 interviews and was coordinating the study.

Training Training discussions in meetings with Kate, and participated in three cooperative inquiry group meetings.

Relationship with participants

6. **Relationship established**
   Most participants had no prior relationship with interviewers, except in case of Maggie Abrahams who was the full time study nurse in the region she had grown up in.

7. **Participant knowledge of the interviewer**
   Participants were informed that she was the study nurse, and that her role was to provide comprehensive assistance to them. Participants were informed that the role of the follow-up interviewer was to understand whether the intervention (1st interview) had been of use to them.

8. **Interviewer characteristics**
   Participants only had positive things to say about all interviewers. Their experience of the intervention was surprisingly satisfactory – perhaps due to the historical and continuing neglect of intimate partner violence as a legitimate, important health concern.
   Significantly also, all first interviewers had left or were living in abusive relationships. Out of 11 potential interviewers, these three committed to participating in the project and from participant's feedback it is clear that their approach was a non-judgmental one of insight, compassion and respect .

Domain 2: study design

Theoretical framework

9. **Methodological orientation and Theory**
   Professional action research framework for a mixed method intervention study

Participant selection

10. **Sampling** 168 participants choose to participate in the intervention

11. **Method of approach** Female patients, 18 and older, were screened during their healthcare consultation

12. **Sample size** 168 women, 18 and older.

13. Non-participation	No idea because it wasn't a feature of the methodology

Setting

14. Setting of data collection	Primary health care facilities (CHCs)
15. Presence of non-participants	Occasionally the participant's child was present.
16. Description of sample	The sample consisted primarily of poor, relatively uneducated, African women and women of mixed origin.

Data Collection

17. Interview guide

The first interview involved piloting a protocol for the screening and management of intimate partner violence (Martin L, Jacobs T. Screening for Domestic Violence: A Policy and Management Framework for the Health Sector. Cape Town: Institute of Criminology, University of Cape Town, 2003.). Professional action research methodology enabled us to modify it for use in the primary health care sector.

The research team compiled the follow-up interview tool to assess participant's experience of the intervention and what action they had subsequently taken to address the care plan she had formulated with the study nurse/researcher.

18. Repeat interviews

Nil

19. Audio/visual recording

Focus groups were audio recorded with a digital device.

First and follow-up interviews were manually transcribed.

20. Field notes

Field notes were made and analysed as part of the bigger study.

21. Duration

First interview (intervention): 60 – 90 minutes

Follow-up interview: 30 minutes

Focus groups: 60 minutes

22. Data saturation

Yes, discussed in supervision with Prof Mash and cooperative inquiry group meetings.

23. Transcripts returned

No

Domain 3: analysis and findings

24. Number of data coders

Coded by principal author and verified by three co-researchers.

25. Description of the coding tree

Evident from results

26. Derivation of themes

Derived from the data

27. Software

SPSS for quantitative data

Manual coding of qualitative data according to Framework Method.

28. Participant checking

Yes, that was the purpose of the follow-up interview and is reported on in the article submitted.

Reporting

29. Quotations presented

Multiple participants' quotations are presented to illustrate themes.

30. Data and findings consistent

Yes

31. Clarity of major themes

Yes, major themes are clearly presented in the findings.

32. Clarity of minor themes

Yes, there is a discussion of minor themes