

**KNOWLEDGE, ATTITUDES AND BELIEFS OF
EMERGENCY CARE PRACTITIONERS TO VICTIMS OF DOMESTIC
VIOLENCE IN THE WESTERN CAPE**

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A research project submitted in partial fulfillment of the academic requirements for the degree of Master of Public Health (MPH) in the School of Family and Public Health Medicine, University of KwaZulu-Natal.

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ABSTRACT

PURPOSE

Domestic violence has a significant prevalence in the world, and certainly in South Africa, yet Emergency Care Practitioner (ECP) training and practice does not have any particular focus on domestic violence intervention. The absence of any clear response protocol to domestic violence in a Health Professions Council of South Africa (HPCSA) regulated profession, suggests the reliance on health practitioner discretion in this regard. This is problematic as the profession is male dominated and focused on tertiary levels of care. ECP's may be positioned to screen for abuse early, yet there is no evidence of success or failure in this endeavour. This study aimed to ascertain what the prevailing ECP knowledge, attitudes and beliefs around domestic violence in the Western Cape are, so that any factors preventing or nurturing early identification and appropriate treatment of domestic violence may be mitigated or supported respectively.

METHODS

Health Professions Council of South Africa (HPCSA) registered ECP's in the Provincial Government- Western Cape (PGWC)- Emergency Medical Service (EMS) Metropole region voluntarily completed a questionnaire.

MAJOR RESULTS

Only 49% of respondents could correctly define domestic violence. ECP qualification was associated with domestic violence definition in that Basic ECP's were more likely to incorrectly define domestic violence than the advanced ECP's. Eighty-one percent of respondents recognized less than thirty domestic violence calls in the preceding six months. The majority of ECP's (89%) experienced no special handling of domestic violence victims. No significant association could be found (Chi-Square: $p = 0.2298$) between qualification and knowledge of domestic violence laws. An ECP's qualification is no predictor of his/her legal knowledge about abuse. Qualification could also not be positively associated with the referral of victims, although the majority of practitioners of all qualifications (78%), had only sometimes referred victims or not at all. The majority of respondents expressed inadequate assessment and management of domestic violence patients. The majority also indicated that their ECP training was inadequate in preparing them for domestic violence intervention.

CONCLUSIONS DRAWN

The attitudes and beliefs of Emergency Care Practitioners elicited from this study suggest a poor level of understanding of the extent and nature of domestic violence. There is a probable low detection rate amongst the majority of ECP's. There exists harbouring of myths that may confound the implementation of a pre-hospital protocol for domestic violence management. There is an inadequacy of current ECP practice with respect to domestic violence crisis intervention with regards screening, management and referral.

The EMS response to domestic violence should be congruent with an appropriate health sector response and should include universal screening (asking about domestic violence routinely); comprehensive physical and psychological care for those patients who disclose abuse; a safety assessment and safety plan; the documentation of past and present incidents of abuse; the provision of information about patients rights and the domestic violence act; and referral to appropriate resources. The ECP curriculum should emphasise the particular nature and treatment of domestic violence. The study supports the need for the introduction of a comprehensive ECP protocol, in training and in practice.

This information should prove useful to all who attempt to design educational programmes and clinical strategies to address this public health issue.

DECLARATION

The author hereby declares that the content of this MPH research project is the author's own unaided original work, except where specific indication is given to the contrary (by reference). This work has not been previously submitted to the University of KwaZulu Natal or any other University.

Signature: Navindhra Naidoo



Date: 01 December 2006

DEDICATION

For ...Ms. Santhoshini Naidoo...

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ACRONYMS AND ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome

ECP: Emergency Care Practitioner

ECP's: Emergency Care Practitioner's

ECP A: Emergency Care Practitioner- Advanced

ECP B: Emergency Care Practitioner- Basic

ECP I: Emergency Care Practitioner- Intermediate

EMS: Emergency Medical Service

CPD: Continuous Professional Development

HCW: Health Care Worker

HIV: Human Immunodeficiency Syndrome

HPCSA: Health Professions Council of South Africa

MRC: Medical Research Council

PGWC: Provincial Government- Western Cape

PBECP: Professional Board for Emergency Care Practitioners

WHA: World Health Assembly

WHO: World Health Organisation

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PREFACE

In developing countries, estimates of domestic violence prevalence vary between 30-75% (Heise *et al.* 1994).

Negative health outcomes result from domestic violence. Yet domestic violence does not feature as an important component of any emergency medical care curriculum or any EMS standard operating procedures. The health care system plays a pivotal role in domestic violence prevention and management (Family Violence Prevention Fund, 1999). Still, there is no research incorporating pre-hospital practitioners with regards domestic violence in South Africa. The Emergency Care Practitioner (ECP) is first in the line of response to many domestic violence victims. This response requires the ECP to have the capacity to identify, assess and assist victims with safety planning, crisis intervention and to provide appropriate referral for other services. Without their first diagnosis, the possibility of any further intervention is ended or delayed. The tragic consequence and anomaly is that the emergency service, and by representation- the health authority, becomes complicit in perpetuating the cycle of violence.

This study seeks to determine the status quo with regards knowledge, attitudes and beliefs of Emergency Medical Care Practitioner's to domestic violence in the Western Cape, as a point of reference for intervention strategies involving the greater Emergency Medical Service community.

CHAPTER 1: INTRODUCTION

1.0 BACKGROUND TO THIS RESEARCH

1.1 PROBLEM STATEMENT

The phenomenon of domestic violence is an international one. In South Africa it is considered a public health priority due to its far-reaching consequences. At the center of the abuse is the need for power and control, which is exercised in a number of psychological, emotional, financial, sexual and physical abuses.

Hospitals are intended to have capacity to address the needs of abused persons through victim empowerment programmes but the screening for these patients are best done in the emergency departments or better still, prehospitally – in the community.

Pre-hospital medicine is operationalised by emergency medical systems whose design it has been to be responsive to emergencies in the curative or rehabilitative phase of health promotion. The lack of primary prevention and early detection by any health entity is counterproductive to the countries primary health care policy, on which health care delivery is founded. There is currently no primary secondary and tertiary domestic violence management protocol for emergency care practitioners to be guided by. The discretion in domestic violence victim management by ECP's is guided by knowledge, attitudes and beliefs around domestic violence, which have all never been previously evaluated in South Africa. This research serves as an important basis for intervention and further development by the emergency services with regards to

early domestic violence intervention, and it will inform any universal screening, responsive treatment and appropriate referral.

1.2 THE AIM OF THE STUDY

The aim of this study was to investigate the knowledge, attitudes and beliefs of Emergency Care Practitioners (ECP's) to victims of domestic violence in the Western Cape, in order to develop a pre-hospital protocol for the early risk identification and medical management of victims in the pre-hospital environment.

1.3 THE HYPOTHESES

1.3.1 Hypothesis One

It was hypothesized that the perceptions of Emergency Care Practitioners are fraught with myths and other untruths that are not conducive to effective and holistic management of victims of domestic violence.

1.3.2 Hypothesis Two

It was hypothesized that the responses of Emergency Care Practitioners contribute to inadequate safety assessments and only superficial management of victims of domestic violence.

1.3.3 Hypothesis Three

It was hypothesized that the development of a pre-hospital medical protocol and training is needed, that will empower Emergency Care Practitioners to respond appropriately in terms of crisis intervention and referral and thereby meet the emergency and other needs of domestic violence victims.

1.4 THE OBJECTIVES OF THE STUDY

1.4.1 Objective One

The first objective was to evaluate the attitudes and beliefs of Emergency Care Practitioners so as to understand their level of understanding of the problem of domestic violence. The benefit here is to identify the harbouring of myths and any other potential barriers to the implementation of a pre-hospital protocol for domestic violence management.

1.4.2 Objective Two

The second objective was to evaluate the adequacy of current ECP practice with respect to domestic violence crisis intervention.

1.4.3 Objective Three

Based on the findings, the third objective was to suggest guidelines for the design and development of a pre-hospital medical protocol for the emergency intervention of domestic violence for the Emergency Care Practitioner.

1.5 THE ASSUMPTIONS

1.5.1 The First Assumption

The first assumption was that the respondents would participate in this investigation without reservation and with honesty.

1.5.2 The Second Assumption

The second assumption was that the Provincial Government of the Western Cape (PGWC) - Emergency Medical Service Management would support this investigation and allow the research to be conducted amongst its sample membership.

1.5.3 The Third Assumption

The third assumption was that the capacity to develop and implement a medical protocol within the area mentioned exists and will enjoy unequivocal support.

1.5.4 The Fourth Assumption

The fourth assumption was that inter-sectoral collaboration would be nurtured so that the Emergency Care Practitioner may facilitate referral of domestic violence victims.

1.6 DEFINING THE TERMS

1.6.1 Emergency Care Practitioner (ECP):

This is a health care professional trained in emergency medical care and/or rescue at basic, intermediate and advanced levels, and is registered with the Health Professions Council of South Africa (HPCSA) as such. ECP is a term that includes all individuals on the ECP registers of the Professional Board for Emergency Care Personnel (PBECP) of the HPCSA.

1.6.2 Domestic violence:

“Any controlling, abusive, fear inducing act that threatens to harm the health, well being or safety of a person in a domestic relationship ” (The Domestic Violence Act, No 116 of 1998). “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life” (United Nations, 1993).

This is contextualised within a past or present relationship. It is generally perpetrated by a male partner, but not exclusively, and is experienced by the woman as harmful and destructive to herself, physically, emotionally, socially and psychologically (Family Violence Prevention Fund, 1999).

1.6.3 Women:

The scope of this study includes female children from 14 years onwards, due to gender related abuse of young girls in abusive relationships.

1.7 ORGANISATION OF THE REPORT: SUMMARY

Chapter one introduces the problem being studied and includes a background to the study, aims and hypotheses as well as definitions. Chapter two presents the literature review that contextualises the study. Chapter three addresses the study methodology with regard to design and population choice, reliability and validity, data handling, and the methodology with regard statistical analysis. It also addresses research ethics and shows how ethical obligations having been met. Chapter four is a compilation of results with respect to the objectives above. Chapter five deals with the discussion of the results. Finally, concluding recommendations may be found in chapter six. References and appendices follow.

CHAPTER 2

2.0 REVIEW OF RELATED LITERATURE

The literature review will address the following topics: the health relatedness of domestic violence; the population of perpetrators and victims; distribution and incidence of domestic violence; existing research on the patterns of abuse and its determinants; myths and truths on the causes of domestic violence; and medical empowerment versus disempowerment.

2.1. HEALTH RELATEDNESS OF VIOLENCE AGAINST WOMEN

2.1.1. Domestic violence as a public health priority

Historically, domestic violence has been perceived as a domestic problem, a police problem and recently, a legal issue but not enough attention may have been granted by health authorities, as this may have been seen as a private issue and not a priority in an overwhelmed health care system. The World Health Assembly, in resolution WHA 49.25, declared violence to be a leading worldwide public health problem (WHO, 2001). The following flow diagram, Figure 1 (adapted from Heise *et al.*, 1994), contextualizes partner abuse as a health-related state. In terms of non-fatal outcomes depicted below (Heise *et al.*, 1994), poor physical health includes injury and resultant functional impairment, physical symptoms, poor subjective health and permanent or severe disability. It is these physical outcomes of domestic violence that the emergency care practitioner (ECP) is called to respond to.

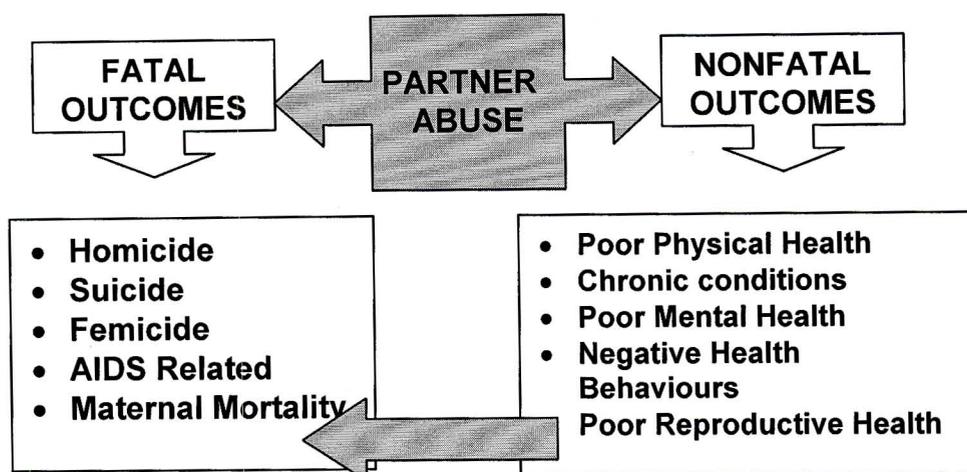


Figure. 1. Health outcomes of violence against women (Heise *et al.*, 1994)

The manifestations of poor physical health do not present a major challenge to detection as the physical danger to life and limb is obvious and is likely to elicit a response from the practitioner. Chronic conditions such as chronic pain syndromes, irritable bowel syndromes, gastrointestinal disorders and somatic complaints are much more difficult to identify as domestic violence related.

Poor mental health outcomes as a result of domestic violence may manifest in substance abuse, low self esteem, sexual dysfunction, eating disorders, phobias, depression and anxiety. Negative health behaviors include smoking, alcohol, drug abuse, sexual risk taking, physical inactivity, and overeating.

Reproductive health outcomes also have pre-hospital emergency impact through unwanted pregnancies, sexually transmitted disease, unsafe abortions, pregnancy implications, miscarriages and pelvic inflammatory disease. Jacobs (2003), believes that violence against women is both a cause and consequence of HIV/ AIDS infection, yet the two issues are rarely placed on the same health

agenda. The challenge to the health care worker (HCW) is to identify whether domestic violence is the underlying or distal cause of the more proximal biomedical problem. Figure 1 (Heise *et al.*, 1994) represents the psycho-socio-environmental model of health outcomes in domestic violence. It is not restricted to clinical outcomes alone.

Katzenellenbogen *et al.* (1999) also purport that the health status of a person is dependent on the agent, the human host and the environment (Figure 2).

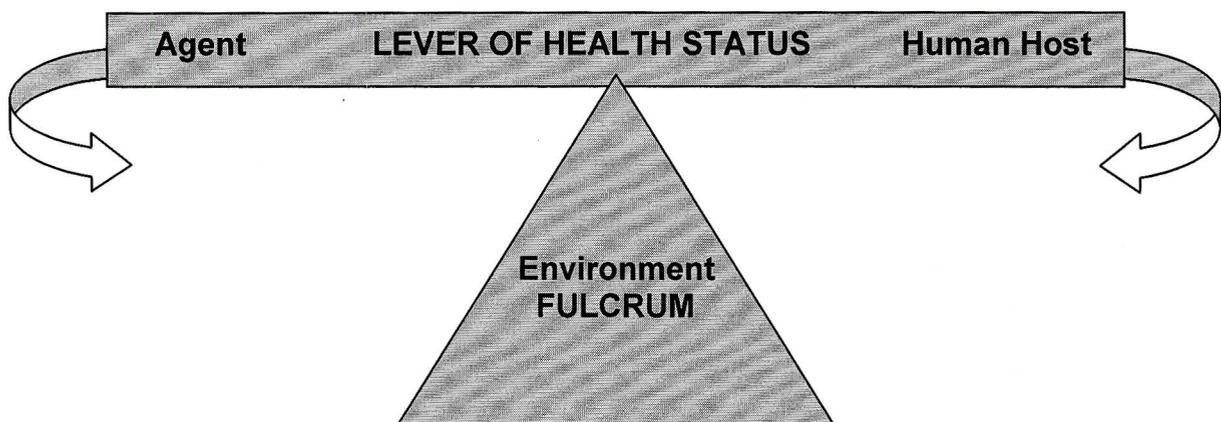


Figure 2. Factors affecting the health equilibrium

(Adapted from Katzenellenbogen *et al.*, 1999)

The abusive environment can be seen as the 'fulcrum' upon which the health status of a person is levered. The constitution of the World Health Organization (WHO, 1948) states that health is '*a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity*'. As domestic violence has mental, physical and social outcomes that include disease and infirmity, it is related to negative health outcomes. The Dictionary

of Epidemiology (Last, 1988) defines public health as '*a social institution, a discipline and a practice*'. As domestic violence is a social problem, by virtue of its determinants, prevalence and consequences, it is a legitimate public health issue.

2.1.2. Domestic violence as a pre-hospital medical priority

Health care staff requires training on gender, screening for gender-based violence, listening to and supporting women if they are to identify women who have experienced intimate partner violence and provide an appropriate and helpful response (Dunkle *et al.*, 2003). ECP's are registered with the Health Professions Council of South Africa (HPCSA): Professional Board for Emergency Care Practitioners and as such have a duty to treat and care for all patients (Health Professions Council of South Africa, 2003). This, in the context of domestic violence, assumes that practitioners understand the dynamics of such abuse and the needs of abused patients, and that they have the capacity to be responsive.

The code of conduct for the Public Service, for which most Emergency Care Practitioners work, requires that they serve the public in an unbiased and impartial manner in order to create confidence in the Public Service (Public Service Commission, 2002). The Bill of Rights, entrenched in chapter two of The Constitution (Act 108 of 1996), protects the health of women with regard to their rights to equality, human dignity, life, health care, food, water and social

security and freedom. Every health care practitioner is therefore constitutionally bound to care for victims of domestic violence.

Apart from the above, there appears to be little regulatory influence over Emergency Care Practitioners to treat domestic violence victims appropriately. Ethical codes such as The Hippocratic Oath, Declaration of Geneva of 1948, International code of Medical Ethics of 1949, the Declaration of Tokyo of 1975, the Declaration of Oslo of 1970 and the Declaration of Helsinki of 1948 do not seem to address Emergency Care Practitioners (McQuoid-Mason *et al.*, 2002). These documents concentrate on medical practitioners. Even the ECP management protocols issued to all members of the Professional Board for Emergency Care Practitioners do not make reference to an appropriate response to victims of domestic violence, despite violence being the major type of response (Professional Board for Emergency Care Personnel, 2003). This is therefore subject to practitioner discretion, albeit discretion informed by personal experience and dominant societal values.

2.2. SPECIFIED POPULATION

The specified population affected by domestic violence can be categorized broadly into that of the perpetrator (or abuser) and the victim (or survivor). The Domestic Violence Act definition is very inclusive. The victim could include people living in rural areas, dating teens and adults, elderly victims, victims with disabilities, immigrants, gays and lesbians, as well as children (Domestic

Violence Act, 116 of 1998). The perpetrator could include: a woman's husband and partner whether they live together or not, same-sex partners living together or not, parents of a child or any person who has or had parental responsibility over the child; any family member related to the victim by blood, marriage or adoption; any person who is or was in an engagement, dating or customary relationship with the woman, including an actual or perceived romantic, intimate or sexual relationship of any duration; or any person who lives, or recently lived, with the woman in the same residence. The difficulty in specifying a population is clear from the endemic nature of domestic violence and the need for the law to be widely applicable. Children are also primary or secondary victims of abuse and may not be separated from the specified population.

2.3. PREVALENCE OF DOMESTIC VIOLENCE

The 'National Injury Mortality Surveillance of South Africa' (NIMSS) reported that 5506 deaths presented to two Cape mortuaries in 2003 (Prinsloo, 2004). The leading external cause of death was firearms (26%), followed by sharp force injuries (22%). The leading apparent manner of non-natural death in Cape Town was violence, at 55%. Violence, as a leading cause of death, stood at 59% in males and 38% in females. A further breakdown of the type of violence for female deaths indicates sharp force injuries at 36%, firearm related injuries at 35% and blunt force injuries at 21%. Strangulation accounted for 8% of female deaths (Prinsloo, 2004). These statistics do not reflect on non-fatal injuries. It does however reflect the nature of violent deaths, domestic or

otherwise and highlights the endemic nature of interpersonal violence in a South Africa not at war. If the domestic environment is a microcosm of the society within which it exists, it is not inconceivable to find a high incidence of violence in the home. In-fact, Prinsloo reports that more than 67% of the scenes of female deaths were private homes.

Domestic violence is a health and human rights issue with serious immediate and long-term impact on welfare of individuals, families, communities and countries. To contextualize the problem, the International Planned Parenthood Federation (the world's largest voluntary organization in sexual and reproductive health and rights and family planning) stated in November 1999, that:

- *“Gender and sexual violence against women causes as much death and incapacity as cancer – and more ill health than malaria and traffic accidents.*
- *Violence against women affects women from all backgrounds, cultures and countries, regardless of class, ethnicity, education and social status. Yet until recently many countries treated the issue as a private one.*
- *Violence against women usually occurs in a sexual context and is linked to HIV/AIDS, sexually transmitted diseases, unwanted pregnancies, teenage pregnancy and unsafe abortion.”* (International Planned Parenthood Federation, 1999).

Domestic Violence is recognized worldwide as a significant, widespread and under-detected medical and public health concern (Heise, 1993). However, studies of domestic violence vary in their definition of the concept and in the way the crime is measured. This makes comparison between studies difficult. International large-scale studies related to prevalence indicate that between 16-52% of women have been assaulted by a husband or partner (World Health Organization, 1997). Twenty two - 35% of woman sought care in European and American emergency departments for domestic violence (Robert *et al.*, 1996; Goldberg *et al.*, 1994; McLeer, 1989). In developing countries, estimates of domestic violence prevalence vary between 30-75% (Heise *et al.*, 1994).

More recently, a retrospective National Study of Female Homicide in South Africa (Mathews *et al.*, 2004), found that in South Africa, 8.8 per 100 000 women 14 years and older were killed by an intimate partner in 1999. This is the highest rate ever reported in research in the world. Translated this implies that four women per day were killed by an intimate partner or one woman is killed every six hours by an intimate partner. Also, it is an intimate partner that is responsible for killing one in every two women where the women were killed by a known perpetrator.

This study found that the intimate femicide rate for Coloured women was more than double (18/100 000) the rate for African women and more than six times that of White women. This is of particular concern as the majority population of the Western Cape is Coloured and the Coloured population is 8.8% nationally

(Statistics South Africa, 1998). Previously, the first major community-based study in three provinces in South Africa, in 1999, identified that approximately 30% of women are victims of abuse by intimate partners (Jewkes *et al.*, 2001). Other main findings were that emotional, financial and physical abuses are common features of relationships and that many women have been raped. Physical violence often continues during pregnancy and constitutes an important cause of pregnancy related reproductive morbidity. These domestic violence-related injuries cost the health sector resources and incur costs in other sectors, including the family, community, employers and the national economy (Jewkes *et al.*, 2001).

The World Health Organisation reports that in 2000, an estimated 520 000 people were killed as a result of interpersonal violence (domestic and otherwise) worldwide- a rate of 8,8/100 000 population (WHO, 2002). According to Mathews *et al.*, this rate equals the homicide by intimate partner rate alone. WHO reports that many more suffered nonfatal and very often repeated acts of physical and sexual aggression. The Mathews *et al.* study was a mortality study and therefore did not quantify the non-mortality sequelae of domestic violence.

Domestic violence occurs in the context of interpersonal violence. According to the World Health Organisation (2001), in the year 2000, 1.7 million deaths in the world were due to violence. Rape and domestic violence account for 5% to 16% of healthy years of life lost by women of reproductive age and between

10% and 50% of women experience physical violence at the hands of an intimate partner during their lifetime. It is difficult to determine the exact incidence of domestic violence. The SA Demographic and Health Survey (1998) documents 13% of women ever having been abused by a partner. It has been estimated, however that perhaps as many as one in three households in South Africa experience violence at some stage, most of it perpetrated on woman and children (Mathews and Abrahams, 2001). The silenced and underreported nature of domestic violence and the conceptualization of the crime as a “private affair” are barriers towards establishing reliable prevalence data. In the United States of America the historical lack of comprehensive and reliable data was due to a wide range of factors including the fragmentation of health and social services, the lack of resources to deal with the problem and the nature of the relationship between the police, doctors and community (Eagle, 1992). The same factors are applicable in South Africa today due to inequity in health care and a historically hospi-centric approach.

From the above, not only is it reasonable to infer that the prevalence of abuse in South Africa is high, but that the mortality associated with it is highest in the world. In fact, violence against women is a pandemic feature of our society. Also, it is mainly men in a domestic relationship that perpetrate this abuse.

2.4. THE PATTERN OF DOMESTIC VIOLENCE

The pattern of domestic violence is one of victim disempowerment and secrecy. This pattern is cyclic in nature and includes abuse preceded by tension building and followed by manipulative kindness (Walker, 1979; Jordean, 1999).

2.4.1. Tension building phase:

The cycle begins with tension build-up within the perpetrator for reasons such as family pressure or work stresses. Other couples will have a range of reactions to this tension that does not include violence, but in the abusive relationship it leads to the stand over phase. In the victim, this phase manifests as stress related illnesses, depression and anxiety for which the woman may seek medical attention (Goodman *et al.*, 1992). It is the duty of the attending medical practitioner to collate the medical and social history in order to diagnose the more distal causes of the immediate problem. Domestic violence as a cause of the chief complaint must be fully explored and an index of suspicion created. Because the prevalence of domestic violence, as alluded to above, is so high, it is very probable that the chief complaint of the woman would have been caused by domestic violence in one form or other.

2.4.2. Stand-over phase:

Usually, because of the perpetrators physical strength and his realistic and frightening threats to hurt the victim, she feels she is under his control. His verbal threats will weaken her further as it is an attack on her character and

personality. In this phase, the woman is most vulnerable and may either cover up her injuries or seek medical attention. At this point in the cycle, the Emergency Care Practitioner's responses in terms of detection and referral prove most crucial in secondary prevention of domestic violence. The failure to detect abuse and refer abused women perpetuates the cycle of domestic violence for many years before the woman breaks through this cycle and a diagnosis of domestic violence is made or she becomes a statistic of homicide.

2.4.3. Violence phase

Violence occurs in many forms and may escalate in intensity and frequency with time. This may eventually result in homicide.

2.4.4. Remorse phase:

The abuser often feels ashamed and may be afraid of consequences or he will deny and play down his actions as far as possible. The woman may go along with this; otherwise she may admit the potentially dangerous situation she and perhaps the children are living in. This is presumably the most opportune time for successful intervention as her denial of her abuse may be at its lowest ebb.

2.4.5. Pursuit phase:

The abusive man may try to buy back his partner with expensive gifts and promises. If she doesn't co-operate he may revert to escalating threats and more cyclical violence, and so many women forgive. The couple now moves into the honeymoon phase.

2.4.6. The Honeymoon Phase:

Having come so close to separation and destruction, the partners cling to each other for comfort and support like any traumatic bonding. The duration and time of this cycle are not preset and are often unpredictable. This unpredictability is one of the coercive techniques in battering relationships. In addition there may be concealment of the abuse, alcohol abuse, extreme psychological abuse, family threats, extraordinary terror through weapons, omnipotence and awareness of the potential of death. There is also a pattern of allocating blame to the victims, and hence removal of responsibility from the perpetrator. The net effect is victim guilt and shame and erosion of her self-esteem (American Psychological Association, 1992).

2.5. MYTHS OF DOMESTIC VIOLENCE

The whole spectrum of family violence is perplexing, more especially since the family is considered the refuge from the pressures of the world. In order to maintain this idyllic belief, society has been guilty of sweeping the entire range of domestic violence under the proverbial 'carpet'. Such an approach is convenient because it makes it possible to resolve the dissidence between the socially desirable view of the family and the unpleasantness of reality.

This is not the only behavior of "lay society" but also that of social scientists and professional medical care providers. Hence the understanding and management of women abuse is fraught with myths and misconceptions about

its causes and cures. This has tended to hinder both the recognition of the problem and effective professional medical practice.

2.5.1. Myth 1: Only a small percentage of women are domestic violence victims

This is disproved in 2.3 above where it is shown that domestic violence prevalence is high, despite under-reporting of the crime.

2.5.2. Myth 2: Only poor women, uneducated and black women are abused

Research evidence produced by Padayachee (1988) and more recently Mathews and Abrahams (2001) have indicated that this is not true. These findings shatter the myth of violence being confined to only the low socio-economic group, non-professional women and black women. It can also be pointed out however that low income and uneducated Black women in South Africa are more likely to seek assistance from public agencies, shelters, government hospitals and social welfare organizations because they have fewer resources than middle and upper income women. They are therefore more likely to be counted in official statistics. The recent public focus on abused women in South Africa has brought a number of middle and upper income women and professional women out of "hiding". Mathews and Abrahams (2001) did however find that women who applied for the protection order were more likely to be employed and therefore less likely to be economically dependant on their abusive partners.

Economic abuse was found to be linked to the socio-economic circumstances of women. The Centre for the Study of Violence and Reconciliation (Callaghan *et al.*, 1997) suggests that African women, who are undoubtedly the poorest sector of our society, are more than 10 times likely to experience an incidence of violence compared to their white counterparts and that levels of rape are often highest in provinces which are economically less developed. The double oppression of poverty and violence create dependence and hopelessness but the latter is not restricted to the poor.

2.5.3. Myth 3: Batterers are mentally ill

Clinical studies on men who batter their partners do not support this view. The majority of wife batterers are not suffering from mental illness, as notions of patriarchy and female subservience are not diagnoses in the Diagnostic and Statistical Manual (DSM). Most present as ordinary respectable men (Padayachee and Singh, 1998; Abrahams *et al.*, 1999). Abusers choose the privacy of their home to abuse. The mentally ill, it can be argued, do not have this discretion.

2.5.4. Myth 4: Battered women enjoy it, are crazy or mentally ill

This is one of the pervasive myths about family violence. This myth palms the burden of guilt on the abused women, claiming that she liked it or deserved it. This argument claims that women are either masochistic, crazy or provoked the abuse. If this was true- masochism implies that the woman experiences

pleasure from the abuse- why then should she complain about the abuse? If the wife provokes the husband verbally, does this justify a physical response? Researchers have found in these respective studies that many abused women certainly suffer in silence and endure physical abuse and remain in the relationship for a variety of reasons other than being crazy or masochistic (Padayachee and Singh, 1998; Wood and Jewkes, 1999). A patriarchal society is one such reason (Abrahams *et al.*, 1999). Over half of all women in Zimbabwe (53%) believed that wife beating was justified in at least one of five situations, such as arguing with the spouse, neglecting the children or going out without permission (Hindin, 2003).

2.5.5. Myth 5: Battered women can always leave home if they want to

Battered women are usually constrained from early leaving home by fear of reprisals, social isolation (Wood and Jewkes, 1999), financial dependence (Gage, 1990; Mathews and Abrahams, 2001), social stigma (Wood and Jewkes, 1999) and emotional dependence (Padayachee and Singh, 1998). In a community based study in rural Uganda (Koenig *et al.*, 2003), more women (90%) than men (70%) viewed wife or female partner beating as justifiable in some circumstances. This acceptance of violence by both genders entraps women in violent relationships. Artz (2005), suggests that despite the violence being unacceptable, women stay because of a lack of financial resources, not having any other place to go, the risk of ridicule and abandonment from the community, the threat to children's schooling and care, fear of contravening

religious values and of course, fear of the partner's threats to kill, injure or destroy her or her children or anyone or anything she loves.

2.5.6. Myth 6: Alcohol and drugs cause domestic violence

Sober offenders also assault their partners. Alcohol does not cause domestic violence but abuse of alcohol is a risk factor that contributes to spouse abuse (Abrahams *et al.*, 1999). Refusing to take responsibility for the abuse, men attribute blame on the loss of control due to the effects of alcohol, drugs, frustration, stress or the victim's behavior (Padayachee and Singh, 1998).

Studies show a high rate of alcohol and drug abuse among men who abuse their partners, but there is insufficient evidence that supports a 'cause and effect' relationship. Women may also turn to alcohol as a form of escapism (Bergman *et al.*, 1989). Abuse is a socially learned behaviour (Bandura *et al.*, 1961; Strauss and Gelles, 1979) and not the sole result of substance abuse. Many men who abuse their wives do not abuse alcohol or drugs. Alcoholism treatment does not cure abusive behaviour; both problems must be dealt with separately. Many alcoholics do not abuse their partners. Strauss (1988) found that the picture of the alcohol and drug crazed partner who impulsively and violently abuses a family member is a distortion.

2.5.7. Myth 7: Abusers are unsuccessful men who are violent in all their relationships

Batterers come from all walks of life and are often very successful, like the abused (Abrahams *et al.*, 1999). Many men publicly condemn wife abuse but privately condone it. Abrahams *et al.* (1999) studied the responses of 1394 male workers at three municipalities in Cape Town. These were all municipal workers of different employment levels and race and were seemingly socially functional. Yet, the findings show that more than 40% of the men reported to have physically and or sexually abused their female partners within the last 10 years. More than a third reported sexual abuse. This figure is likely to be an under-estimate. Emotional abuse was five times more likely to be used during conflict with the women by the men who abused.

2.5.8. Myth 8: Couples should try to resolve their domestic disputes naturally rather than making it open to doctors, psychologists, police etc.

This is not true. Attitudes of health personnel may tend to reflect the dominant social values in their response to domestic violence, as they see it as a “personal problem” of the patient and not a health problem or public problem requiring attention. Such attitudes of general medical practitioners contribute to the secondary victimization of women and make them more reluctant to seek help (Warshaw, 1989; Stark and Flitcraft, 1996). Women do not report incidents of abuse no matter how serious it becomes because they are afraid of repercussions, they are embarrassed, they do not know who to report to, they feel guilt and helplessness, and feel powerless to do anything (Padayachee and

Singh, 1998; Mathews and Abrahams, 2001). Failure to expose and report abuse to doctors, police or psychologist etc. may result in the perpetuation of the cycle of violence resulting in fatal and non-fatal health outcomes (Heise *et al.*, 1994).

2.6. CAUSES OF DOMESTIC VIOLENCE

The ecosystemic perspective on domestic violence suggests that not only is the individual perpetrator at blame, but the relationship, the community and society at large (Population Reports, 1999). Also a product of this society is the victim of abuse. And while she is not the cause of abuse, her socialization renders her vulnerable in an abusive relationship. She may have a low self-image, believing in the woman's traditional gender role and in family unity. She also assumes responsibility for the beatings leading to feelings of guilt and denial. This is perpetrated by the perpetrator and endorsed by society. Her father may have established patterns of male dominance and possession or abuse. Another prevailing risk factor is physical abuse of children. Children learn at an early age that the people who love them can also abuse them. Hence, the acceptance of abuse within a relationship and condemnation of a stranger that inflicts the same harm. Children also learn that it is acceptable to hurt the ones we love (Population Reports, 1999).

Notwithstanding this, central to the causative factors is the abuser's need for power and control, and the notion of masculinity linked to dominance, honour and aggression (Population Reports, 1999). The roots for the above lies in the

patriarchal nature of our society, where women are viewed as inferior to men, often as their possessions (Wood and Jewkes, 1999). Commonly, control is exerted over a woman's sexuality by violence...for refusing a proposal, wanting to end a relationship and sometimes to ensure fidelity (Wood and Jewkes, 1999). Other risk factors include personality disorders, drug and alcohol abuse, a violent disposition, stressful lifestyles, and exposure to violence. The danger with the above is that they could be used as excuses for violent behaviour, thus absolving the guilty party of blame. They may predispose the person to abuse but certainly does not predetermine them. The determination is not prescribed nor is it isolated from each other. Men abuse women from all spheres of the social strata, and also of diverse backgrounds (Abrahams *et al.*, 1999).

Subordination in a patriarchal society such as ours is learnt through sexualisation and violation of women's bodies, which makes women subjects, and objects of subordination (Artz, 2001). This phenomenon has been documented internationally. It has been one of deafness, deafness on the side of the male-dominated power structure called patriarchy. Domestic violence is seen as not as pressing as peace negotiations in the Democratic Republic of Congo (DRC) or Rwanda, or the housing needs of the poor. Gender abuse, however, is at the heart of these issues. Elaine Salo (2005), of the African Gender Institute asks "*How can one negotiate peace without addressing the role that rape of women played in these wars because their bodies represented the enemy?*" As recently as the beginning of the 21st century millions of women were kept as slaves, used as objects in war, physically and sexually mutilated

and kept tortured in their own homes. Heyzer (1995) stated that *“women are the worst victims of war and hence the highest stakeholders of peace...who have to fight to protect even their own bodies from abuse...[and thus] are the ones who understand the full potential of what destruction means”* (in Artz, 2001).



2.6.1. Intra-individual theories of wife abuse

The intra-individual theories explain violence in terms of some characteristics of the individual person. These theories spotlight the offender's personality and the effects of alcohol and drugs.

2.6.1.1. Psychopathology as a theory of wife abuse

This approach to claims of violence is an abnormality that occurs within some individuals. According to these theories, individuals are violent because of some internal aberration, abnormality or defective characteristic. These characteristics include inadequate self-control, sadism, psychopathic personality types and undifferentiated types of mental illness (Padayachee, 1988). The drawback of these theoretical explanations of domestic violence is a combination of inadequate scientific evidence to support the theory and the inability of the theories to adequately explain which abnormal personality traits are associated with violence as an indication of mental illness. These theories omit the theoretical explanations based on genetic, instinctual and biological factors.

2.6.1.2. The alcohol and drug theory of conjugal violence

This theoretical explanation of wife abuse is more a 'conventional wisdom' than a fully-fledged theory. This theory postulates that alcohol and drugs act as disinhibitors and release violent tendencies that exist in humans. This theory has since been de-bunked. According to Strauss and Gelles (1979), this is a favourite "folk theory" of inter familial violence. Yet, victims, offenders, and mass media prefer to accept alcohol and drugs as an explanation for abuse due to the fact that batterers in domestic violence are often drinking or drunk prior to the event.

2.6.2. The social psychological theories of wife abuse

These theories locate the source of violence in relationships within the social environment, individual groups and organizations. This theoretical approach claims that abuse can be best understood by a careful examination of the external environmental factors that impact on the family. Some of the theories and their explanation for wife abuse are as follows:

2.6.2.1. The frustration aggression theory of wife abuse

This theory was first postulated by Dollard *et al.* (1939) and was later modified by Miller (1941), and Gelles and Strauss (1974). This theory postulates that aggressive behaviour results when some purposeful activity is blocked. Hence, people "transfer" the aggression to a safer object or person, namely wife or child. This theory further acknowledges that, although cultural forces can inhibit or accentuate aggression, the tendency to respond aggressively is built into the

human organism. Gelles and Strauss (1974) contrives this theory as partially relevant to the explanation of violence in the family, since the family is a likely setting for aggression because it is the geographical location of many frustrating events. They made two modifications to the original theory. They restrict one of the theories to the tendency to express aggressions as a response to the emotion that the individual feels when some goal is blocked. They regard the displayed aggression to be the result of learning rather than innate drive.

2.6.2.2. The social learning theory of wife abuse

This theory accounts for violent behaviour as a learned phenomenon. According to the learning theorists, Bandura *et al.* (1961) learning can take place through exposure to violence and imitation. Exposure to violence may lead to learning norms that approve of violence. There is also the approach that proposes that violence can be learned through viewing violence in an appropriate role model (Singer, 1971). The learning theory when applied to the family, postulates that the family serves as a training ground for violence. The family provides examples for imitation and role models that can be adopted in later life, as the individual draws from his childhood experiences to develop the appropriate conjugal role. The family also provides rewards and punishments that encourage and reinforce violence. Hence, the theory appears to be quite relevant to explain violence in the family.

2.6.2.3. The dependency theory (Cinderella complex)

This theory was proposed by Dowling (1982), in her book "The Cinderella Complex". She argues that women are inherently dependent and afraid to face up to the fact that they are responsible for themselves. This is one of the few theories explaining the reasons for battered woman remaining in the abusive relationship; hereby shattering the myth of battered woman can leave home if they want to. The Dependency Theory is a modification of the Social Learning Theory as it explains that women are socialized and taught to take flight from any stress situation. Hence women learn to be dependent on males. Dowling blames this dependency syndrome on the early child rearing practices. Girls, according to this theory are taught to be unhealthy to an unhealthy degree and also to be dependent on some males. Like Cinderella, such women wish for something external to transform them. Modern research argues in favour of this theory and states that their central theoretical argument is that patriarchy leads to the subordination of women and contributes to a historical pattern of systematic abuse directed against wives.

2.6.3. The socio-cultural theory of wife abuse

These theories of violence examine the social structures or organizations such as norms, values and organizational institutions to explain individual violence. These theories provide a macro-level analysis of family violence.

2.6.3.1. The culture of violence theory of wife abuse

This theory suggests an uneven distribution of violence in social structures, due to differences in cultural norms and values concerning violence. The Culture of Violence Theory views violence as a learned response and the learning comes about as a result of membership in a cultural or sub-cultural group. The various scriptures and teachings from religious books reflect gender issues in its content, the arguments for which are beyond the scope of this research project. Men and women interpret religious writings to support notions of male dominance and female subservience. No scriptures however purport or condone violence against women. It is imperative therefore that Emergency Care Practitioners themselves are aware that women's rights are in fact human rights and to be conscious of their own religious and cultural biases that may serve as barriers to the handling of domestic violence victims.

2.6.3.2. The structural theory of abuse

The structural theory of violence explains violence as a result of the differentiated distribution of violence producing factors such as stress, frustrations and deprivation. Therefore, one would expect to find a greater prevalence of family violence among certain groups such as those who live in poverty, with overcrowded situations and with differential learning experiences, which in turn provide models, norms and values that legitimize the use of violence. The shortcoming of this theory is that it does not include some of the major aspects of the family and family relations that would refine the explanation and prediction of intra-familial violence. Practitioners should not

assume that family violence occurs only amongst the poor and uneducated. The rich and literate are not excluded from violence producing factors such as stress, frustration and deprivation as their causes are relative to individual values. While the poverty stricken and the uneducated are not exclusively pre-disposed to violence, they may be more susceptible (Padayachee, 1988).

2.7. THE ROLE OF HEALTH CARE PROVIDERS TOWARDS FEMALE VICTIMS OF DOMESTIC VIOLENCE.

The great majority of incidents of domestic violence against woman are not reported to police. The reasons for the low reporting set out in the Human Rights Watch Report (1997) relate both to the hostile and unsympathetic treatment that women in many cases receive from the criminal justice system and to the low rate of convictions for the cases that are reported.

In 1995, many women chose to use other avenues of support and justice where available to them, rather than risking the trauma of interaction with the police, health care practitioners and courts, at a time when they feel most vulnerable. In most cases a woman who was abused or sought medical attention would therefore see a general practitioner in private practice (Human Rights Watch Report, 1995). After a decade of South African health care reform, this may be changing as access to public health improves.

Practitioners receive victims of domestic violence when they are most vulnerable and therefore are positioned to play a vital role in secondary prevention of domestic violence. Recent experience with AIDS, smoking cessation, improved outcomes in breast cancer and cardiovascular disease support the efficacy of early identification and prevention. To this effect, the Center for Health and Gender Equity (Population Reports, 1999) describe how the role of health care providers can either assist in the prevention of secondary domestic violence through the empowerment of abused women or the disempowerment of abused women through medical power and control, thereby perpetuating the cycle of domestic violence as described earlier (Johnson, 1990).

Secondary prevention of family violence is guided by three principles (Strauss, 1988). First, health care providers should reject the violence and the abusers or victims justifications for it. Second, the provider should support the victim and validate the correctness of his/her action in seeking help. Thirdly, the abuser should be brought to face the consequences of his/her behaviour. The major goals in secondary prevention of violence are to protect the victim from further abuse and break the cycle of violence as described earlier (American Medical Association, 1992).

2.7.1. Ways in which health care providers disempower victims of domestic violence

2.7.1.1. Blaming the victim

Health care providers (HCP's), upon identifying cause of abuse, may not take action to deal with the abuse. A reason given for this inaction in one study included feelings of powerlessness to do anything about the situation especially among female physicians (Eagle, 1992). HCP's can often feel powerless when dealing with victims of domestic violence. This may add to the powerlessness being experienced by both women and men in violent relationships. In situations where people experience powerlessness, the roles of victim/ rescuer / persecutor are often adopted (Padayachee and Singh, 1998).

2.7.1.2. Not respecting her autonomy

Women in violent relationships have low self-esteem. Being supportive whilst also encouraging her to take control over her life can be difficult. Health care providers have demonstrated their medical power and control by prescribing diverse medication and not advocating going to a shelter, couples counseling or police involvement. Health Care Providers who address the problem often take on a militant attitude towards intervention (Clarke, 1996). Although militant actions may protect the victim from further abuse they also serve to increase danger to the victim. Militancy may also violate the victim's desires and needs and may further impair the Health Care Providers ability to assist the victim.

2.7.1.3. Violating confidentiality

Confidentiality and privacy is one of the most important ethics of a HCP. If confidentiality cannot be guaranteed an abused person will not speak out and will continue to be abused. Intervening in front of family, telling colleagues issues discussed in confidence without her consent and calling the police without her consent are all forms of violating an abused woman's confidence.

2.7.1.4. Trivializing and minimizing abuse

Health Care Providers may not take the danger the victim feels seriously, assuring her that if the victim can endure abuse for years then it cannot be that bad. The Health Care Provider's failure to believe clients or suggesting that they are exaggerating the problem might be interpreted as rejection on the part of the victim (Clarke, 1996). This perceived rejection could result in reluctance by victims to seek further help, further victimizing the victim.

2.7.1.5. Ignoring the need for safety

Health Care Providers are guilty of failing to recognize an abused woman's sense of danger. They fail to ask: "Is it safe to go home? Do you have a place to go if the situation gets worse?"

YES=1/ NO=0	THE PHYSICAL ABUSE RANKING SCALE
	1. Throwing things, punching the wall.
	2. Pushing, shoving, grabbing, throwing things at the victim.
	3. Slapping with an open hand
	4. Kicking and biting.
	5. Hitting with closed fists.
	6. Attempted strangulation.
	7. Beating up (pinned to the wall/floor, repeated kicks, punches)
	8. Threatening with a weapon
	9. Assault with a weapon

Table 1. Physical abuse ranking scale (Selber and Taliaferro, 1995).

According to Selber and Taliaferro (1995), one of the most important questions a physician can ask is if the victim thinks it is safe to go home. The patient knows her situation better than anyone else. The decision about going home or not must ultimately be made by her and respected by the physician. Selber and Taliaferro (1995), states that an important tool that can assist a physician when assessing danger is the Abuse Rating Scale (Table 1 above). A ranking of more than 5 implies extreme danger.

2.7.1.6. Normalizing victimization

Health Care Providers may fail to respond to her disclosure of abuse. They may accept intimidation as normal in relationships. There is a general belief that abuse is the usual outcome when women disobey their male partners.

2.7.2. Ways in which health care providers empower female victims of domestic violence.

2.7.2.1. Acknowledge the injustice

Acknowledging the injustice and rejecting the justification for the violence by the abuser or victim is an important guiding principle towards secondary prevention, as pointed out by Strauss (1988).

It is important for the health care provider to let the victim know that she is not to blame for the violence. Health Care Providers should state clearly that the responsibility lies with perpetrator and unless he accepts this responsibility he is unlikely to change. Equally important is to confront any myths she may have about domestic violence (Population Reports, 1999). It is imperative to explain to her that no one deserves to be abused and it goes against her human rights. The Bill of Rights argues that women's struggle is not against men but is for humanity (Act 108, 1996). The starting point for the above is to ask routinely about their experiences of domestic violence as part of history taking (Martin and Jacobs, 2003)

2.7.2.2. Believe and validate her experiences

Believing and validating her experiences is yet another important guiding principle towards secondary prevention of family violence. It is important to let her know that you believe her, since often family and other elements in society blame her. Allowing the woman to describe what is happening to her through

open-ended questions is therapeutic and can serve as the first step in stemming the cycle of abuse (King and Ryan 1989). It is important that the medical practitioner conveys to the woman that she does not deserve to be abused and that he/she (the medical practitioner) is sorry that this has happened to her (King and Ryan, 1989).

2.7.2.3. Respect confidentiality

All discussions between the ECP and the victim of domestic violence must occur in private, without other family members or friends present. This is essential to build trust and ensure her safety. This also means that the ECP must separate the victim from anyone, including the perpetrator who accompanies her to the ambulance. Selber and Taliaferro (1995) suggest that Health Care Providers do this in a way that does not arouse any suspicion and therefore protects her. Depending on the medical setting there are many ways of doing this. Either ask the other person to leave during a physical examination or send the patient to another area for examination.

2.7.2.4. Promote access to community services

Women in abusive relationships require services beyond those traditionally provided in the medical setting. Therefore the Health Care Provider needs to be aware of the availability of such services in the community. Selber and Taliaferro (1995) suggests that health care providers develop lists with phone numbers of places for referral such as battered woman shelters, safe homes and other crisis centers. They also suggest that health care providers update

these lists annually since many hotline and shelters may close due to inadequate funding or other factors. Knowing what is available will help her plan for her immediate safety (Padayachee and Singh, 1998). Whatever the options are, one must remember to respect her autonomy (Population Reports, 1999).

2.7.3. Reasons for the non-detection of domestic violence victims by health care providers

Although a significant number of domestic violence victims present routinely at health care facilities research has shown that detection rates by health care providers are low (Robert *et al.*, 1996). As domestic violence is still regarded as a private issue in most societies and women do not volunteer abuse readily, this leads to low rates of disclosure (Robert *et al.*, 1996). Attitudes of health care providers may tend to reflect the dominant values in society in their response to domestic violence that see it as a personal problem of the patient and not as a health problem or a public problem requiring attention (Robert *et al.*, 1996).

There is a lack of appropriate training and education regarding the identification and management of abused woman when attending a health facility (McLeer and Anwar, 1989). An inability to acknowledge the abuse experienced by women and the inappropriate response by Health Care Providers contribute to secondary victimization of women and makes them more reluctant to seek help (Warshaw, 1989 and Stark and Flitcraft, 1996). This approach confines the health sector intervention to the treatment of medical symptoms as outlined in Figure 1, the prescription of tranquilizers and offering little help and assistance

by way of referral. 'Medicalisation' of women's trauma also reduces their options and accessibility to appropriate help. Dearwater *et al.* (1998), state that health care providers often treat women without ever enquiring about abuse therefore never recognizing or addressing the underlying cause of health problems.

2.8. THE LEGAL RIGHTS OF ABUSED WOMEN IN SOUTH AFRICA

Violence against woman is the most pervasive form of human rights violation. Gender-based-violence represents a substantial burden for women in terms of morbidity and mortality rates and makes a significant negative impact on their physical and mental health (WHO, 1997; WHO, 2002).

Domestic violence is endemic in most societies across the world, but remains unrecognized as a silent socio-economic public health and political issue, largely absent from national and international agendas. It has only recently recognized by the United Nations as a fundamental abuse of Women's Human Rights (Human Rights Watch, 1995; WHO, 2002). The South African government has expressed a commitment at policy level to eradicate gender violence. The South African Constitution (Act 108 of 1996), specifically chapter two, The Bill of Rights, contain clauses that safeguard and protect women's rights as human rights. There is explicit reference to gender violence in Clause (12) 1 of the Constitution: '...protecting the rights to freedom and security to the person, which includes the right ... to be free from all forms of violence from

either private or public sources'. This commitment is further translated through the establishment of various gender organizations and structures such as the Commission on Gender Equality and through new legislation that aim to ensure that constitutionally entrenched rights are not infringed.

2.8.1. The Domestic Violence Act 116 of 1998

The Domestic Violence Act came into effect in 1998. The Domestic Violence Act 116 of 1998 was intended to serve as an important legislative tool for persons in abusive relationships to obtain protection orders and redress through the criminal justice system as well as access appropriate support from other sectors including the health sector. The latter should include appropriate referral to the health and social services for psychological and physical care. Thus the health sector needs to be well acquainted with the legislative tools available to the victims of domestic violence. It is not known what the level of ECP awareness of The Domestic Violence Act 116 of 1998 is. If a woman has seen only her own doctor, she may as a consequence, never learn any legal remedies available to her. A NGO working against domestic violence in Braamfontein found that general practitioners only referred 1 or 2 of more than one hundred cases (Human Rights Watch, 1997; Maquoid-Mason *et al.*, 2002).

The provisions, protections and remedies of the Domestic Violence Act 116 of 1998 are premised on the knowledge of the endemic nature of domestic abuse and violence between intimates. The Act is intentionally gender-neutral, stressing recognition of the fact that both men and women are victims of such

abuse and are, accordingly, protected by the provisions of the Act. Having regard to the United Nations Declaration on the Elimination of Violence Against Women (GA Resolution 48/104), the Universal Declaration of Human Rights, and the Bill of Rights (ACT 108 of 1996) all of which specifically entrench the rights of equality, dignity and security of a person, the Domestic Violence Act provides measures to assist victims of domestic abuse (Maquoid-Mason *et al.*, 2002). In accordance with the various legislative enactments, men and women, in South Africa, have equal rights:

- They have equal rights to the law.
- They have equal protection under the law.
- Even after marriage, husbands and wives are equal partners. Marriage does not give the husband the authority to chastise/discipline his wife.
- Despite the law recognizing the husband as the 'head of the home', this does not place the wife in an inferior role, nor does it give him control over the person and property of his wife.
- If the marriage relationship deteriorates, either party may apply for a divorce. A husband may refuse to divorce his wife.
- Marriage is a consensual agreement between the parties. Where one party has been forced into marriage, she may apply to court to have the marriage set aside if she can show that the duress was such that it rendered him/her incapable of acting in any other way than to go through with the ceremony. Where the marriage is so set aside, the effect will be as if it had never occurred (Maquoid-Mason *et al.*, 2002).

Mathews and Abrahams (2001) evaluated the impact of the Domestic Violence Act in a study in the Western Cape. The study found that the most common forms of violence reported by women were physical and psychological abuse, with an average of 81% of cases experiencing both forms of violence. Sexual abuse was least likely to be reported. A large number of women suffered severe depression without it being adequately recognized and managed. Despite the responsibilities of the police, women still experience the police as ineffective due to attitudes and perceptions of intimate violence (Mathews and Abrahams, 2001). The State has committed itself, in principle, to the elimination of domestic violence – it is the practice of effectively translating rights into reality for the victims of abuse that is the challenge.

Emergency Care Practitioner's may present as more than just transporters of the sick and injured but as sentinels for surveillance of abuse and as role-players integral to the holistic management of domestic violence. The Protection Order on its own cannot change women's experiences as their socio-economic environment compounds it. The Protection Order has limited impact as a tool to shelter women from domestic violence.

2.9 SUMMARY

International bodies across the globe are beginning to recognize the devastating implications of domestic violence and the need to draw up action plans to address abuse. The 1995 UN World Conference on Women's Platform

for Action identified domestic violence as a human rights issue and not only as a fight against men (WHO, 1997). It urges governments to recognize that effective education campaigns must involve the entire community, health, police, social workers, justice, educational workers and should never exclude men.

Addressing and preventing domestic violence is viewed as a key component to the attainment of women's social and economic rights i.e., if there is no security at home it will be difficult to achieve peace and sustainable development. A comprehensive human rights vision cannot afford to leave out the relationship between the tolerance in the home and the culture of violence in civil society as manifestations from our repressive and revolutionary history of apartheid. The unique historical conditions produced by apartheid have portrayed the police as the occupying enemy which has contributed to the under reporting of domestic violence. Hence the challenge to render police accessible lies in the transformation of the police to be comprehensively community-service orientated.

Comprehensive prevention strategies must be aimed at preventing problems before they occur (Primary Prevention) or identifying a problem at its earliest possible point (Secondary Prevention). In this way harm to individuals is reduced and the impact on the various systems is minimised. Throughout the globe improved sanitation systems prevent the spread of infectious disease and environmental regulations reduce pollution-related illness. Domestic violence

must be dealt with from a health promotion perspective. When primary and secondary prevention strategies are not in place or are ineffective, tertiary prevention is required. However tertiary prevention only limits the impact of an injury or disability once it has already become serious. In fact, when public health depends on tertiary education, this may indicate to some extent, a failure of the health care system and other institutions to intervene early enough.

It is envisaged that attending to women's social, economic and medical rights can prevent domestic violence. Active strategies must be used to maximize the safety of women and their children. Domestic violence and gender violence must be made a public health priority by creating awareness of the health consequences such as an increase in morbidity and mortality, acute and chronic physical, somatic and emotional problems and physical, psychological and economic effects on women. It has been shown that domestic violence fits the profile of a public health issue (WHO, 2006); there is a need for the provision of support and care for survivors of abuse and their significant other and to provide rehabilitation for the perpetrator.

Finally, if the struggle against domestic violence is to be at all successful the approach must move away from an exclusive reliance on criminal justice responses towards one that recognizes the advantages of a true public health prevention model that addresses the environment permitting the violence to occur and continue. The Emergency Care Practitioner is an integral part of this environment. Christofides *et al.* (2003), in a study of the state of sexual assault

services in South Africa points out the inadequacy of current services. ECP's are not even a feature of the study. There exists, no evidence of the current role of paramedical personnel in domestic violence intervention in South Africa.

CHAPTER 3

3.0 METHODOLOGY

3.1. INTRODUCTION

The knowledge, attitudes and beliefs of ECP's toward victims of domestic violence have never been previously evaluated in South Africa. This study aimed to describe the knowledge, attitudes and beliefs of ECP's to domestic violence, across the qualification spectrum of the EMS. This research was observational in nature and precedes other types of research choices because before progress can be made in solving certain problems, one needs to show what the existing facts and prevailing conditions are. While this research is primarily concerned with conditions as they are, it nevertheless involves much more than mere fact-finding. It seeks to discover associations, cause and effect relationships and attempts to give interpretations as well. Domestic violence has neither simple solutions nor a single cause. This premise has served as the foundation for the design of this study. This chapter presents information on the methodology employed in the above research with regards to study design and study population. The data reliability and validity as well as ethical considerations in this study are presented.

3.2 TYPE OF RESEARCH

This was a public health systems research. The frequency, distribution and cause of domestic violence were interrogated through ECP's at both, a policy and an operational level.

3.3 STUDY DESIGN

The study was a cross-sectional, descriptive study.

3.4 STUDY SITE AND POPULATION

3.4.1 Study site

The location of the study was the Western Cape Province of South Africa.¹

3.4.2 Study population

The population in this study was HPCSA registered ECP's in South Africa. The study population was male and female ECP's who were employees or volunteers of the PGWC EMS, working in the metropole region of the PGWC EMS. They were between 20-50 years of age and included a spectrum of

¹ The principal investigator (PI) in this study is a lecturer at the Cape Peninsula University of Technology (CPUT): Academy of Emergency Care, which is located in this province. It may be the non-profit facilitator to the provincial government and private sector in the event of curriculum development for Emergency Care Practitioner intervention in domestic violence. High prevalence of violence, poverty and alcohol abuses in this locale also make the research relevant. Most of the Emergency Care Practitioners in the Western Cape are now trained at the same institution.

qualifications and experience. The qualifications are Basic, Intermediate and Advanced Life Support which are based on the extent of training and how they are registered with the HPCSA. The scope of practice for each differs, but common medical ethics apply to all. Intermediate and Advanced practitioners are registered as independent practitioners whilst Basic practitioners are supervised practitioners.

3.4.2.1 Inclusion/ Exclusion

Emergency Care Practitioners are employed in hospital casualties, Emergency Medical Services and both the public and private sectors. These differing environments could confound this study. Private sector emergency care practitioners were excluded from the study. Private ambulance services have fewer staff and more resources relative to their lesser caseload than the Provincial Emergency Service. This study is limited to those practitioners within the Provincial Government - Western Cape (PGWC), Emergency Medical Service (EMS). Volunteers in PGWC EMS were included provided that they were registered with the HPCSA as an ECP. Basic, Intermediate and Advanced ECP's participated.

Due to higher caseload and higher emergency care practitioner numbers in the Western Cape Metropole compared to the rest of the Province, the study area was restricted to the Western Cape Metropole. The most advanced skills base and other resources are in abundance in the Metropole. Deficiencies found here are likely to be compounded in the rural areas. There is also a more

stable management structure in the Metropole. Emergency Service personnel involved in the study are rostered at bases in locations at Pinelands, Mitchell's Plain, Delft, Somerset West and Stellenbosch.

3.4.3 Sampling Method

The sample was a census of all the ECP's. All full time or voluntary ECP's working in the Western Cape Metropole were eligible and encouraged to participate. This included male and female practitioners as well as all basic, intermediate and advanced staff. The context of the study and instructions on what was expected of those who were to participate were explained at the start of a shift and returns were collected at the end of a shift. The provincial and regional management support was elicited. In order to obtain as complete a census as possible at least 30 visits were made to 5 facilities over a time period of 3 weeks to encourage the ECP's to respond in the whole study area.

3.4.3.1 Sample Size

Even though the full staff complement of the EMS was 313, only operational personnel were considered representative for this study. Fifteen percent of the 313 personnel are estimated by management to be non-operational (due to secondment, sick leave, vacational leave, injury on duty leave, leave without pay, and study leave). Hence the total available operational population was 266 (100%). The anticipated sample size was initially 320 ECP's. The intention was to achieve as high a return rate as possible. A probability sample would have required a random selection of 74 of the 320 ECP's in order to achieve a result

with a confidence limit of 95% and a variability of 10% about the mean expected frequency. Therefore all practitioners were consulted.

3.5 DATA SOURCES

3.5.1 Measurement instruments

A semi-structured questionnaire was used to obtain data rapidly from ECP's. The questionnaire was developed after reviewing literature and studying the contributions made by other researchers in the field. The contents of the draft questionnaire were discussed with an expert on gender violence research from the MRC and the Chairman of the PBECP (HPCSA). Their input helped improve the instrument. Some questions used a Likkert type rating scale and others requiring personal opinions were open-ended questions (see appendix 5).

3.5.2 Variables

The questionnaire probed the knowledge, attitudes, beliefs and practice of the ECP with respect to victims of domestic violence.

The first objective was to evaluate the perceptions and understanding Emergency Care Practitioners have of the problem, and to identify the harbouring of myths and any other potential barriers to the implementation of a medical protocol. This was done by asking about their attitudes and experiences, their screening methods, training and education, knowledge, and level of awareness with respect to domestic violence in their society.

The second objective was to investigate the responses of Emergency Care Practitioners to identify the adequacy of current practice in crisis intervention with respect to victims of domestic violence. The respondent's current practice was elicited and compared with currently known best practice for handling domestic violence.

The third objective was to suggest guidelines for the design and development of a pre-hospital medical protocol for the emergency intervention, safety assessment and appropriate referral of domestic violence victims for the Emergency Care Practitioner. The needs identified from the study were analysed and may be used in the ECP curriculum.

3.5.3 Reliability

Stability of the sample could not be efficiently evaluated due the shift-work nature of the respondents. Internal consistency, as a characteristic of reliability, is only appropriate when the instrument is measuring one type of construct (Brink, 1999). The questionnaire in this study focuses on a number of constructs. However, many differently phrased questions refer to individual concepts to ensure reliability, therefore parallel forms were not used.

3.5.4 Validity of measurement instrument

3.5.4.1 Content validity

The content of the questionnaire emanates from the literature review. The essential aspects included are:

- The levels of exposure the ECP has had to domestic violence in his or her capacity as an ECP.
- The ECP's definition of domestic violence.
- The ECP's experience of who the victims and perpetrators of domestic violence are.
- Identification of and supporting myths linked to abuse.
- The reporting, detection or identification, referral, and causes of cases of abuse.
- The current practical treatment of victims and what is needed for best practice.

The above content was presented to experts from the MRC - Gender Studies, University of Cape Town - Department of Forensic Medicine, University of KwaZulu-Natal - School of Family and Public Health Medicine, and the HPCSA PBECP. The experts found that the variables to be tested were adequately represented and that the instrument was appropriate, with minor alterations.

3.5.4.2 Face validity

At face value, the instrument appeared to measure what it sought to measure. The variables were congruent with the objectives of the study.

3.5.4.3 Criterion-related validity

As no other data was available from the same group of subjects, predictive validity could not be employed. Concurrent validity was tested with regards to

the criterion of recognition of abuse, myths of abuse, referral of victims and treatment.

3.5.4.4 Construct validity

Construct validity is useful mainly for measures of traits or feelings (Brink, 1999). Therefore it is less applicable to this study. There are contrasting groups in terms of qualification, experience, gender, etc, within the study; but the scope of this study is limited to measuring the status quo of domestic violence management and a true contrast group is not yet available.

3.5.4.5 Measures to ensure validity

3.5.4.5.1 Internal validity

To ensure validity the words used in the questionnaire are simple, direct, and familiar to all respondents. The questions are clear and as specific as possible. The questions do not try to cover more than one point with each question. They are neither leading nor loaded. Words are not emotionally charged and do not threaten self-esteem. The questions are applicable to the ECP's in terms of their exposure to domestic violence and in terms of the study objectives. The questions cannot be shortened without losing any meaning. They also read well.

3.5.4.5.2 Reduction of bias

There are mechanisms in place to avoid bias associated with 'yes' answers to items without regard to their content. Some 'yes' answers also require

explanations. To avoid socially acceptable answers rather than the respondent's own view, some items are repeated in different forms, for example, direct questions and open questions requiring value judgments and questions relating to attitude and beliefs. The definitions purported in chapter one serve as terms of reference against which the ECP's definition of domestic violence is measured. This is aimed at preventing information bias.

3.5.5 Pilot study

A pilot study was conducted with three practitioners, one at each of the three levels of skill, all of whom had no problems completing the instrument. They had no significant changes to add and practitioners were particularly pleased that this research is being contemplated. In addition, second year ECP students at the Cape Peninsula University of Technology participated in a focus group to identify training needs on domestic violence. The above verified the research instrument for efficiency and content.

3.5.6 Data collection

The research assistant introduced the research questionnaire at the beginning of each shift to all ECP's present. The attainment of consent of the EMS Director and the Operations Manager preceded this. Consent was first obtained from the respondents before collection of questionnaires. Each respondent that volunteered answered the questionnaire and returned it to the shift officer/team leader by the end of the 12-hour shift in a sealed pre-numbered envelope. A separate page with contact details was handed in to the assistant, and not to

the researcher, for purposes of feedback and control. Anonymity was secured in this way. The questionnaire for each person was self-administered at the EMS base per shift.

3.5.7 Data handling

A unique identification number was assigned to each respondent's questionnaire. Responses to open-ended questions were categorised. All data was entered into a database and forwarded to the statistician.

3.5.8 Statistical analysis

The questions and responses from the measurement tool were coded and captured on an excel spreadsheet. Categorical and numeric data were summarized using appropriate descriptive measures of central tendency and dispersion and presented in frequency distribution tables and graphs. The statistics were mostly descriptive in nature. Some statistical analysis with regards Chi-Square Test and Fisher's Exact Test was also conducted. A 'p' value of <0.05 constituted statistical significance.

3.5.8.1 List of possible confounders

- Emergency Care Practitioners are now employed in hospital casualties, Emergency Services, the public and private sectors, all of which offer differing experiences. These differing environments could be a confounding factor.
- Also, as a male dominated profession, the majority of the research population of Emergency Care Practitioners is of the male gender.

- Differing training standards.
- Personal experience as a perpetrator or victim.
- Incomplete or dishonest responses.

3.5.8.2 List of associations measured

- The representativity of the sample to the provincial racial and gender populations, the divisions concerned, the BLS/ ILS/ ALS population and the total EMS operational population in the Metropole.
- The distribution of the respondent's age groups and the respondent's place of highest medical qualification.
- The respondent's definition of domestic violence and age/ qualification.
- The extent of domestic violence experienced in the community and domestic violence prevalence.
- Association between belief in myths and qualification.

Qualification was associated with knowledge of laws, screening and referral, level of preparedness, causes of domestic violence, and current practical treatment.

3.6 ETHICS

3.6.1 Institutional review board

Anonymity, confidentiality and understanding were ensured. All conditions of the ethics approval to commence the study have been complied with. No

ethical breach has been reported. The Institutional Review Board has approved the study.

3.6.2 Permissions (see appendix 1B, 2)

The Director of the PGWC- EMS has also consented to the involvement of staff in the study. The CPUT HOD-Emergency Medical Care has also allowed logistical support and approved the pilot study. The respondent's informed consent was also attained prior to questionnaire completion.

3.7 SUMMARY

The methodology employed was intended to attain a representative sample of an appropriate cross section of population of ECP's in the Western Cape. The measurement tool was selected for time, logistical and empirical efficiency. Reliability and validity underpinned the design, implementation and analysis of the measurement tool. Lastly, all ethical obligations were satisfied.

CHAPTER 4

4.0 RESULTS

This chapter presents processed data and results of this study that investigated the knowledge, attitudes and beliefs of Emergency Care Practitioners in the Western Cape. The first objective of this study was to determine the knowledge, attitudes and beliefs of ECP's to domestic violence. Demographic information of respondents such as race, gender and qualification and EMS experience is also presented. Central to the ECP's knowledge is their definition of domestic violence. The ECP's exposure to domestic violence is then presented as well as evidence of belief in myths of abuse. In terms of domestic violence detection by ECP's, reporting of violence, legal knowledge and place of detection are explained.

Objective two looks at an evaluation of the ECP's management of victims of domestic violence and is achieved by analysing the difficulty and frequency in diagnosing domestic violence in the community and the referral of domestic violence victims. Finally, the EMS training, and current ECP's treatment of victims, and the needs of ECP's pertaining to domestic violence management inform objective three. Guidelines for the design and development of a prehospital medical protocol in the emergency medical intervention of domestic violence for the ECP are presented.

4.1 OBJECTIVE 1: KNOWLEDGE, ATTITUDES AND BELIEFS OF ECP'S

4.1.1 Demographic information of respondents

4.1.1.1 Race of sample population

The sample population was representative of all the racial groups (except for the Indian group that was deliberately excluded from the statistical analysis) in the Cape metropole region and in the entire province (Table 2, Statistical test used: Chi-Square, $p = 0.0001$). In terms of the White group, 12% in the Provincial population were white, compared to 7% in the Metropole population and 23% in the Sample population; and for the Coloured population, 75% of the Provincial population were coloured, compared to 69% in the Metropole and 56% in the sample. For the Black population: 12% of the Provincial group was black, compared to 20% in the Metropole and 19% in the sample.

Table 2. Race of the sample population of ECP's, the regional (Metropole) and provincial EMS, 2006.

Race	White		Coloured		Indian		Black		N
	n	%	n	%	n	%	n	%	
Provincial EMS	104	12	657	75	11	1	106	12	878
Metropole EMS	19	7	183	69	11	4	53	20	266
Sample	35	23	87	57	2	1	30	19	154

Chi-Square, $p = 0.0001$

4.1.1.2 Gender of sample population

The majority (67%, $n=103$) of respondents were male (Table 3, Statistical test

used: Chi-Square, $p = 0.0001$). Eighty two percent (82%) of the EMS workers in the Provincial population were males, compared to 85% in the Metropole, and 67% in the sample. With regards females: 18% of the EMC workers in the Provincial population were females, compared to 15% in the Metropole and 33% in the sample.

Table 3. Gender of the sample population of ECP's, regional (Metropole) and provincial EMS, 2006.

Population	Male		Female		N
	n	%	n	%	
Provincial EMS	720	82	158	18	878
Metropole EMS	226	85	40	15	266
Sample	103	67	51	33	154

Chi-Square, $p = 0.0001$

4.1.1.3 Age group of sample population of ECP's.

Nearly half (48%) of the sample was in the 25 - 34 age group (Figure 3).

Comparative data of the PGWC EMS and the Western Cape Province was not available.

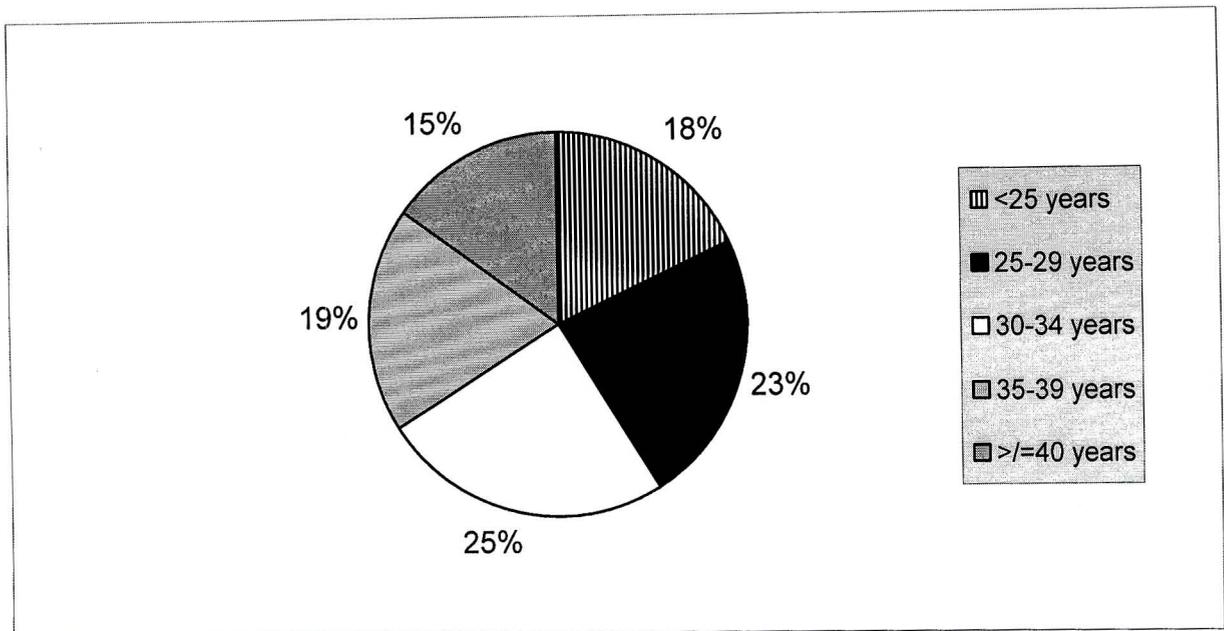


Figure 3. Age group of ECP's in the sample population, 2006 (N= 152).

4.1.1.4 Qualification of the sample population

Most of the sample (47%) were ECP Intermediate practitioners, 40% were ECP Basic practitioners (n=62), and 13% were ECP Advanced qualified (Table 4, Statistical test used: Chi-Square, $p = 0.0309$). With regards workers with basic training: among provincial workers, 46% had basic training compared to 35% in the Metropole group, compared to 40% in the sample. Workers with intermediate training amongst provincial workers were 45%, compared to 52% in the Metropole and 47% in the sample. With regards workers with advanced training: among provincial workers 10% had advanced training, compared to 13% of those in the Metropole and 13% of those in the sample.

Table 4. Qualification in the sample population of ECP's, the regional (Metropole) EMS and provincial EMS, 2006.

Qualification	Basic		Intermediate		Advanced		N
	n	%	n	%	n	%	
Provincial EMS ECP	404	46	395	45	88	10	878
Metropole EMS ECP	93	35	138	52	35	13	266
Sample EMS ECP	62	40	72	47	20	13	154

Chi-Square, $p = 0.0309$

4.1.1.5 Place of qualification of ECP's

The majority service provider of EMS education for this sample (N=143) was the PGWC EMS "Further Education Training" (FET) institution (62%, n=88), which provides in-service training. Graduates of The CPUT (Higher Education) and the private service providers (FET) were also represented [15% (n=22) and 20% (n=28) respectively]. The PGWC EMS training stopped operating as such in 2003.

4.1.1.6 EMS experience of respondents

Table 5. Years of EMS experience of ECP's, 2006 (N= 151).

EMS experience in years	Frequency	Percentage
0-1	14	9
2-5	63	42
6-10	44	29
11-15	16	11
>15	14	9

Forty two percent (n=63) had 2-5 years of experience (Table 5 above). Nine percent had between 0-9 years of experience.

4.1.2 Definition of domestic violence by ECP's

In answer to an open-ended question on their definition of domestic violence, 49% of the respondents (N= 154) correctly defined domestic violence as any form of abuse (physical, emotional, psychological, and economic) occurring within a domestic relationship.

Twenty percent (n=31) of all respondents defined it incorrectly or incompletely. Incorrect definitions included statements such as an inability to control aggression, physical abuse only, two or more types of abuse only (without the context), and workplace violence or domestic worker abuse. Thirty-one percent (n=48) had not answered the question. An understanding of domestic violence definition is also linked to an understanding of the Domestic Violence Act, mentioned in 4.1.6.2 below.

Exposure variables such as age group, length of experience and qualification were matched with responses about knowledge of domestic violence. With regards the definition of domestic violence, there was no association in this study to age group or experience as an ECP. However, a significant association ($p = 0.0169$) was shown between qualification and definition. Of those who indicated the correct definition, 28% (n=21) had ECP Basic training, compared to 55% (n=17) of ECP Basics who had incorrect definitions. In addition, of

those who indicated the correct definition, 16% (n=12) had ECP Advanced training, compared to those who had indicated incorrect definitions, 3% (n=1) had ECP Advanced training (Table 6).

Table 6. Frequency (number & percentage) of correct and incorrect definitions of domestic violence by ECP's of different qualification, 2006.

Definition	ECP Basic		ECP Intermediate		ECP Advanced		Total Respondents
	n	%	n	%	n	%	
Correct	21	28	42	56	12	16	71
Incorrect	17	55	13	42	1	3	29
Total	38	A%	55	B%	13	C%	100

Chi-Square, p = 0.0169

4.1.3 Exposure of ECP's to domestic violence

In terms of all emergency response calls (including domestic violence calls), 66% (n=94) of respondents attended to less than 100 calls in the preceding month, whilst 34% (n=48) attended to more than 100 in the preceding month (Table 7). A varied range of responses was given to a question on whether domestic violence was present. About a third (31%) of 143 respondents recognised domestic violence in less than 10% of emergency calls. Fifteen percent (n=21) of 143 respondents recognised domestic violence in 10-20% of emergency calls (Figure 4). When asked how many domestic violence calls were recognised in the last six months, six percent (n=9) reported none, 42% (n=60) reported 1-10 and 24% reported 11-20. Only 19% (n=28) reported more

than thirty. Essentially, 81% (N=144) of respondents recognized less than thirty domestic violence calls over the previous six months.

Table 7. Frequency of total EMS responses made by respondents in the previous month, 2006 (N=142).

Total EMS responses made/month	Frequency of respondents	Percentage of respondents
<50	51	36
50-74	32	22
75-99	11	8
>100	48	34

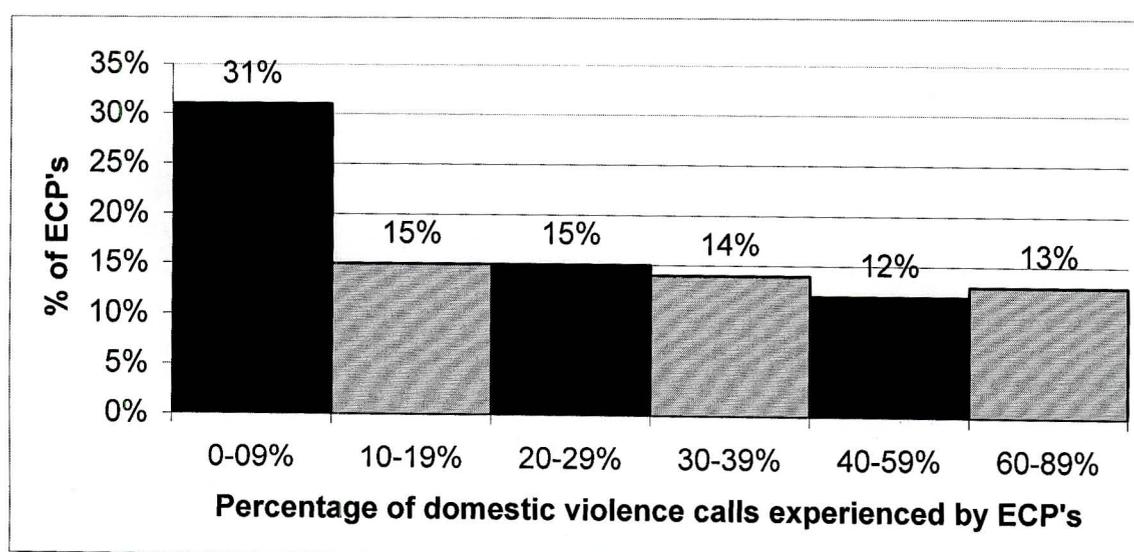


Figure 4. Percentage recognition of domestic violence calls by ECP's (N = 143) when responding to emergency calls in the Western Cape, 2006.

4.1.4 ECP's recognition of the gender of the victim/ perpetrator

The victims were reported to be female by 82% of respondents (N=150); male by 11% and 7% identified both sexes as victims. Perpetrators of abuse were reported by 89% (N=148) to be male, and by 7% to be female. Five percent reported both sexes as perpetrators.

4.1.5 ECP belief in myths or truths about abuse

The majority of respondents agreed with the definition of domestic violence (87%, N=152) and identified women as the principle victim (66%, N=151) [Table 8].

Ninety-seven percent (N=152) believed that alcohol and drugs were the main cause of domestic violence (Table 9). A large percentage of respondents held belief in most of the myths stated below, but even belief in a single myth, by professionals, is problematic.

Table 8. Respondents (number and percentage) who identified truths about domestic violence correctly, 2006.

Statement of "Truth"	n	N	% Correct responses
Violence includes any controlling, abusive or fear-inducing act that threatens to harm the health, well-being or safety of a person.	132	152	87%
Domestic abuse mostly includes violence against women.	99	151	66%

Table 9. ECP's (number and percentage) who identified myths about domestic violence correctly, ranked according to correct response, 2006.

STATEMENT OF "MYTH"	n	N	% Correct responses
Women who do not listen to their partners deserve to be abused.	147	153	96%
A woman who nags is asking to be abused.	131	151	87%
Women who are abused enjoy it or are mentally ill.	120	152	79%
Domestic violence is a private matter.	119	150	79%
Only poor, uneducated and mostly Black or Coloured women are abused.	108	153	71%
Physical abuse is worse than emotional abuse.	88	152	58%
Abused women can leave home whenever they want to.	70	150	47%
Men who beat their wives are mentally ill and cannot control their violence.	61	149	41%
Violence and love cannot exist together in one home.	52	151	34%
Alcohol and drugs are the main cause of domestic violence.	4	152	3%

4.1.6 Domestic violence detection by ECP's

4.1.6.1 Reporting of domestic violence by ECP's

The ability to detect domestic violence is influenced by one's knowledge, attitude and belief about domestic violence. Most (72%) of the 149 ECP's thought that there was under-reporting of domestic abuse to the EMS. Reasons

for this included the victim being ashamed or afraid to call for help (55%, N=108). Sixteen percent (n=17) suggested that there was poor handling of calls by the EMS or that it was not seen as a priority by the call centre. In answer to whether there is any special handling of domestic violence calls, in terms of call taking, dispatch and response in EMS, almost 10% (N=149) answered 'yes', 49% did not know and 41% answered 'no'. Of all those that answered 'yes', only half could explain that this meant a trauma counselor would be referred.

4.1.6.2 ECP's legal knowledge of domestic violence

With regards knowledge of any laws that aim to support people against domestic violence, 40% indicated that they did not know nor had knowledge of the laws. The rest (60%, n=90) reported having knowledge of laws related to domestic violence. However, only 15 (10%) identified the Domestic Violence Act as relevant. Eight (5%) others identified the Constitution as relevant. Noteworthy, is that 125 (84%) of the 154 respondents did not list any laws, yet, 92% of 146 respondents agreed that domestic violence detection was important.

4.1.6.3 Location of domestic violence detection by ECP's

As to where one would detect domestic violence in the pre-hospital environment, 56% of 102 respondents answered 'upon arrival at a domestic violence scene' but 24% answered 'at a hospital or police station'. Only 11% (n=11) suggested the use of 'an index of suspicion'. Of those with ECP Basic training (as seen in Table 10), 35% (N=102) detected domestic violence at the

scene. This compared with 71% (N=102) of those with ECP Intermediate training who detected domestic violence at the scene; and those with ECP Advanced training, 54% (N=102) detected domestic violence at the scene (Fisher's Exact Test: $p=0.0124$).

Table 10. Location of detection of domestic violence by Emergency Care Practitioners of the Western Cape by qualification, 2006.

Qualification	Upon arrival at domestic violence scenes		Everywhere, based on index of suspicion		At hospitals or Police stations		Total
	n	%	n	%	n	%	
ECP Basic	13	35	11	30	13	35	37
ECP Intermediate	37	71	8	15	7	13	52
ECP Advanced	7	54	2	15	4	31	13
TOTAL	57	A%	21	B%	24	C%	102

Fisher's Exact Test: $p=0.0124$

When qualification was cross-referenced with knowledge of domestic violence laws (Table 11), no significant association could be found.

Table 11. ECP knowledge of domestic violence laws, 2006.

Qualification	Some knowledge of domestic violence law		No knowledge of domestic violence law		Total	
	n	%	n	%	N	%
ECP Basic	31	53	28	47	59	40
ECP Intermediate	46	64	26	36	72	48
ECP Advanced	13	72	5	28	18	12
TOTAL	90	60	59	40	149	100

Chi-Square, $p = 0.23$

4.2 OBJECTIVE 2: CURRENT ECP PRACTICE WITH RESPECT TO DOMESTIC VIOLENCE INTERVENTION

4.2.1 Difficulty and frequency in diagnosing domestic violence by ECP's

As reflected in Table 10 above, of those with ECP Basic training, 35% detected domestic violence at the scene, whereas with ECP Intermediates, 71% detected domestic violence at the scene, and with ECP Advanced practitioners, 54% detected violence at the scene. Using Fisher's Exact Test, a significant association ($p = 0.0124$) was found between the above variables. In routine calls, difficulty is experienced in finding domestic violence, by 32% (N=141) of respondents. Of interest also, is that 13 of 141 respondents (9%) reported never having diagnosed an incidence of domestic violence. Fifty-two ECP's (34% of sample) reported that difficulty experienced was due to victims being ashamed or afraid to report abuse. Of all the respondents (N=154), 6% reported being uncomfortable to ask about abuse.

4.2.2 Referral of domestic violence victims by ECP's

Qualification could also not be positively associated with the referral of victims, although the majority (78%) of practitioners of all qualifications (N=145), had only sometimes referred victims or not at all (Table 12).

Table 12. Frequency of referral of domestic violence victims by ECP's, 2006.

Qualification	Referral always		Referral sometimes or not at all		Total	
	n	%	n	%	N	%
ECP Basic	13	22	46	78	59	41
ECP Intermediate	17	25	52	75	69	48
ECP Advanced	2	12	15	88	17	11
TOTAL	32	A%	113	B%	145	100

Chi-Square, $p = 0.5183$

During the previous six months, 74% (N=145) of respondents reported having referred domestic violence victims either always or sometimes. Of these, 57% (n=73, N=128) stated that their last referral was a few months ago (Figure 5).

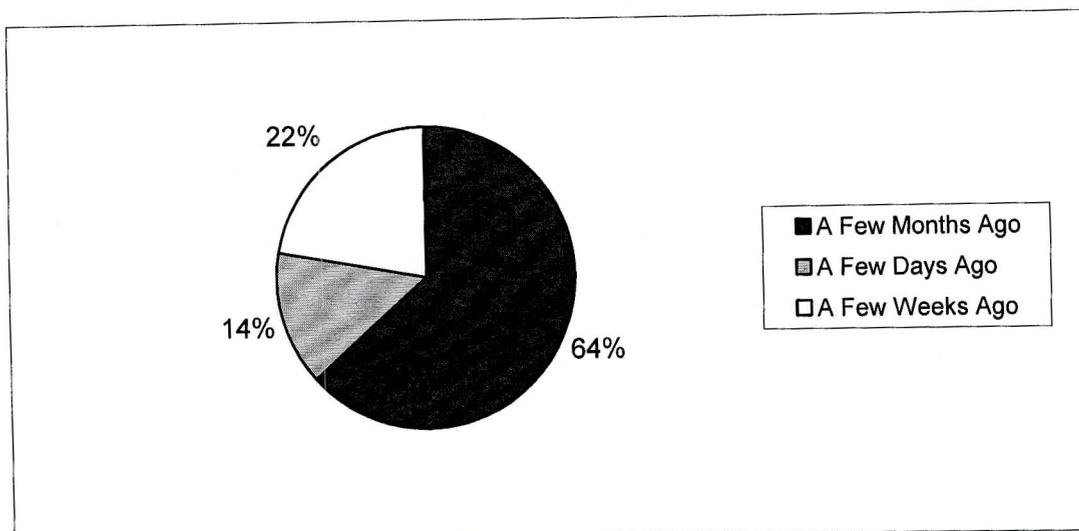


Figure 5. Most recent referral of victims of domestic violence by Emergency Care Practitioners in the Western Cape, 2006 (N=128).

A further analysis of qualification and the last referral is presented in Table 13 below. No association was found between qualification and last referral (Chi-Square: $p > 0.05$).

Table 13. The last time period of ECP referral of a domestic violence victim in the Western Cape by qualification, 2006 (N=128).

Qualification	A few days ago		A few weeks ago		A few months ago		Total	
	%	n	%	n	%	n	%	n
ECP Basic	12	6	30	15	58	29	39	50
ECP Intermediate	17	10	32	19	51	31	47	60
ECP Advanced		0	28	5	72	13	14	18
Total	13	16	30	39	57	73	100	

Further more, only 20% (N=148) of practitioners in this study would refer victims to a clinic or hospital and 31% would refer to the police or courts. A referral telephone number or referral address was only known by 19% (n=27).

4.3 OBJECTIVE 3: PROPOSED GUIDELINES FOR THE DESIGN AND DEVELOPMENT OF A PREHOSPITAL MEDICAL PROTOCOL FOR THE EMERGENCY INTERVENTION OF DOMESTIC VIOLENCE BY THE ECP

4.3.1 ECP's reflection on domestic violence training in EMS training

With regard to the extent EMS training had prepared ECP's for dealing with domestic violence, only 5% reported it was more than adequate, 14% reported adequate preparation, 44% reported it was not adequate, and 37% of the 145 respondents reported that training did not prepare them at all for managing domestic violence (Figure 6).

Of 154 respondents, 81% of the practitioners could not answer as to what domestic violence training they had received.

An open-ended question on causes of domestic violence showed that 42% attributed it to alcohol and drug abuse, and 38% (n=43) believing the cause to be a combination of alcohol and drugs, the nature of the society, and mental illness.

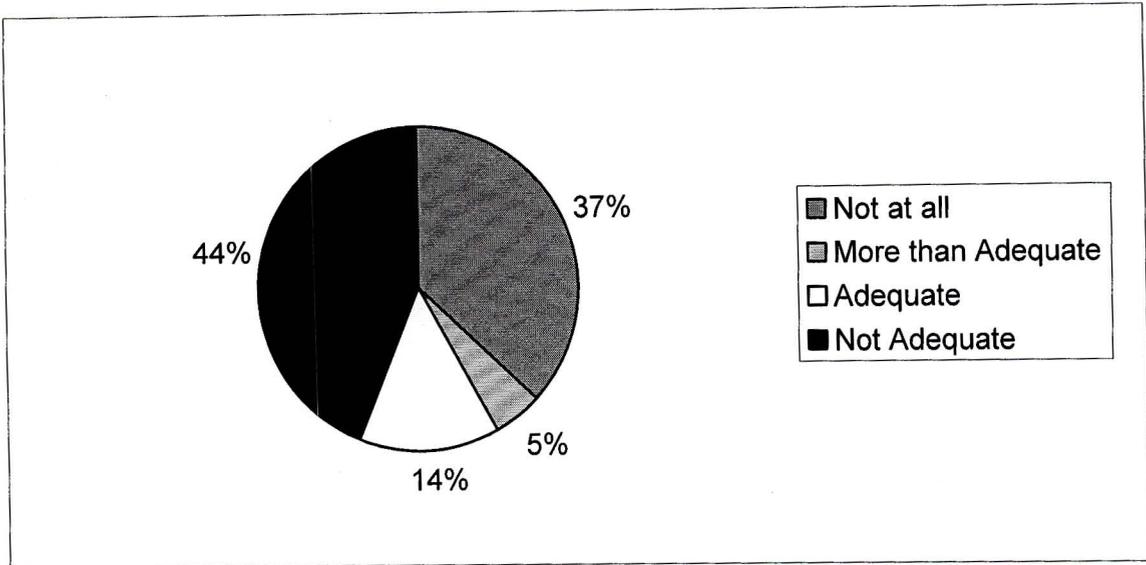


Figure 6. ECP's perception of training having prepared ECP's in the Western Cape to manage domestic violence, 2006 (N=145).

4.3.2 Current ECP's treatment of domestic violence victims

The current practical treatment by ECP's of domestic violence victims were analysed according to treatment upon arrival, during assessment and medical management. This was assessed against the international best practice guidelines evidenced in the literature review and the general standards of ethical medical practice of the HPCSA PBECP.

4.3.2.1 Current ECP's treatment of domestic violence victims upon arrival at a domestic violence scene

The treatment was found to be unacceptable by 70% of 115 ECP's upon arrival at a domestic violence scene, 79% of 115 ECP's during assessment of a victim and by 81% of 112 respondents for medical management. Treatment of victims upon arrival at a scene was also matched with qualification

[Chi-Square ($p = 0.0764$)]. Of those 44 ECP's who had ECP Basic qualification, 18% ($n=8$) had treated acceptably (upon arrival at a scene); compared to those ECP's who had an Intermediate qualification, of whom 37% ($n=22$) had treated acceptably; compared to those ECP's who had an Advanced qualification, 42% ($n=5$) had treated acceptably.

4.3.2.2 Current ECP's treatment of domestic violence victims during patient assessment

No association could be found between qualification and treatment during patient assessment (Chi-Square: $p = 0.1606$). However, ECP's of all qualifications had documented only 21% ($n=24$) acceptable assessment practice. Ninety-one respondents (79%) documented unacceptable assessment practice.

4.3.2.3 Current ECP's treatment of domestic violence victims during medical management

A significant association, however, was reflected between qualification and medical management of victims (Chi-Square: $p = 0.0157$). Of 41 Basic ECP's, 5% had acceptable management; compared to 28% of 58 Intermediate ECP's who had acceptable management; compared to 23% of 13 Advanced ECP's who had acceptable management of domestic violence victims (Figure 7).

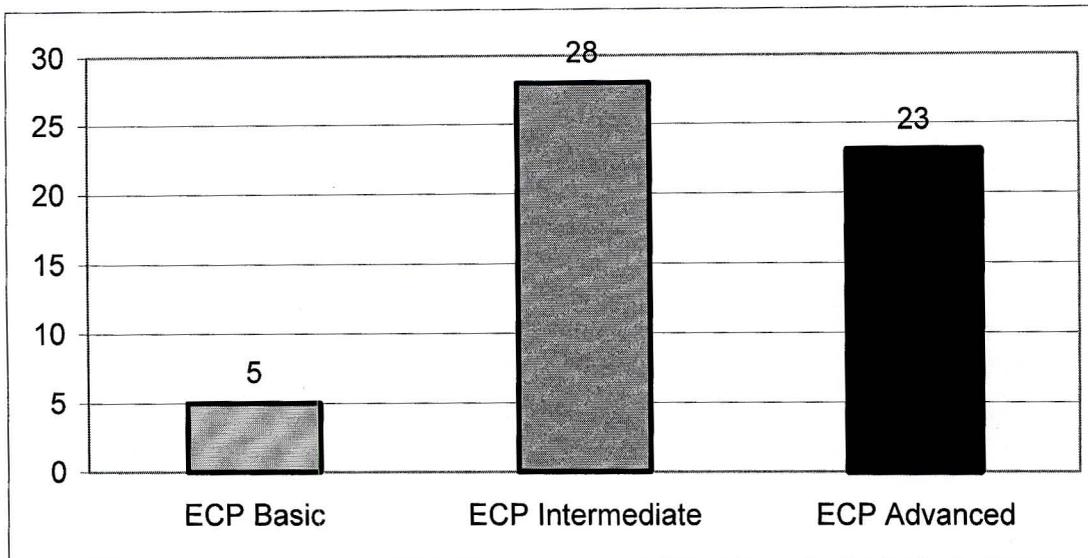


Figure 7. Percentage of ECP's in the Western Cape with acceptable medical treatment of domestic violence victims by qualification, 2006 (N=112).

4.3.3 Needs of ECP's regarding domestic violence

Forty nine percent of Emergency Care Practitioners that responded here (n=44) suggested that more training and sensitivity for early identification of victims was needed and that this was not currently happening in EMS. Nineteen percent (n=17) identified information dissemination and support as lacking in the current EMS modus operandi.

4.4 RESULTS SUMMARY

In summary, the first objective- to evaluate the knowledge, attitudes and beliefs of ECP's- reveals the level of understanding of the problem of domestic violence for this group of health care professionals is severely lacking.

There is harbouring of myths and other potential barriers to the implementation of a pre-hospital protocol for domestic violence management. The hypothesis that the ECP practice contributes to inadequate safety assessments and only superficial management of victims of domestic violence was supported in this study. The second objective analysed reveals there is inadequacy of current ECP practice with respect to domestic violence crisis intervention. Objective 3- to present guidelines for the emergency intervention of domestic violence- is fulfilled in the results and in the following discussion. It is not borne out of raw results, but by inference and rational conjecture based on these results as well as the literature review.

Fundamentally, the current training is inadequate to meet the needs of victims of domestic violence, and therefore, more training- with specific intervention content, context and methodology- is required.

CHAPTER 5

5.0 DISCUSSION

The following discussion addresses deficiencies in the body of knowledge about domestic violence and the ECP. It also reflects on the purpose and hypothesis of this study. Data strengths and weaknesses are also presented followed by directions for future work in this area of research.

5.1. DEFICIENCIES IN THE BODY OF KNOWLEDGE

It is accepted that health personnel have an integral role to play in domestic violence situations (Saunders, 2001). In the context of primary health care, this role involves primary prevention, early detection and risk assessment, and responsive treatment.

In South Africa, there exists no research into the ECP's role regarding domestic violence. This is not surprising when one considers that adequate means of assessment of prehospital care in general has not yet evolved as the complexity and number of variables make indicator development difficult (MacFarlane and Benn, 2003). Much has been written about the response of the police, courts and social workers to victims of abuse, but none of the literature includes ECP's as first responders. Even a study on '*Violence against women in Metropolitan South Africa: Impact and Service Delivery*' (Bollen *et al.*, 1999) neglects to mention ECP's as role-players. It does however find that emergency rooms,

clinics and district surgeons require a change in attitude and greater sensitivity. Sugg *et al.* (1999) assessed the attitudes and beliefs of the primary care provider team (physician, physician assistants, nurses, and medical assistants) toward the identification and management of abused patients and perpetrators of domestic violence. The results of this urban study showed that these primary care providers did not have appropriate attitudes, practices, and beliefs toward the early diagnosis and management of domestic violence victims. No previous study, speaks to the knowledge, attitude and beliefs of emergency care practitioners to victims of domestic or any other type of abuse in South Africa.

An epidemiological perspective on domestic violence appears to be lacking amongst ECP's. Less than half could correctly define domestic violence. There was no unanimous support for 'truths' about abuse. Instead there was also no unanimous disagreement with 'myths' about abuse. Significant non-responses to some pertinent questions probing knowledge suggest the absence there-of. There appears to be poor identification, referral and treatment of victims. The possible explanation for this is the lack of training of practitioners as domestic violence interventionists. The motivation for training is highlighted by the deficiencies highlighted above. Further, the respondents represent a microcosm of the patriarchal society and in the absence of sensitisation, are likely to purport dominant societal paradigms. The high exposure to violence also has the risk of normalizing it. The EMS system has no effective methodology in addressing abuse, and is rather reactive in approach. The ECP curriculums do not give adequate expression to issues such as violence, with

exception to treatment of the critically ill. The health care worker may respond to abuse in a number of ways. He/ she may present as a rescuer, persecutor or facilitator. The former is self-limiting, and where there is non-imminent danger it is in-fact disempowering – as is blaming or ‘persecuting’ the victim. The latter is appropriate, as it does not lend itself to secondary abuse by the ECP.

Traditionally, the role of the ECP has been that of rescuer. The insidious nature of domestic violence implies that overt physical violence is not always apparent and represents advanced length of abuse. Saunders (2001), in a South African continuous medical education journal, recommends to primary care providers to increase awareness, screen routinely, build trust, document diligently, treat associated complications, assess for safety and refer responsibly.

5.2.PURPOSE/ HYPOTHESIS ADDRESSED

The purpose of this study was to investigate the attitudes and beliefs of Emergency Care Practitioners (ECP’s) to victims of domestic violence in the Western Cape, in order to inform the development of a pre-hospital protocol for the early risk identification and medical management of victims in the pre-hospital environment. The purpose has been achieved. It was hypothesized in chapter one, that the perceptions of Emergency Care Practitioners are fraught with myths and other untruths that are not conducive to effective and holistic management of victims of domestic violence. This has been proven. It was hypothesized that the responses of Emergency Care Practitioners contribute to further dis- empowerment, inadequate safety assessments and only superficial

management of victims of domestic violence. This too, has emerged in this study.

It was hypothesized that the development of a pre-hospital medical protocol and training will empower Emergency Care Practitioners to respond appropriately in terms of crisis intervention and referral and thereby meet the emergency and other needs of Domestic Violence Victims. This is congruent with the results of this study. The harbouring of myths as a potential barrier to the implementation of a pre-hospital protocol for domestic violence management was identified. When qualification was cross-referenced with knowledge of domestic violence laws, no significant correlation could be found (Chi-Square: $p > 0.05$). This implies that an ECP's qualification may not be a predictor of his/her legal knowledge about abuse, or that the EMS training attained did not inform the presence or lack of domestic violence knowledge prior to the training. When one considers that 89% (N=154) of respondents said there was no - or did not know of any - special handling of domestic violence calls, in terms of call taking, dispatch and response in EMS; this implies that neither the practitioner nor the communications centre may be responsive to victims of domestic violence. The inadequacy of current ECP practice with respect to domestic violence crisis intervention is now documented and serves as a starting point for the design and development of a pre-hospital medical protocol and curriculum for the emergency intervention, safety assessment and appropriate referral of domestic violence victims for the Emergency Care Practitioner.

5.3. DATA STRENGTHS AND WEAKNESSES

5.3.1 Demographic representivity

The sample represented more than half (58%) of the operational metropole population (154 of 266). In terms of qualification, the percentage of ECP Basic practitioners in the metropole and in the sample was 35% and 40% respectively. For ECP Intermediate practitioners it was 52% and 47% respectively. The proportion of ECP advanced practitioners was equal at 13%. The differences in gender representation in the metropole and in the sample was 85% and 67% respectively for males and 25% and 33% respectively for females. With regards racial representation, the metropole population of White, Coloured, Indian and Black ECP's stood at 7%, 69%, 4.5% and 19.5% respectively. This compared with a sample representation of 22% White ECP's, 57% Coloured ECP's, 1% Indian ECP's and 20% Black ECP's. The above suggests a representative sample in terms of race, gender and qualification ($p=0.0001, 0.0001, 0.0309$ respectively).

The generalisability of the study outcome to the rest of the province, is confounded by the historical resource inequity and therefore even poorer accessibility of care in the rural areas. The qualifications however, were all undertaken in the metropole, and their ineffectiveness in providing capacity for domestic violence intervention is an outcome of this study.

Difficulty was experienced in attaining a higher return rate. This necessitated repeat visits and repeat explanations of the study purpose. The primary reasons for non-return of the questionnaire, were indifference and the perception that no feedback would be forthcoming (as was the experience with previous studies by other researchers on other topics using the same sample population).

5.3.2 Selection bias

While it is acknowledged that some Emergency Care Practitioners function in emergency departments, the emphasis of this study was on those in the pre-hospital field. This is understandable as these environments differ widely and the emergency room was not an intended field of this study, due to the difference in resource availability and the quest for specific data collection. The majority male population of ECP's was addressed by including all ECP's in the chosen locale. Even though proportionate random sampling could be selected for its relative ease, speed and accessibility, this is logistically difficult as it is affected by non-participation, shift-work, differing level of skill and group dynamics. One did not wish to exclude the female minority of ECP's that was the risk of sampling. As the areas in which ECP's work differ in geography, demography and sociology, all Emergency Care Practitioners were issued questionnaires and accompanying letters (see appendix).

5.3.3 Information bias

To reduce the risk of information bias, in terms of the literature review, a broad

spectrum of literature- both national and international- has been considered. Only literature that has scientific or legal basis was considered. The data and opinions are recent and compared with previous data. Violence is understood to affect both men and women, whomever the perpetrator. The end point of this study was the ECP's realisation of the basic human right to appropriate health care for all victims of domestic violence. The research tool had a choice and freedom of responses for all questions and was not meant to be leading.

5.3.4 External validity

The Chairman of the HPCSA PBECP, a content expert from the MRC, and both research supervisors had examined the questionnaire for validity. At face value, it appeared to address the research question. The content of the questions is specific to the ECP's work structure, process and purpose and are congruent with the ECP's ability to respond.

The data has revealed associations between qualifications and definition, screening and management of domestic violence victims. As qualifications determine the scope of practice, this has been a focus in the data analysis. For example, ECP Basics are more likely to define domestic violence incorrectly whilst advanced ECP's are less likely to do so. The limitation of this study is that it does not fully explore race and gender biases of the practitioners. This is deliberate, as biases that preclude appropriate treatment are best explored in training for ethical and educational reasons. Another limitation is that the study does not provide the ECP's or other health care users qualitative experience of ECP intervention.

5.4. DIRECTIONS FOR FUTURE WORK

It is established that ECP's are well focused on the critically ill and injured. What is required is an emphasis on the primary prevention and early detection of domestic violence at a strategic and operational level in the EMS. There is a need for specific domestic violence and crisis intervention training for the communication centre and field personnel, including management and educators. Another pertinent finding of Bollen *et al.* (1999) was that "education is the key in changing belief systems and educing violence against women". Service providers are amongst the target groups for education. Also suggested here for emergency clinics and hospitals, is the need to lengthen service hours and improve environment.

The ambulance is de facto an extension of the emergency department and works 24 hours a day. Training programmes must aim to improve attitudes for more compassion and to be non-judgmental. Any protocol must enhance confidentiality and efficiency as well as screening. Staff resources and working conditions must also be improved. Treatment must be gender sensitive by prevention of secondary abuse, provision of a female examiner, moving away from a clinical approach and asking questions after medical care has been administered (Bollen *et al.*, 1999).

With increasing specialization come gaps in health care. Sakr and Wardrope (2000) suggest we must start to plan now to develop the broad skills and

experience we need. As specialists in emergency medicine, ECP's must not specialize to the extent that they are no longer available to women and children who are in abusive situations. Monitoring and evaluation of training and interventions must also be undertaken in the interest of quality. The HPCSA or the EMS should provide a domestic violence protocol for ECP's to be guided by. A network should be established between the EMS and the receiving facilities and service providers to ensure continuity of care and easy referral. Finally, ECP's should be debriefed routinely to avert critical incident stress.

Early detection of domestic violence provides a critical opportunity for disclosure of it and allows a woman and her health care provider the chance to develop a safety plan to protect her safety and improve her health. The efficacy of early identification and intervention of health care needs - in general - is supported by experiences with HIV/AIDS, smoking cessation, breast cancer and cardiovascular disease. The evaluation of any EMS intervention remains to be documented. New intervention strategies need to be tested in the pre-hospital environment. The health, social and economic costs of domestic violence requires equivalent attention and equally effective actions by the health system, of which the EMS is an integral role-player. Any practice that does not encourage early detection and intervention would reduce health care practitioners to tertiary role-players only and in so doing, miss invaluable opportunities and underutilise an accessible resource.

5.5 SUMMARY

There are large deficiencies in the knowledge around South African EMS culture and capacity- enough to warrant a study of this nature. The purpose and hypothesis of the study have been addressed. There are controls for validity and reliability. The study has shown that, by the practitioner's own admission; the current knowledge around domestic violence is insufficient for the National health-care mandates that ECP's carry, despite reasonable exposure to patients. Also, belief in myths and incorrect causes of abuse signals an attitude that is incongruent with effective domestic violence intervention. The screening, treatment and referral of victims of domestic violence by ECP's are not in line with international best practice guidelines. In fact, it is severely lacking. The need therefore exists to empower ECP's at an individual, organisational and regulatory level with regards domestic violence intervention in South Africa.

CHAPTER 6

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

The sample was representative of the metropole and of the Provincial EMS. The attitudes and beliefs of Emergency Care Practitioners elicited from this study suggest a poor level of understanding of the problem of domestic violence. Only 49% of respondents could define domestic violence. ECP qualification was associated with domestic violence definition in that ECP basics were more likely to define incorrectly than their advanced counterparts. 81% of respondents recognised less than thirty domestic violence calls in six months. There is a probable low detection rate amongst the majority of ECP's.

There is harbouring of myths that may confound the implementation of a pre-hospital protocol for domestic violence management. There is an inadequacy of current ECP practice with respect to domestic violence crisis intervention with regards screening, management and referral. The majority of ECP's (89%) experienced no special handling of domestic violence victims. No significant correlation could be found (Chi-Square: $p > 0.05 = 0.2298$) between qualification and knowledge of domestic violence laws. An ECP's qualification is no predictor of his/her legal knowledge about abuse. Qualification could also not be positively correlated with the referral of victims, although the majority of

practitioners of all qualifications (78%), had only sometimes referred victims or not at all.

6.2 RECOMMENDATIONS

The recent Multi-country study on Women's Health and Domestic Violence against Women, by WHO (2006) reflects that the wide variations in prevalence and patterns of violence from country to country, and, even more important, from setting to setting within countries, indicate that there is nothing "natural" or inevitable about it. *"Attitudes can and must change; the status of women can and must be improved; men and women can and must be convinced that partner violence is not an acceptable part of human relationships"* (WHO, 2006).

The WHO (2006) report recommends:

Strengthening national commitment and action

- Promoting primary prevention
- Involving the education sector
- Strengthening the health sector response
- Supporting women living with violence
- Sensitizing criminal justice systems
- Supporting research and collaboration

For the EMS systems in South Africa, this translates to National Department of Health commitment, HPCSA intervention, and the adoption of an ecosystemic

view to medicine; ECP educational programmes that support intervention, and responsible referring.

With regard to the WHO recommendation to develop a comprehensive health sector response to the various impacts of violence against women: guidelines for the design and development of a pre-hospital medical protocol for domestic violence victims for the Emergency Care Practitioner are best summarised in a publication by Martin and Jacobs (2003): "*Screening for Domestic Violence: A Policy and Management Framework for the Health Sector*", which appears in the Appendix. The EMS response to domestic violence should be congruent with that of the health sector and should include universal screening (asking about domestic violence routinely); comprehensive physical and psychological care for those patients who disclose abuse; a safety assessment and safety plan; the documentation of past and present incidents of abuse; the provision of information about patients rights and the domestic violence act; and referral to resources (Martin and Jacobs, 2003).

A protocol/ curriculum guiding the behaviour of ECP's in domestic violence situations is urgently needed and is the responsibility of both the EMS as a Department of Health functionary, and the HPCSA as regulator. The components of an ECP protocol/ curriculum should include the definition and dynamics of domestic violence; the clarification of any legal requirements for health workers; screening and management guidelines (Figure 8); intervention strategies; the procedure for collection of evidence and medical record

documentation; safety assessment and planning guidelines; and referral information (Martin and Jacobs, 2003).

The WHO (2006) recommendations inform the content of ECP education in so far as domestic violence is concerned. The health sector, and by representation- the EMS, needs to find ways to ensure that:

- (a) Women who have experienced violence are not stigmatized or blamed when they seek help from health institutions.
- (b) Women will receive appropriate medical attention and other assistance.
- (c) Confidentiality and security will be ensured.
- (d) Training should aim, among other things, to ensure that providers are appropriately sensitised to issues of abuse, treat women with respect, maintain confidentiality and do not reinforce women's feelings of stigma or self-blame, as well as being able to provide appropriate care and referral as needed.
- (e) Research on the causes, consequences, and costs of violence against women and effective prevention measures, is supported.

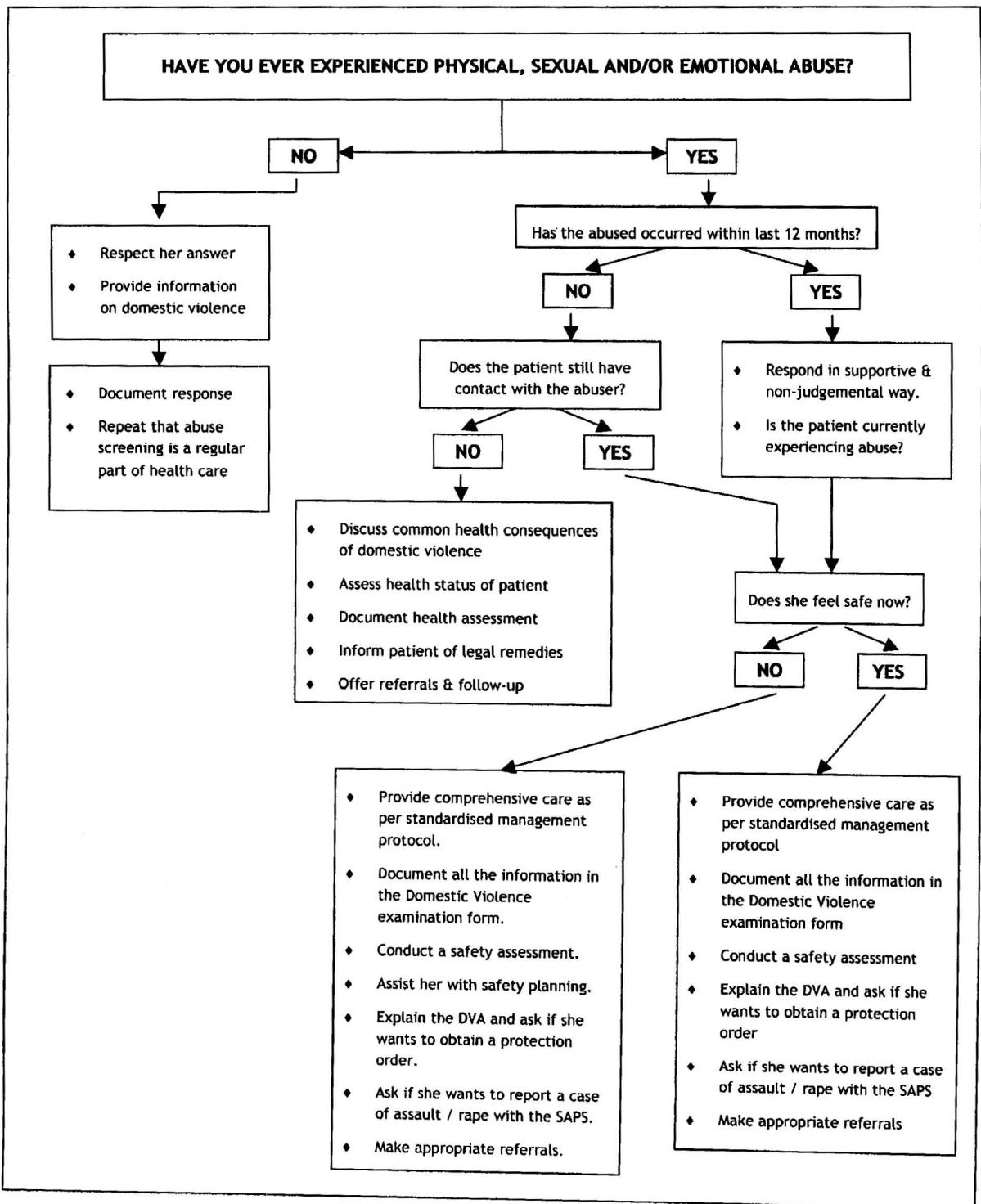


Figure 8. Universal screening protocol for domestic violence

(Adapted from: Martin and Jacobs, 2003)

6.2.1 Screening for domestic violence in the primary and emergency care environments

6.2.1.1 Who should be screened for domestic violence?

All females aged fourteen years and older should be screened for domestic violence. Men of any age may also be screened, based on the ECP's index of suspicion. Abuse and neglect of children may also suggest incidence of domestic violence.

6.2.1.2 Who should screen for domestic violence?

Screening should be conducted by an ECP who has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency. The ECP must have been trained on how to ask about abuse and to intervene with identified victims of abuse. Of course the ECP must also secure the opportunity to speak to the patient in a private setting to maintain trust and confidentiality. The ECP curriculum should emphasise the particular nature and treatment of domestic violence, as concertedly as it does myocardial infarctions and CPR. Educational facilitators and managers in EMS need to be sensitized to the magnitude of the problem.

At the service level, responses to violence against women should be integrated into all areas of care (e.g. emergency services, reproductive health services such as antenatal care, family planning, and post-abortion care, mental health services, and HIV and AIDS-related services) [WHO, 2006]. The EMS should

no longer undermine its life-saving role in primary prevention and early detection. To this end, paradigm shifts in management and education of ECP's towards domestic violence intervention must occur and should include the content detailed below.

6.2.1.3 How should screening occur?

The universal screening protocol (Figure 8) was aimed at a health facility. The emergency service vehicles are de-facto mobile health facilities and ECP's may therefore legitimately use this tool to guide screening and management.

Screening for abuse over the past year should occur at every trauma emergency call. For non-trauma calls, patients should be screened for any domestic violence that occurred anytime in their lives. Screening should occur as part of routine health history taking or during a review of systems. It should be a standard part of a health assessment, but particularly important in cases of new chief complaints and new intimate relationships.

During a face-to-face health care encounter, the ECP must be direct and non-judgmental. Screening must take place in private, where no friends or relatives of the patient are present. Preferably, no children over two should be present as they pose a risk to confidentiality. Patients should be told of the confidentiality of the conversation and also told of the limits of that confidentiality. Ideally, screening for domestic violence should also be included as part of a written health questionnaire and in the patients primary language.

The EMS communication centre in the EMS has the technology to facilitate telephonic screening, more appropriate dispatch, appropriate referral, and even telephonic crisis intervention. The call centre operators, however, do need capacity in terms of domestic violence crisis intervention skills.

6.2.2 Documenting domestic violence

As a result of routine screening, patients may disclose domestic violence. These patients must be assessed as soon as possible and the findings documented on a specific domestic violence examination form (see appendix). ECP's must remember to believe victims testimony and to respond correctly and with dignity.

The examination form is a confidential medical record and must be treated as such. Where applicable, the exact words of the patient must be documented, as must be the identity of the offender and his relationship with the patient. All history of abuse as well as the presenting complaint must be documented. Using the body chart on the form, all injuries with dates and its nature should be documented.

6.2.3 Safety assessment

A safety assessment must be done for all patients who disclose domestic violence. Continued exposure to the violence may place the patient in grave danger. If the patient feels unsafe, referral to the Police may be prudent. If the

patient is uncertain, establish the following and then facilitate the development of a safety plan:

- Has the violence increased?
- Does the perpetrator use alcohol and drugs?
- Has the perpetrator threatened to kill her/ him?
- Does the perpetrator have access to weapons?
- Is the patient afraid to go home?
- Has the patient/perpetrator thought about killing herself/ himself?

6.3 THE WAY FORWARD

6.3.1 Status quo explained

This study provides important information about current knowledge, attitudes, and beliefs of health care practitioners in the Western Cape EMS toward the understanding, diagnosis, and management of domestic violence. This serves as a premise for intervention strategies. As the Department of Health has embarked upon a revitalization strategy for Emergency Medical Services nationally, the current time may be prudent to encourage domestic violence intervention by the EMS.

6.3.2 Ecosystemic process

The process to achieve the above, suggested by WHO (2006), is an ecosystemic approach to domestic violence intervention by the EMS. This implies that any intervention aimed at an individual should be simultaneous with

the interventions aimed at the context or environment in which the individual operates.

The macrosystem involves the culture of violence in the society and the organisational culture of the EMS concerned. The exosystem interventions are aimed at the community in which there is an increase in violence, and where there is an absence of support systems. Microsystems requires particular focus as this has to do with the interpersonal relations, in terms of personal relationships, co-workers on an ambulance, co-students in training, patients, instructors, emergency medical dispatchers, doctors and administrative staff. The link between exosystems and microsystems is the mesosystem. This involves the inputs such as protocols, logistics, communication technology, emergency calls, salaries, power and status, and peer comradery. Lastly, interventions must also address ontogenetic development of the ECP, the manager, the individuals needs, values, past experience, personality traits, perceptions of gender and coping strategies (Rundell, 1994).

6.3.3 Research and quality improvement of interventions

The output of the above strategy is based on the implementation and application of universal screening. The efficacy of universal screening for domestic violence, particularly in the Western Cape, is an area for potential research. Training programmes too must be evaluated for validity and effectiveness. What is likely to inform the success of universal screening is the mindset change of EMS managers, educators and operational crew alike, but

this is only sustainable if the ecosystemic strategy is pursued. Therefore, key to its effectiveness is the level of training on domestic violence, EMS and hospital support and continuity. Programmes must be sustained to ensure continuous professional development.

6.3.4 Screening protocol endorsed

The endorsement and application of the “*Screening for Domestic Violence: A Policy and Management Framework for the Health Sector*” (Martin and Jacobs, 2003) is congruent with the recommendations by the WHO *Multi-country study on Women’s Health and Domestic Violence against Women* (2006) and is strongly recommended for application by all the Emergency Medical Services of South Africa. Non-compliance with such a protocol must be deemed to be unprofessional conduct of the individual by the EMS concerned as well as by the HPCSA PBECP. The complex and dynamic nature of EMS lends itself to the successful implementation of domestic violence screening.

6.3.5 Opportunity to intervene

The reality that Emergency Care Practitioner’s work in the settings where domestic violence is perpetrated, allows a perspective on screening, second only to the patient’s experience of abuse. This level of exposure may have the inherent risk to ‘normalise’ the occurrence of abuse and condone the subsequent EMS non-response, or it could be used as a unique opportunity to break the cycle of domestic violence by early detection, appropriate care and responsible referral.

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APPENDICES

APPENDIX 01 A: PGWC- EMS APPLICATION FOR CONSENT

APPENDIX 01 B: PGWC- EMS APPROVAL DOCUMENT

APPENDIX 02: UKZN INSTITUTIONAL ETHICS APPROVALS

APPENDIX 03: INFORMATION GIVEN TO PARTICIPANTS

APPENDIX 04: INFORMED CONSENT DOCUMENT

APPENDIX 05: RESEARCH QUESTIONNAIRE

APPENDIX 06: PROPOSED SCREENING QUESTIONNAIRE AND PATIENT
EXAMINATION FORM

APPENDIX 01 A: PGWC- EMS APPLICATION FOR CONSENT

18 Forel; Street

Soneike

Kuils River

7580

14 November 2005

Dr. C. Robertson

Director: EMERGENCY MEDICAL SERVICES-PGWC

Dear Sir

Re: REQUEST FOR AUTHORITY TO CONDUCT RESEARCH AMONGST EMS METROPOLE PERSONELL

In part fulfillment of a Masters Degree in Public Health (UKZN), I am conducting research entitled: **Knowledge, Attitudes and Beliefs of Emergency Care Practitioners to victims of Domestic Violence in the Western Cape**. I kindly request authority from your good office to conduct the above research amongst the EMS personnel in the Metropole, using a questionnaire.

Preventing violence against women is a National Government prerogative, and therefore also an area of work for the Academy of Emergency Care and the Provincial Government- Western Cape. Emergency Care Practitioners are often first responders to primary or secondary domestic violence calls. Our response in this regard is untested. The study aims to identify current practice of domestic violence intervention and identify training needs. This study asks for honest responses regarding your personnel's experience in this regard. All responses will be treated confidentially. Should any respondent experience any discomfort or risk by answering the questionnaire, interventions in this regard are available. Questionnaires will be submitted in a self-addressed envelope together with a contact details page to the research coordinator at the particular base. The coordinator will use the contact details page for control purposes, to

check respondents need to be re-contacted and will not be handed to the researcher. All data will be treated as confidential and anonymous.

Please note that The University of KwaZulu-Natal Ethics Committee as well as Mr. L. D. Christopher, the Head of the EMC Programme Emergency Medical Care, has granted protocol approval for this study (Reference: H247/05), pending your authorization. Should you have any concerns, please contact Ms. Borresen of the Ethics Committee (Tel:031- 2604495 or e-mail: borresen@ukzn.ac.za), or myself. The questionnaires will be self-administered, issued at the beginning of shift and collected before the end of shift, and is not expected to interfere with normal operations. Should you grant authority, I will appreciate your notification of the metropole managers to facilitate progress, and extend my sincere gratitude. The study will commence upon your granting of authority and notification of the University Ethics Committee. I eagerly await your response.

Yours faithfully

.....

Mr. Navindhra Naidoo

Cc. Mr. A. Ahmed, Regional Manager, Metropole EMS

Cc. Mr. P. Papu, Operations Manager, PGWC EMS

APPENDIX 01 B: PGWC- EMS APPROVAL DOCUMENT



Departement van Gesondheid
Department of Health
iSebe lezeMpilo



Reference: CCR/tlg
Enquiries: Dr Cleeve Robertson

Mr Navin Naidoo
Lecturer: N.Dip: Emergency Medical Care Program
Cape Peninsula University of Technology
Academy of Emergency Care
TYGERBERG HOSPITAL

Dear Mr Naidoo

REQUEST FOR AUTHORITY TO CONDUCT RESEARCH AMONGST EMS METROPOLITAN PERSONNEL

Thank you for your letter dated 14 November 2005 requesting permission to conduct research on the knowledge, attitudes and beliefs of Emergency Care Practitioners to Victims of Domestic Violence in the Western Cape.

Permission is hereby given and enthusiastic support provided with the proviso that:-

- confidentiality is maintained.
- the research is processed through the appropriate Research and Ethics Committees of the University.
- the results are shared with the Department of Health before the research is published.

I will issue notice to the Metropolitan Management in order to solicit the support you require.

Yours faithfully

DR CLEEVE ROBERTSON
DIRECTOR: EMERGENCY MEDICAL SERVICES

Date: 14 November 2005

CC Mr A Ahmed, Regional Manager, Metropole

Directorate: Emergency Medical Services
Private Bag X24
Bellville
7535

Office: +27 21 948 9908
Fax Number: +27 21 948 9909
Email: croberts@pgwc.gov.za

APPENDIX 02: UKZN INSTITUTIONAL ETHICS APPROVALS



25 October 2005

Mr N Naidoo
18 Forel Street
Soneike
KUILSRIVER
7580

e-mail : naidoon@cput.ac.za

Dear Mr Naidoo

PROTOCOL: Knowledge, attitudes and beliefs of emergency care practitioners to victims of domestic violence in the Western Cape. N Naidoo, Community Health. Ref.: H247/05

The Postgraduate Education Committee considered the abovementioned application and the protocol is approved for your MPH degree.

Please note that the study may not begin without ethics approval – a copy of which must be submitted to this Committee.

May I take this opportunity to wish you every success with your study.

Yours sincerely

PROFESSOR M ADHIKARI
Chair : Postgraduate Education Committee

c.c. Dr S Knight, Community Health
Professor C C Jinabhai, Community Health
Mr S Siboto, Postgraduate Education

Nelson R Mandela School of Medicine, Faculty of Health Sciences, Medical Research Administration

Postal Address: Private Bag 7, Congella 4013, South Africa

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RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 - 2603587
EMAIL: ximbap@ukzn.ac.za

25 NOVEMBER 2005

MR. N NAIDOO (985205575)
FAMILY AND PUBLIC HEALTH MEDICINE

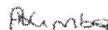
Dear Ms. Naidoo

ETHICAL CLEARANCE APPROVAL NUMBER : HSS/05204A

I wish to confirm that ethical clearance has been granted for the following project:

"Knowledge, attitudes and beliefs of emergency care practitioners to victims of domestic violence in the Western Cape"

Yours faithfully


.....
MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

APPENDIX 03: INFORMATION GIVEN TO PARTICIPANTS

INFORMATION DOCUMENT

Study title: KNOWLEDGE, ATTITUDES AND BELIEFS OF EMERGENCY CARE PRACTITIONERS TO VICTIMS OF DOMESTIC VIOLENCE IN THE WESTERN CAPE

Dear Emergency Care Practitioner,

I, Mr. Navindhra Naidoo, am doing research on the KNOWLEDGE, ATTITUDES AND BELIEFS OF EMERGENCY CARE PRACTITIONERS TO VICTIMS OF DOMESTIC VIOLENCE IN THE WESTERN CAPE. Research is just the process to learn the answer to a question. In this study, I want to learn about your current knowledge, attitudes, and beliefs towards victims of domestic violence. The study is being done to ascertain the current ECP knowledge, attitudes, and beliefs towards domestic violence so that it could inform any training plans in the future. This is also in part fulfillment of the requirements toward a Masters degree in Public Health (MPH) from the University of KwaZulu-Natal (UKZN).

You are invited to participate in this research study. What is involved in the study is for all emergency care practitioners in the Western Cape Metropole of the Emergency Medical Service (PGWC) to complete a simple questionnaire. Your involvement will be to answer questions relating to your attitudes, beliefs and knowledge of the management of domestic violence victims. Your responses should only take 10-15 minutes of your time. There should be no other costs to you, except your time. Approximately 350 ECP's are requested to participate in this study. My research assistant will administer the questionnaire at the commencement of your shift and will collect them at the end of your shift. You will be anonymous and all information is treated as confidential. For the sake of control and feedback to you only my research assistant will document

your contact details, but not on the questionnaire. Incomplete questionnaires will not be used in the study.

The benefit of being in the study is that your input may impact on the training of ECP's and on the manner in which victims of domestic violence, men and women alike, are treated by the emergency services. Your input will help determine what the strengths and weaknesses are in the management of domestic violence victims. You will be given pertinent information on the study after the results are available.

There is no obligation for you to participate. Participation is voluntary. You may choose to stop participation at any time, without prejudice, by informing the research assistant of your intention to withdraw. Should you experience any discomfort during the study, please contact myself or the research assistant for clarity or for referral to a specialist counselor. Anonymous telephone counseling is also available. Again, participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and that the subject may discontinue participation at any time without penalty loss of benefits to which the subject is otherwise entitled.

Efforts will be made to keep personal information confidential. Absolute confidentiality cannot be guaranteed. Personal information may be disclosed if required by law. Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the Research Ethics Committee. If results are published, this may lead to PGWC EMS ECP identification.

Contact details of researcher: **for further information or reporting of study related adverse events: Mr. Navindhra Naidoo, Private Bag X24, Bellville, 7535**

Telephone: 0219384118/ 0823372647

Fax: 021 9384269

E-mail: naidoon@cput.ac.za

Contact details of Research Ethics Committee administrator and chair – for reporting of complaints / problems: **Medical Research Administration**

Telephone: 031 2604495

Fax: 031 2604410

e-mail: ethicsmed@ukzn.ac.za

Chair: Professor A. Dhai

Telephone: 031 2604604

Fax: 031 2604410

e-mail: dhaia1@ukzn.ac.za

APPENDIX 04: INFORMED CONSENT DOCUMENT

Consent to Participate in Research

You have been asked to participate in a research study.

You have been informed about the study by Mr. Navindhra Naidoo.

You may contact Mr. Navindhra Naidoo at 021- 9384118/ 0823372647 at any time if you have questions about the research.

You may contact the Medical Research Office at the Nelson R Mandela School of Medicine at 031-260 4604 if you have questions about your rights as a research subject.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate.

Signature of Participant

Date

Signature of Witness

Date

Signature of Translator
(Where applicable)

Date

APPENDIX 05: RESEARCH QUESTIONNAIRE

**DEPARTMENT OF COMMUNITY HEALTH
NELSON. R. MANDELA SCHOOL OF MEDICINE
UNIVERSITY OF KWAZULU NATAL (UKZN)**

**MASTER OF PUBLIC HEALTH (MPH) RESEARCH PROJECT
RESEARCH QUESTIONNAIRE:**

**KNOWLEDGE, ATTITUDES AND BELIEFS OF EMERGENCY CARE
PRACTITIONERS TO VICTIMS OF DOMESTIC VIOLENCE
IN THE WESTERN CAPE**

PLEASE NOTE:

- 1. Please sign attached informed consent form before commencing.**
- 2. You will remain anonymous. Answering this questionnaire cannot identify you to the researcher.**
- 3. Please provide sincere answers.**
- 4. Mark the blocks of your choice with a cross (X) and provide brief explanations where requested. Choose only one block per question.**
- 5. Please complete all questions.**
- 6. Place completed questionnaires in envelopes, seal and convey to research assistant only, on day of administration.**
- 7. Contact details are only for control purposes and if need for feedback.**

**N.B.: TICK ONE BLOCK ONLY, UNLESS OTHERWISE STATED.
THANK YOU FOR YOUR PARTICIPATION**

DATE: _____ NOVEMBER 2005 TIME: _____

QUESTIONNAIRE NUMBER: A _____ B _____ C _____ D _____

RACE : WHITE _____ COLOURED _____ BLACK _____ INDIAN _____

1. INDICATE YOUR SEX.

MALE	FEMALE

2. INDICATE YOUR AGE GROUP.

< 25	25-29	30-34	35-39	40-44	> =45

3. STATE YOUR QUALIFICATION.

ECP BASIC	ECP INTERMEDIATE	ECP ADVANCED	OTHER QUALIFICATIONS

EXPLAIN OTHER

QUALIFICATIONS _____

4. IN WHICH GEOGRAPHICAL AREA OR DIVISION DO YOU MOSTLY WORK?

EASTERN	WESTERN	SOUTHERN	NORTHERN

5. WHERE DID YOU COMPLETE YOUR HIGHEST MEDICAL QUALIFICATION?

CAPE TECHNIKON CPUT	PGWC-EMS Before 2003	PRIVATE INSTITUTION	OTHER
			Name

6. WHAT IS THE LENGTH OF YOUR EMS EXPERIENCE?

0-1 YEAR	>1-5 YEARS	6-10 YEARS	11-15YEARS	>15 YEARS

7. HOW WOULD YOU DEFINE DOMESTIC VIOLENCE?

8. IN GENERAL, HOW MANY CALLS DID YOU RESPOND TO LAST MONTH?

< 50	50-74	75-99	100-124	125-150	>150

9. IN WHAT PERCENTAGE OF THESE RESPONSES DID YOU RECOGNISE THE PRESENCE OF DOMESTIC VIOLENCE?

<10%	<20%	<30%	<40%	<50%	<60%	<70%	<80%	<90%	<100%

10. IN THE LAST SIX MONTHS, HOW MANY CALLS DID YOU
RECOGNISE WERE DOMESTIC VIOLENCE CALLS?

NONE	1-10	11-20	21-30	>30

11. IN YOUR EXPERIENCE, **VICTIMS** OF DOMESTIC VIOLENCE ARE
MOSTLY...

MALE	FEMALE

11. IN YOUR EXPERIENCE, **PERPETRATORS** OF DOMESTIC
VIOLENCE ARE MOSTLY...

MALE	FEMALE

13. DO YOU AGREE WITH THE FOLLOWING STATEMENTS?

STATEMENT	YES	NO	SOMETIMES
1. Alcohol and drugs are the main cause of domestic violence.			
2. Abused women can leave home whenever they want to.			
3. Men who beat their wives are mentally ill and cannot control their violence.			
4. Domestic violence is a private matter.			
5. A woman who nags is asking to be abused.			
6. Physical abuse is worse than emotional abuse.			
7. Women who do not listen to their			

partners deserve to be abused.			
8. Only poor, uneducated and mostly black/coloured women are abused.			
9. Violence includes any controlling, abusive or fear-inducing act that threatens to harm the health, well-being or safety of a person.			
10. Violence and love cannot exist together in one home.			
11. Domestic abuse mostly includes violence against women.			
12. Women who are abused enjoy it or are mentally ill.			

14. DO YOU THINK THERE IS UNDER-REPORTING OF DOMESTIC ABUSE TO THE EMERGENCY MEDICAL SERVICE?

YES	NOT SURE	NO

WHY?

NO TELEPHONE AVAILABLE	IT IS NOT SEEN AS A PRIORITY BY THE VICTIM	IT IS NOT SEEN AS A PRIORITY BY THE CONTROL CENTRE	POOR HANDLING OF CALLS BY EMS	THE VICTIM IS ASHAMED TO CALL FOR HELP

OTHER _____

15. IS THERE ANY SPECIAL HANDLING OF DOMESTIC VIOLENCE CALLS, IN TERMS OF CALL TAKING AND DISPATCH AND RESPONSE IN EMS?

YES	DON'T KNOW	NO

IF YES, EXPLAIN:

16. ARE THERE ANY LAWS THAT AIM TO SUPPORT PEOPLE AGAINST DOMESTIC VIOLENCE?

YES	DON'T KNOW	NO

17. IF YES, PLEASE LIST THEM

18. IS DOMESTIC VIOLENCE DETECTION OR IDENTIFICATION IMPORTANT?

YES	NO	SOMETIMES

19. WHEN AND WHERE WOULD YOU DETECT DOMESTIC VIOLENCE IN THE PRE-HOSPITAL ENVIRONMENT?

20. DO YOU EXPERIENCE DIFFICULTY IN FINDING DOMESTIC VIOLENCE IN ROUTINE CALLS?

YES	NO	NEVER DIAGNOSED

IF YES, DO YOU EXPERIENCE DIFFICULTY BECAUSE...

THERE IS NO PRIVACY	YOU ARE UNCOMFORTABLE TO ASK ABOUT ABUSE	VICTIMS OF ABUSE ARE ASHAMED/ AFRAID TO ADMIT ABUSE	THERE IS NOTHING YOU CAN DO ABOUT ABUSE, ANYWAY	YOU DO NOT WANT TO GET INVOLVED IN A PRIVATE MATTER

OTHER

21. HAVE YOU REFERRED DOMESTIC VIOLENCE VICTIMS IN THE PAST 6 MONTHS?

ALWAYS	SOMETIMES	NOT AT ALL

22. WHEN WAS THE LAST TIME YOU REFERRED A DOMESTIC VIOLENCE VICTIM FOR HELP?

A FEW DAYS AGO	A FEW WEEKS AGO	A FEW MONTHS AGO

23. TO WHOM WOULD YOU REFER DOMESTIC VIOLENCE VICTIMS?

CLINIC/ HOSPITAL	POLICE/ COURTS	CRISIS CENTRES	WELFARE/ PSYCHOLOGIST	DO NOT REFER	RELIGIOUS GROUPS

OTHER _____

24. DO YOU KNOW OF A SERVICE PROVIDER THAT DEALS WITH DOMESTIC VIOLENCE, IN YOUR DIVISION?

YES	NO

25. IF YES, WHAT IS THE DOMESTIC VIOLENCE SERVICE PROVIDER EMERGENCY TELEPHONE NUMBER OR ADDRESS?

26. DID YOUR EMS TRAINING PREPARE YOU FOR DEALING WITH DOMESTIC VIOLENCE?

MORE THAN ADEQUATELY	ADEQUATELY	NOT ADEQUATELY	NOT AT ALL

27. SPECIFY WHAT DOMESTIC VIOLENCE MANAGEMENT TRAINING YOU HAVE HAD AND BY WHOM:

29. WHAT, IN YOUR OPINION, IS THE CAUSE OR CAUSES OF DOMESTIC VIOLENCE?

30. WHAT IS YOUR CURRENT PRACTICAL TREATMENT OF VICTIMS OF DOMESTIC VIOLENCE?

ARRIVAL _____

ASSESSMENT _____

MANAGEMENT _____

31. WHAT IS NEEDED IN THE TREATMENT OF DOMESTIC VIOLENCE VICTIMS THAT IS NOT CURRENTLY HAPPENING IN EMS?

END

**APPENDIX 06: PROPOSED SCREENING QUESTIONNAIRE, UNIVERSAL
SCREENING PROTOCOL, STANDARDISED MANAGEMENT GUIDELINES
AND PATIENT EXAMINATION FORM.**

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SCREENING FOR DOMESTIC VIOLENCE: A POLICY AND MANAGEMENT FRAMEWORK FOR THE HEALTH SECTOR

**Based on research conducted by the Consortium on Violence
against Women:**

Division of Forensic Medicine and Toxicology, University of Cape Town
Health Sector and Gender Violence Project
Institute of Criminology, University of Cape Town
Gender Project, Community Law Centre, University of the Western Cape
Rape Crisis Cape Town

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STRUCTURE OF THE REPORT

This document is intended to stimulate discussion towards developing and implementing policies and protocols to address domestic violence as part of a comprehensive health sector response. It is divided into five parts:

Part One: Introduction

This section introduces the conceptual framework for this research, and provides background to the development of this policy by the Consortium on Violence Against Women.

Part Two: Policy Framework for Domestic Violence

Part two sketches the context of gender-based violence and highlights the responsibility and opportunity that the health sector has to respond to this pervasive problem. Screening for domestic violence is explained and examined, and a proposed vision, objectives, service description and norms are set out. Requirements for monitoring and evaluation, training, equipment and budget allocations are set out.

Part Three: Sample Screening Form

This section provides an example of a screening questionnaire to be used within a health facility. It provides examples of indirect and direct screening questions, as well as a universal screening protocol.

Part Four: Management Protocol for a Health Facility

Part Four is an example of standardised management guidelines for disclosed domestic violence.

Part Five: Domestic Violence Examination Form

Part Five provides an example of a domestic violence examination form, and includes a report on the domestic violence examination, consent form, the history of the assault, body charts, special investigations, treatment plan, safety assessment and plan, referrals, and follow-up.

DEFINITIONS

The following definitions are used in this report:

Domestic Violence

For the purpose of this Policy the definition of domestic violence will be adopted from the Domestic Violence Act (Act 116 of 1998). According to this Act, domestic violence means any controlling or abusive behaviour that harms the health, safety or well being of the applicant or any child in the care of the applicant and includes but is not limited to-

- a) Physical abuse or threat of physical abuse;
- b) Sexual abuse or a threat of sexual abuse (any contact which abuses, humiliates, degrades or otherwise violates sexual integrity);
- c) Emotional, verbal and psychological abuse (including insults, name-calling, ridiculing, degrading conduct, threats to cause emotional pain, jealousy);
- d) Economic abuse (including not paying household necessities, bond or rent, selling/ giving away property);
- e) Intimidation (meaning making threats or sending threats);
- f) Harassment (watching, loitering, making phone calls, letters, packages, emails, faxes etc.);
- g) Stalking (meaning following and accosting);
- h) Damage to or destruction of property; or
- i) Entry into the applicant's residence without consent, where the parties do not share the same residence.

Health Workers

Refers to medical officers and professional nurses, unless otherwise stated.

Health Facility

Refers to all state health facilities from tertiary hospitals to primary health care clinics.

PART ONE

INTRODUCTION

Gender-based violence is the most pervasive form of abuse and a violation of essential human rights¹, yet it remains an undetected public health priority. Domestic violence, as one of the most common forms of gender-based violence, is often invisible; either directly when it happens in homes or indirectly, because criminal justice and societal systems have tended to treat it as a private matter and one that is normal².

Research by the Consortium on Violence Against Women³ has confirmed that domestic violence needs to be addressed as a public sector priority. They suggest that co-ordinated action and intervention by all sectors, including health, is required to ensure the effective implementation of the Domestic Violence Act (DVA). However, this research has also shown that the DVA has made dealing with domestic violence the responsibility of the criminal justice sector. However, health services often represent the point of first and only contact for women with public sector services. Abused women often interact with the health care system for routine or emergency care before turning to criminal justice or domestic violence services, thus placing health workers in a unique position to identify abuse and intervene. In spite of this, there is relative 'silence' with regard to the critical role that health has in relation to the DVA, and the essential part this sector should play in the management of domestic violence.

The Consortium's earlier research has provided a conceptual framework on which to build a response that maximises the potential of the health sector to assist in addressing domestic violence in South Africa. Key recommendations from the Consortium's research include the following:

- It must be recognised that the health sector has a critical role to play in the effective implementation of the Domestic Violence Act.
- There is a need for the acknowledgement of domestic violence as a health priority by all levels of the health sector. Furthermore, there is a need for the recognition of the ethical obligation to implement a comprehensive health approach to manage the survivors of domestic violence.
- The development of policies and guidelines for all levels of the health sector is essential to comprehensively address domestic violence. This should include an examination protocol for the management of women who have experienced abuse.
- Advocacy strategies must include dialogue with health sector management in order to secure their support and commitment to addressing domestic violence.

¹ Human Rights Watch (1995)

² World Health Organisation (2002)

³ The Consortium on Violence Against Women consists of the Gender, Law and Development Project of the Institute of Criminology at UCT; Rape Crisis Cape Town; the Gender Project of the Community Law Centre at UWC; the Division of Forensic Medicine and Toxicology at UCT and a health consultant (previously from the Women's Health Research Unit at UCT).

- Capacity building programmes must be implemented in the form of in-service training to address both professional skills as well as personal attitudes of health sector personnel towards domestic violence.
- The development of local, provincial and national intersectoral partnerships and referral structures across the health and criminal justice sectors are key to the management of domestic violence.

Building on this research, a key objective for the Consortium became the development of a provincial health protocol in relation to domestic violence, to fall within an integrated intersectoral service delivery framework. This policy is founded on the following principles:

- All policy, protocols and services surrounding the use and disclosure of health information, should respect client autonomy and confidentiality.
- A health systems approach is essential to ensure that domestic violence is addressed in a comprehensive manner.
- Management support at provincial level is essential in order to redefine what constitutes an appropriate response to domestic violence (including attitudinal responses and support systems).
- An appropriate health sector response to domestic violence would include:
 - 4 Asking about domestic violence i.e. screening;
 - 4 Comprehensive physical and psychological care for those patients who disclose abuse;
 - 4 A safety assessment and safety plan;
 - 4 The documentation of past and present incidents of abuse, including any physical injuries;
 - 4 The provision of information about the patient's rights and the DVA;
 - 4 Referral to resources
- The basic components of a protocol should therefore include:
 - 4 A definition of domestic violence;
 - 4 The clarification of any legal requirements for health workers;
 - 4 Management guidelines;
 - 4 Intervention strategies;
 - 4 The procedure for collection of evidence and medical record documentation;
 - 4 Safety assessment and planning guidelines; and
 - 4 Referral information.

A public health approach emphasises the importance of prevention programmes with the co-ordination of criminal justice and available social support structures.⁴ Early identification, comprehensive management, documentation of the abuse and injuries sustained, and appropriate referral may be one of the most effective strategies to prevent further injury and stem the medical and psychological consequences of domestic violence.

For this policy to become effective it is essential that there be a recognition within the Provincial Department of Health that the management of domestic violence requires special training and an integrated approach. This guiding principle impacts on the consequences for a survivor's future safety, mental and physical well being and will improve the standard of criminal justice interventions in protecting women from their abusive partners.

Any policy on the management of domestic violence must give cognisance to the historical deficiencies that these survivors have been exposed to at every level of the system from health to the police and courts. This policy framework recognises that domestic violence is one of the most pervasive and serious public health problems and that it deserves to be prioritised both in terms of resource allocation and services available to survivors.

This document has been developed after an analysis of international and local literature and is based both on the Primary Health Care package for South Africa⁵ and the Policy and Standardised Guidelines for the Management of Rape and Sexual Assault Survivors in the Western Cape Province⁶. This document is also based on discussions held by an informal Reference Group⁷ established in 2002 to develop a provincial policy and a management protocol of domestic violence at the health care facilities in the Western Cape Province after consultation between the Consortium on Violence Against Women and the Western Cape Department of Health.

This document aims to provide health managers and health workers with a framework for the introduction of screening for domestic violence as a preventative health care measure within the Comprehensive Primary Health Care Services of the Department of Health. It also provides a policy for the management of survivors of domestic violence in relation to patients who disclose. Part 3 (Screening Questionnaire for a Health Facility), Part 4 (Standardised Management Guidelines for Disclosed Domestic Violence) and Part 5 (Domestic Violence Examination Form) further support this policy. It is intended that this document be used to begin discussion within the Regions on the development of a Policy and Management guidelines for Domestic Violence, following the same successful process employed by the Rape Reference Task Team⁸.

⁴ World Health Organisation (1997)

⁵ Released by the National Department of Health in September 2001.

⁶ (Notice H 91/2001), drafted by Drs L. J. Martin and L. Denny.

⁷ This Reference Group consisted of a forensic pathologist, health managers, NGO's and criminal justice experts.

⁸ Constituted in 2000 to develop a management protocol for victims of sexual assault. Co-ordinated by Leana Olivier of the Directorate of Maternal, Child and Women's Health of the Department of Health, Western Cape.

PART TWO

A POLICY FRAMEWORK

1. RATIONALE FOR THE DEVELOPMENT OF A POLICY FRAMEWORK AND A MANAGEMENT PROTOCOL

Violence against women is the world's most pervasive form of human rights violation. It is endemic in most societies, but remains unrecognised as a 'silent' public health priority.⁹ Domestic violence statistics in South Africa are among the highest in the world, with estimations being that 1 in every 4 to 6 women will be beaten by their intimate partner¹⁰. There is no indication that the levels of violence against women in South Africa are decreasing or are likely to do so in the future, despite our progressive constitution and legislation such as the DVA. Violence against women is still regarded as culturally acceptable, and in many contexts, is legitimatised¹¹.

The World Health Organisation Report on Violence (2002) shows that violence against women has been linked to a number of immediate and long-term consequences, including physical injury, and depression. It affects women's earnings, job performance and parenting abilities. Further negative health consequences range from serious injury, disability, hypertension, diabetes, anxiety, headaches, various psychosomatic disorders and even death. The report further notes that in some countries up to 69% of women report having been physically assaulted and that nearly half of the women who are murdered are killed by their current or former husband or boyfriend.

Internationally, research has shown that abused women often seek medical attention via emergency rooms, primary health care settings and mental health facilities, yet abuse is rarely recognised by health workers¹². Increasingly the link between violence against women and the HIV/AIDS pandemic is being emphasised as research shows that violence against women is both a cause and consequence of HIV/AIDS. At present there is no national or provincial Department of Health guideline to address the problem of domestic violence other than the guidelines contained within the Primary Health Care Package¹³.

Historically, the management of domestic violence survivors has been sub-optimal on many levels. Some of the problems have included:

- Lack of access to adequate facilities for examination and treatment.
- Inadequate knowledge, understanding and/or guidelines for health workers on the management and health consequences of domestic violence.
- Poor quality performance and documentation of the medical/health assessment or examination resulting in poor quality evidence or no medical evidence presented to the courts, thus contributing to the low conviction rates.

⁹ World Health Organisation (1997)

¹⁰ NICRO

¹¹ Parenzee, Artz and Moulton (2001)

¹² World Health Organisation (1997)

¹³ National Department of Health (2001)

- Secondary traumatisation of survivors by fragmented, dysfunctional systems resulting in survivors who are either sub-optimally cared for or not cared for at all.
- No screening protocols advocated at all in any health care facility.

In addition there are ethical and specific obligations to eliminate 'discrimination against women' in its myriad forms placed on the state (and the Department of Health) by numerous international agreements. These include:

- The United Nations Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW);
- The Beijing Declaration and Platform for Action, a document resulting from the Fourth World Conference on Women in Beijing, China in September 1995
- The United Nations Declaration on the Elimination of Violence Against Women
- The Addendum to the SADC Declaration on Gender and Development

Despite the South African government's ratification of these instruments that condemn violence against women, and the promulgation of national legislation to combat the problem, there seems to be no significant change to women's lives. Women continue to be primarily the victims of violence, and to be subjected to secondary victimization when they seek assistance from the criminal justice and health sectors. Reasons for this secondary victimization are numerous and varied and range from a lack of knowledge and sensitivity on the part of personnel to a scarcity of resources available to implement protective legislation and provide services.

The denial of equality to women, based on the social constructs of gender identity, is the most pervasive, systematic and deep-rooted violation of human rights. The fostering of human rights begins in the home, in the neighbourhood, at school, on the farm and in the office. Health care practitioners are in a position to play an important role in the elimination of violence against women. They are respected members within the community and are often the first, or only, point of contact for women who have been abused. Research has furthermore shown that abused women seek more medical care than non-abused women, and that women who experience violence are more likely to suffer from any number of serious health problems.

In the consideration of the role of health care practitioners in preventing and eliminating violence against women, the World Health Organisation espoused the following requirements for health care practitioners:¹⁴

- Firstly, do no harm.
- Be able to recognise the occurrence of domestic violence and develop appropriate tools and interventions.

¹⁴ World Health Organisation (1997) and Romer, C (1999)

- Be able to share this knowledge with other role players in the social services and criminal justice systems.
- Be aware of possible signs and symptoms of abuse.
- Where feasible, ask all routinely about their experiences of domestic violence as part of history taking.
- Provide appropriate care for physical and psychological injuries and document these in the clients' medical records.
- Refer the client to the relevant social, legal and community resources.
- Maintain confidentiality of client information and records.

Health managers and administrators also have a critical role to play in the acknowledgement of the magnitude and impact of domestic violence and ensuring the appropriate allocation of resources for policy implementation, capacity building, service provision and research.

2. SCREENING - INTERVENTION THROUGH ASKING ABOUT ABUSE

The health sector has an important role in secondary and tertiary prevention as early identification of domestic violence can reduce its consequences and decrease the likelihood of further victimisation. Internationally early identification of domestic abuse has been emphasised in specific settings, such as antenatal care, primary health care and mental health services. Many professional associations and health services use guidelines and protocols to identify women who are abused, a process referred to as 'screening' for domestic violence.

The following principles need to be adhered to when using screening interventions through asking women about abuse:

- Ensuring that women's safety is paramount.
- Do not ask unless privacy and confidentiality can be ensured.
- A non-judgemental and supportive attitude is critical.
- Training is essential.
- Support and referral resources need to be in place.

In the published literature on domestic violence 'screening' is used in the context of **universal screening** and/or **selective screening**:

- **Universal screening** consists of asking all women in all settings or asking all women in a specific setting such as antenatal care or PHC, about domestic abuse.
- **'Selective screening'** involves health workers asking women in whom the presenting problem suggests abuse e.g. unexplained bruises or persistence headaches.

The level of intervention or the screening method employed, will be dependent on the available human and financial resources at each health care facility, and this decision needs to be made by the relevant management structures for each district, region and at provincial level. In order for this policy to be successful and sustainable formal systems must be developed between the Programme Development, Information Management and Finance Directorates both at a provincial and regional level.

It is of great importance that the implementation of a policy and protocol for domestic violence is accompanied by the training of health workers to avoid the problems associated with the implementation of a domestic violence screening policy. On-going research is also essential to monitor and evaluate the effectiveness and sustainability of the screening intervention within the context of broader multi-disciplinary and community based responses. Importantly, the experiences and perspectives of women who have been screened must form part of the evaluation of the impact of such interventions. Research¹⁵ has shown that screening is a viable practise only if there is a clear policy, comprehensive training, management support, debriefing and increased links to support structures.

A general consensus seems to exist that questioning women about domestic violence is a positive intervention. Gielen et al (2000) note that many women, irrespective of whether they have experienced domestic violence nor not, value questioning by health workers. A sympathetic and non-judgmental attitude from health workers can make women feel supported and safe enough to talk about her experiences. However, issues which need careful attention in the development and implementation of a screening policy and protocol include:

- Who should ask?
- Who should be asked?
- In what context/setting should the patient be asked?
- What training is necessary to equip the healthcare worker to ask?

Screening for domestic violence should not be the end in itself, but rather the beginning of working partnership with a range of service providers including support organisations, the criminal justice sector and domestic violence advocates.

¹⁵ Vetten, L (2003). This study piloted a screening protocol in six primary health care clinics in Gauteng.

3. VISION

The adoption of a domestic violence screening protocol will ensure that survivors of domestic violence are provided with co-ordinated, holistic, expert and humane care, which ensures the prevention of secondary traumatisation and serves the needs of the individual, the community and justice. Screening for domestic violence will promote early intervention and will reduce further victimisation. In order for this to be realised, health care professionals must be given training, as they are the most important resource to ensure the effective implementation of the protocol.

4. OBJECTIVES

Implementation of the policy and management guidelines will help to achieve the following objectives:

- To provide for 'screening' and identification for domestic violence for all women and girls.
- To provide an integrated and comprehensive service to survivors of domestic violence that incorporates the best possible clinical, psychological and medical care available at a minimum of one health facility per district by the end of 2004.
- To provide on-going training, support and supervision of health workers involved in the management of survivors of domestic violence to ensure a consistently high standard of care. This will also ensure that the courts are provided with high quality evidence to assist with the prosecutions and conviction of perpetrators.
- To facilitate an intersectoral mechanism at local, and provincial level.
- To provide health information to survivors and families which promotes easy of use of available services in the community and to inform them of their rights.

5. SERVICE DESCRIPTION

The services included in this protocol require co-operation between the health sector, the police and the Department of Justice. The services will provide:

- Counseling and referrals of survivors.
- STD prophylaxis and HIV testing, emergency contraception, and care of injuries.
- Medico-legal advice and documentation of injuries

6. NORMS

This protocol is based on the following norms, and are adapted from the Primary Health Care Package for South Africa:

- Every clinic will have established working relationships with the nearest police station, social welfare office, NGO's and CBO's, and hold quarterly visits or meetings with them.
- A member of staff of every clinic will have received training in the identification of domestic and gender-related violence. This training will include gender sensitivity and counselling.

7. IMPLEMENTATION

One of the first steps in creating a management system for the screening of survivors of domestic violence and the management of those survivors who disclose domestic violence would be to establish domestic violence forums on provincial, regional and district level. These forums could be incorporated into the already existing network of forums, for example the Rape Forums established in 2001 following the implementation of the Policy on the Management of Rape Survivors in the Western Cape Province¹⁶.

The broad functions of these forums would be to:

7.1. Provincial DV Forum

- Determine and regularly re-view a Provincial Domestic Violence Policy involving all the relevant stakeholders (e.g. Departments of Justice, SAPS, Social Services, Health and NGO's) in order to share information, facilitate co-operation and to avoid duplication.
- Lobby for the development of an appropriate intra-departmental central complaint mechanism to manage complaints of non-compliance to the policy and guidelines.
- Provide and update standardised guidelines for medical, nursing, psychological and forensic management of domestic violence survivors.
- Annual evaluation on the implementation of the domestic violence forums, and if appropriate, lobby for the national implementation thereof.

7.2. Regional DV Form

- Liaise with the Provincial Domestic Violence Forum.
- Assess existing facilities to evaluate whether they are appropriate for the establishment of domestic violence screening and management services.

¹⁶ Western Cape Department of Health (2001)

- Ensure equitable access to all survivors to a domestic violence service at all State health care facilities.
- Monitor the implementation and adaptation of the policy and standardised management guidelines and ensure that adequate standards of care are maintained.
- Identify deficiencies and obstacles in the care of domestic violence survivors and develop strategies to address these.
- Work in collaboration with other initiatives, which focus on the prevention and management of victims of violence and abuse to co-ordinate service provision.
- Keep accurate statistics and demographic data on the service and domestic violence survivors.
- Convene regular meetings (e.g. 3 - 4 monthly) to ensure fluid co-operation and to support domestic violence service providers at district level.
- Co-ordinate regional interdepartmental co-operation.

7.3. District DV Forum

- Liase with the Regional domestic violence Forum.
- Monitor the provision of a 24-hour health service for domestic violence survivors within all health facilities in the district.
- Monitor accessibility of facilities to the majority of survivors in a district.
- Monitor the implementation and adaptation of the policy and standardised guidelines and ensure that adequate standards of care are maintained.
- Ensure that sufficient health workers are trained to provide an appropriate service to domestic violence survivors.
- Ensure that a trained person is available on call for consultation when a survivor is brought in for management.
- Co-ordinate roles and responsibilities of different agencies e.g. SAPS, Justice, Social Services and NGO's at district level.
- Each facility offering a service to domestic violence survivors should have a designated room/area for the initial counselling and management of the survivor and his/her support system after initial disclosure.
- Hold regular meetings (e.g. 3 - 4 monthly) to ensure proper implementation of the domestic violence policy and guidelines and to adapt these to local circumstances.

8. MONITORING AND EVALUATION

In a Provincial Department of Health the Maternal, Child and Women's Health Sub-directorate, supported by the Mental Health, Gender Focus and Reproductive Health Sub-directorates, could be tasked with the responsibility for driving this process. In order to facilitate, monitor and evaluate the implementation of this policy the following is needed:

- Co-ordination of on-going inter- and intra-departmental collaboration (e.g. Departments of Justice, SAPS, Social Services, Health, NGO's, etc.)
- Distribution of the policy and standardised guidelines to all the relevant stakeholders.
- Monitoring of the correct implementation and regular up-date thereof.
- A central departmental liaison for reports regarding non-compliance and/or problems.
- Establishment (together with the Directorate Health Information) of a provincial database for domestic violence statistics to monitor and evaluate on-going provision of services.
- Provision of regular feedback to the stakeholders.
- Facilitation of appropriate training of health workers.

9. TRAINING

The successful implementation of this policy depends on the skills and competencies of the health workers performing the service. A training program is an integral part of the development of this policy in order to equip health workers adequately to perform the necessary screening and management interventions. It is crucial that the comprehensive health sector response includes addressing the barriers to health workers asking about abuse, barriers to women disclosing abuse as well as the broader institutional and structural barriers such as lack of co-ordination with criminal justice system.

Training as an isolated intervention will be ineffective. It needs to be a component of a sustainable strategy and programme that ensures structural and administrative change as well as the contribution to policies and protocols for health services at all levels. A Training Programme on domestic violence needs to include the following:

- The policy and legislative framework.
- The extent and nature of domestic violence.
- The health and societal impact of domestic violence.
- The contents of the Domestic Violence Act (1998).

- The components of a comprehensive health sector response including:
 - 4 Asking about domestic violence i.e. screening;
 - 4 Screening for and identifying domestic violence
 - 4 Safety assessment and safety planning
 - 4 Medical intervention (physical and psychological care)
 - 4 Documentation of abuse
 - 4 Appropriate referral
- The health workers' own experience of domestic violence.
- Discussion of attitudes, values and societal prejudices and norms.
- Working partnerships with other sectors, both government and NGO

Training workshops should include 20-25 participants per workshop and should continue until sufficient staff have been trained and then offered on an annual basis as refresher courses. These workshops could be offered in the regions on request via the Gender Focus Coordinator. A Reference Group should be constituted to develop a training manual and in-service training course. This manual must be made available to the Human Resource Development Directorate and regional offices. The regional Human Resource Directorate and Training officers should be responsible for the facilitation of the continued in-service training of health workers.

10. REQUIRED EQUIPMENT

In order to enable health workers to adequately identify and manage survivors of domestic violence after initial disclosure the following is necessary at the designated service points:

- Private/designated room/area.
- Adequate stationary, pre-printed management guidelines (see Part Four for an example), examination forms (see Part Five for an example) and referral letters.
- Access to a telephone and fax machine.
- Access to emergency care.
- Access to bath/shower and/or toilet facilities.
- Posters, pamphlets and information about domestic violence, counselling and human rights.
- A list of names, addresses and telephone numbers of the nearest accredited health care practitioners, police and social workers who would be involved in dealing with domestic violence cases.

- A list of names and addresses of NGO's, Cobs or other organisations which undertake appropriate counselling for domestic violence
- Reference and educational material.
- All relevant guidelines related to women's health issues.
- A suitable library of references and journals on sexual offences, domestic and gender violence

11. BUDGET

11.1. Service provision

As far as possible it is envisaged that existing staff and health facilities should be used. The designated health care facilities for rape survivors should also be designated for the management of domestic violence survivors. The same area designated for the examination of rape survivors can be used for the examination of identified domestic violence survivors.

11.2. Equipment and medicine

The equipment required to perform the examinations should already be available at the designated health care facilities for rape survivors. The necessary drugs (for example emergency contraceptive pills) should also be available in these health care facilities. The relevant forms and referral letters can be ordered from the central stores.

11.3. Training budget

Training should form part of the continued in-service education programme for health workers (see item 9 above). An initial budget will be necessary for the development of the training manual and course. Thereafter the trainers will need to be compensated for every training session conducted, until such time as the Human Resources Directorate for each region can appoint properly skilled and qualified staff to continue with the in-service training.

12. PLANNING FOR SUSTAINABILITY OF THE POLICY

The following are necessary to ensure the implementation and sustainability of such a program:

- Commitment from top management to the implementation of the program.
- Allocation of budget to ensure the sustainability of the program.
- Support to health workers, especially psychological support.
- External evaluation of program after one year of inception.
- Incorporation of evaluator's recommendations into provincial policy.

PART THREE

EXAMPLE OF A SCREENING QUESTIONNAIRE FOR A HEALTH FACILITY

NOTE: This screening tool should only be used by appropriately trained health workers and in circumstances of complete confidentiality.

1. BACKGROUND

Universal screening means that asking about abuse is a regular part of health care and that every woman is asked whether she has ever experienced physical, sexual and/or emotional abuse. This means that staff must always include a question on domestic violence in the history taking from women with depression, headaches, stomach pains or a known abusive partner. Staff must include diplomatic probing of the domestic situation when taking histories of children who fail to thrive, present with recurrent episodes of trauma or have behavioural problems.

2. SCREENING QUESTIONS

Screening can be done through asking either directly or indirectly. Some examples of screening questions are as follows:

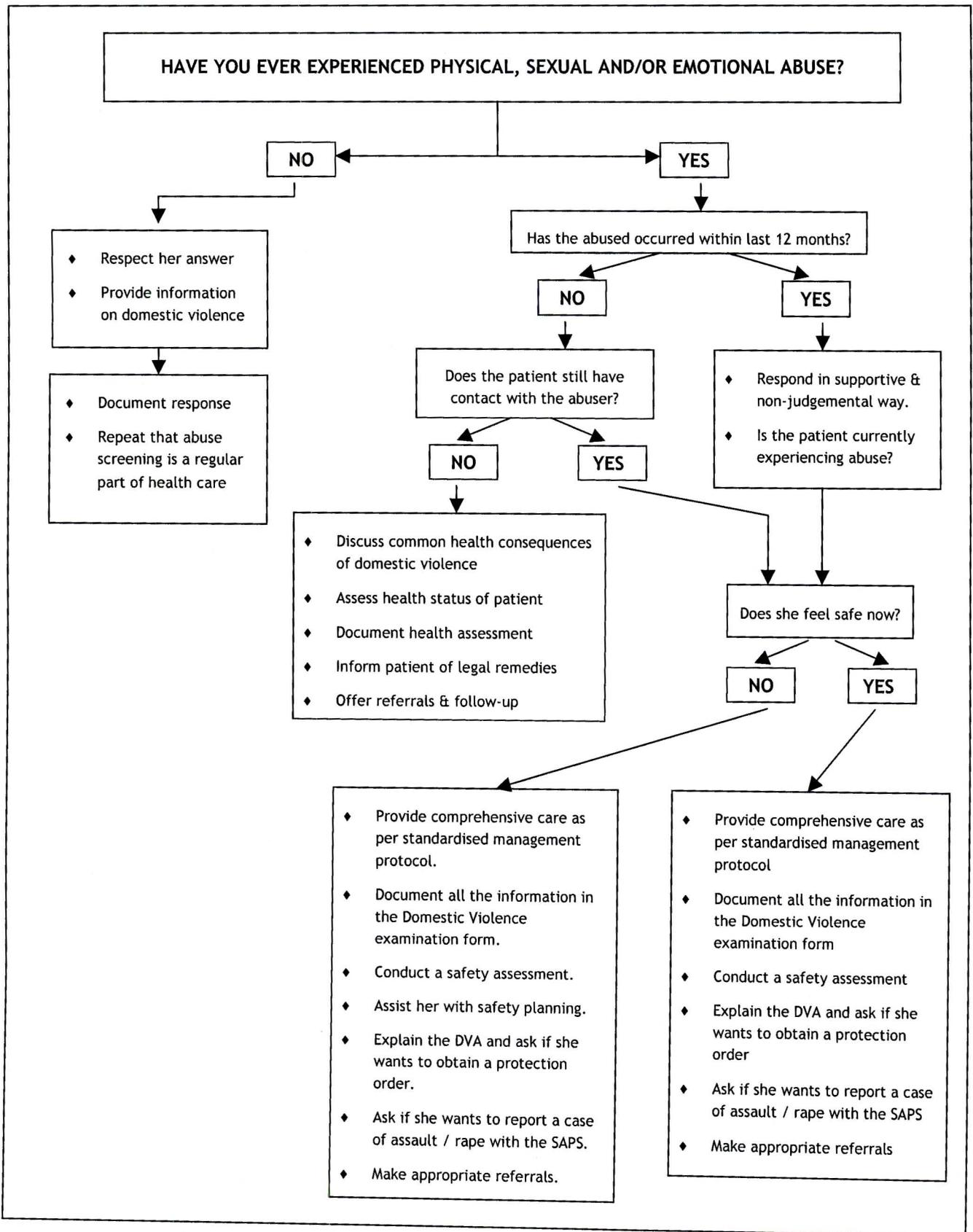
2.1 Asking indirectly:

- ? How are things going in your relationship?
- ? Your symptoms may be related to stress. Do you and your partner tend to fight a lot? Have you ever been hurt?
- ? What happens when your partner gets angry?
- ? Does your partner have any problems with alcohol, drugs or gambling? How does it affect his behaviour with you and the children?

2.2 Asking directly:

- ? As you may know, it's not uncommon these days for a person to have been emotionally, physically or sexually victimised at some time in their life and this can affect their health many years later. Has this ever happened to you?
- ? In this clinic we ask all women patients if they have ever experienced any form of abuse. Have you ever experienced abuse?
- ? Sometimes when I see an injury like yours, it's because someone hit them. Did this happen to you?
- ? Has your husband/partner or ex-husband/partner ever hit you or physically hurt you?
- ? Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?
- ? Has your boyfriend/husband/partner ever forced you to have sex when you did not want to?
- ? Has a boyfriend/husband/partner ever threatened your life, isolated you from your family or friends or refused to give you money?

3. UNIVERSAL SCREENING PROTOCOL¹⁷



¹⁷ Adapted from: Task Force on the Health Effects of Woman Abuse, Middlesex-London Health Unit (2000).

PART FOUR

EXAMPLE OF STANDARDISED MANAGEMENT GUIDELINES FOR DISCLOSED DOMESTIC VIOLENCE

1. All patients who disclose domestic violence must be assessed as soon as possible using the attached domestic violence examination form.
2. When a person presenting to a clinic discloses domestic abuse or alleges to have been abused or assaulted the allegation is assumed to be true and the victim is made to feel confident they are believed and are treated correctly and with dignity.
3. Under no circumstances should any patient be turned away to seek help from another facility.
4. The **Domestic Violence Examination Form** constitutes the confidential medical record of the patient. It may however be subpoenaed as a court document if the court deems it necessary. It is essential to record all information and findings accurately, legibly and to remember that the original document could become part of a court record.
5. Complete the **Domestic Violence Examination Form**. A checklist for documentation is noted below:
 - 4 Document the exact words used by the patient.
 - 4 Do not ask the patient about abuse in the presence of children as they pose a risk to confidentiality.
 - 4 Document the identity of the offender and his relationship to the patient.
 - 4 Record the history of abuse - the presenting complaint of recent abuse, and all incidents of past abuse.
 - 4 Document all symptoms experienced and injuries sustained for present and past abuse.
 - 4 Document all injuries by recording the measurements thereof with a ruler, the exact anatomic location, the nature of injury, the age and any healing that has occurred. Use the body charts for recording a sketch.
 - 4 If possible state that the injury is consistent with the patient's account.
 - 4 Take photographs if resources permit.
 - 4 Ensure that all medical records are stored safely, preferably in the Superintendent's office.
6. Remember to label each page with the patient's name and folder number.
7. Establish whether the patient has reported the matter to the police. Explain to her the advantages and disadvantages of reporting the incident mindful of the patient's risk of danger of doing so at this instant. Respect the patient's choice of not to report.

8. If she chooses to report the case to the police, then the health worker must phone the police station in the area in which the domestic violence occurred and ask for a police officer to come to the health facility to take a statement from the patient.
9. If the survivor declines to report the domestic violence to the police or to undergo a full physical assessment, this choice should be respected and no undue pressure exerted on her.
10. A J88 form must be filled in for all cases where the patient has reported the incident to the police and in instances where the patient indicates that she will lay a charge of assault or where she will seek relief in terms of the Domestic Violence Act. The J88 form will be used for the court record in the first instance, and must be given to the SAPS after examination.

PLEASE NOTE: Detailed notes made on the J88 form may obviate the need to testify in court at a later date. However, if court testimony is necessary, the detailed notes on the domestic violence screening form will serve as an aide d' memoir to compiling an additional affidavit or testifying from, to complement your J88 notes, that will provide the court with good medical evidence.

11. All domestic violence survivors are to be interviewed by the appropriate health professional in a confidential manner in a private room for appropriate examination and counselling. It is advisable that the spouse/partner or children are not present during the interview.
12. Routine clerking notes of the patient must be kept in the patient's folder, especially special investigations performed, treatment given and follow up appointment dates.
13. Domestic violence survivors should be advised to have an HIV test.
14. Domestic violence survivors should be given the option of going for counselling to:
 - Social worker
 - Trained counsellor (region specific)
 - Private therapist, e.g. psychologist
 - Domestic violence support services or other local services
15. The survivor and family should be given an updated list of local resources, if it has been established by the health professional that is safe for the patient to do this.
16. The survivor and family should receive literature on domestic violence to take home and read later, if it has been established by the health professional that is safe for the patient to do this.
17. Domestic violence survivors should be referred to the next level of care when their needs fall beyond the scope or competence of clinic staff.
18. All patients, community and children attending clinic are educated and informed on abuse.
19. As part of community outreach clinic staff establish links with relevant organisations already operating and providing services to victims and survivors of abuse.
20. If you are subpoenaed to give medical evidence in a domestic violence case, you are strongly advised to consult with the prosecutor and other medico-legal experts before giving testimony in court.

PART FIVE

EXAMPLE OF A DOMESTIC VIOLENCE EXAMINATION FORM

NOTE: This examination form should only be used by appropriately trained health workers and in circumstances of complete confidentiality.

1. Ensure the examination is conducted in a safe and secure place.
2. Allow any support persons that the survivor requests to be present during the examination.
3. Document the exact words used by the patient.
4. Do not ask the patient about abuse in the presence of children as they pose a risk to confidentiality.
5. Document the identity of the offender and his relationship to the patient.
6. Record the history of abuse - the presenting complaint of recent abuse, and all incidents of past abuse.
7. Document all symptoms experienced and injuries sustained for present and past abuse.
8. Document all injuries by recording the measurements thereof with a ruler, the exact anatomic location, the nature of injury, the age and any healing that has occurred. Use the body charts for recording a sketch.
9. If possible state that the injury is consistent with the patient's account.
10. Take photographs if resources permit.
11. Ensure that all medical records are stored safely, preferably in the Superintendent's office.

Patient Name: _____ Folder No. _____

CONSENT:

Authorisation for collection of evidence and release of Information:

I hereby authorise _____ CHC/Hospital
(name of clinic or hospital)

And _____
(name of health worker)

Please tick:

To document all injuries and collect any blood, urine, tissue or any other specimen needed.

To take photographs of my injuries.

To supply copies of relevant medical reports including laboratory reports to the South African Police if requested.

I recognise that the Domestic Violence Examination Form is solely to direct the appropriate clinical and forensic management of me and to record any injuries I may have evidence of. This information is confidential and will remain with my confidential medical records.

I understand that the medical and forensic information handed over to the South African Police Service will be contained in the J88 form.

Person examined: _____
(Print Name) (Signature)

Witness: _____
(Print Name) (Signature)

Parent/guardian: _____
(Print Name) (Signature)

Date: _____ / _____ / _____

Name of Institution: _____

Official Stamp:

Patient Name: _____ Folder No. _____

2. Other episodes of assault:

Describe frequency & severity of past abuse, using direct quotes from the patient. Describe mechanism, location and extent of injury and/or other symptoms/conditions.)

3. Emotional Status:

4. Medical Information:

Is the patient pregnant?

Yes

No

Date of Last Menstruation: _____

Other Medical Concerns (e.g. insomnia, pain, headaches, signs of stress or depression):

5. Examination:

General Appearance: _____

Height: _____

Weight: _____

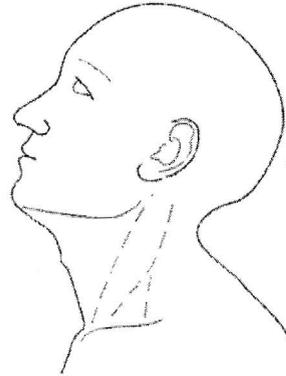
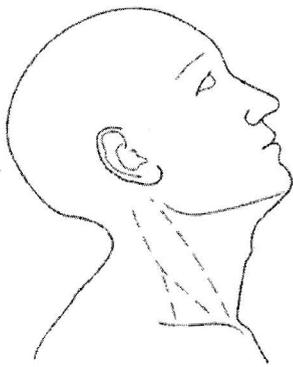
Body Build: _____

Description of Injuries

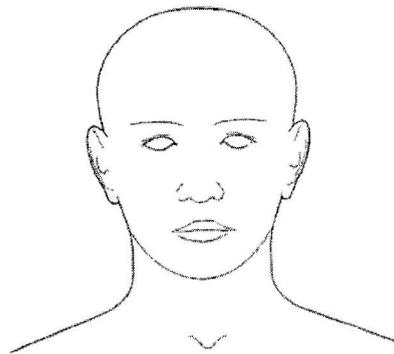
Patient Name: _____

Folder No. _____

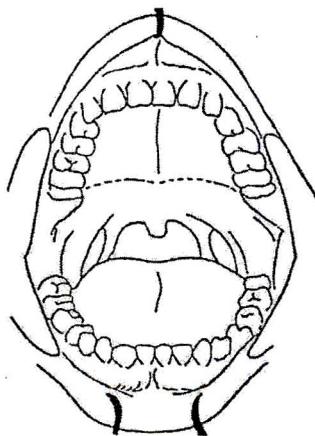
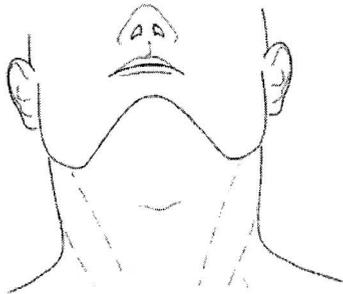
6. Body Charts:



Right



Left

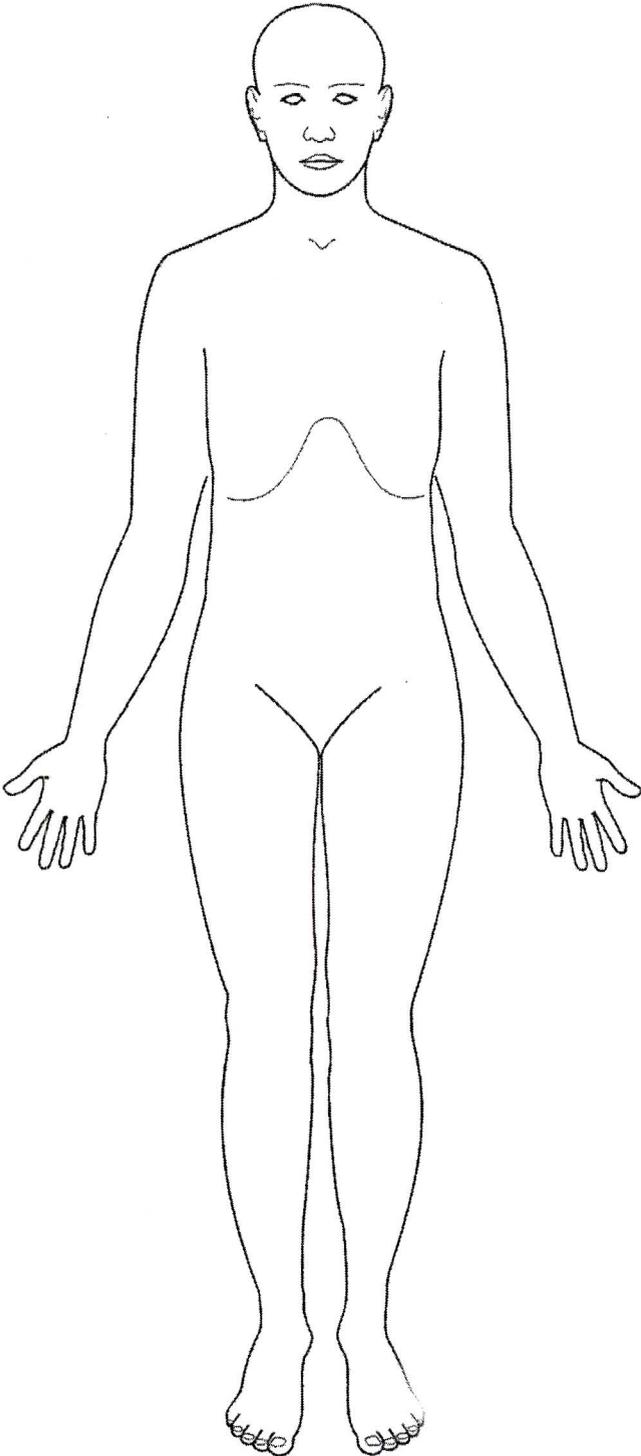


Patient Name: _____

Folder No. _____

Right

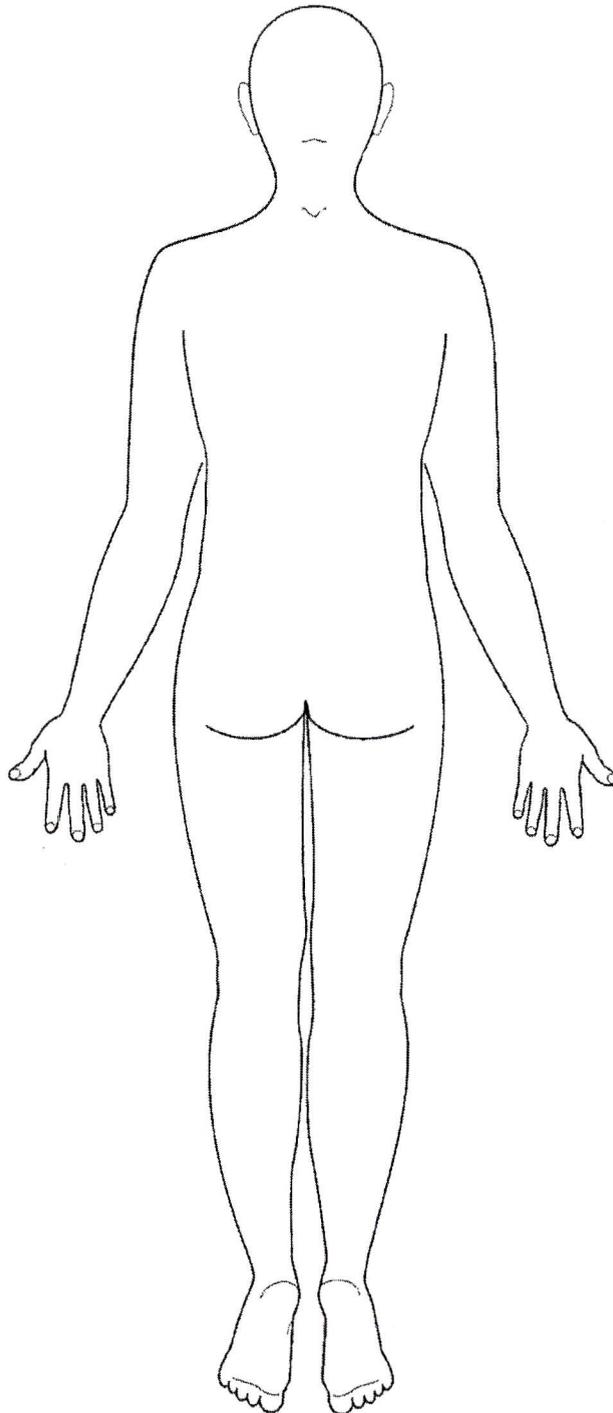
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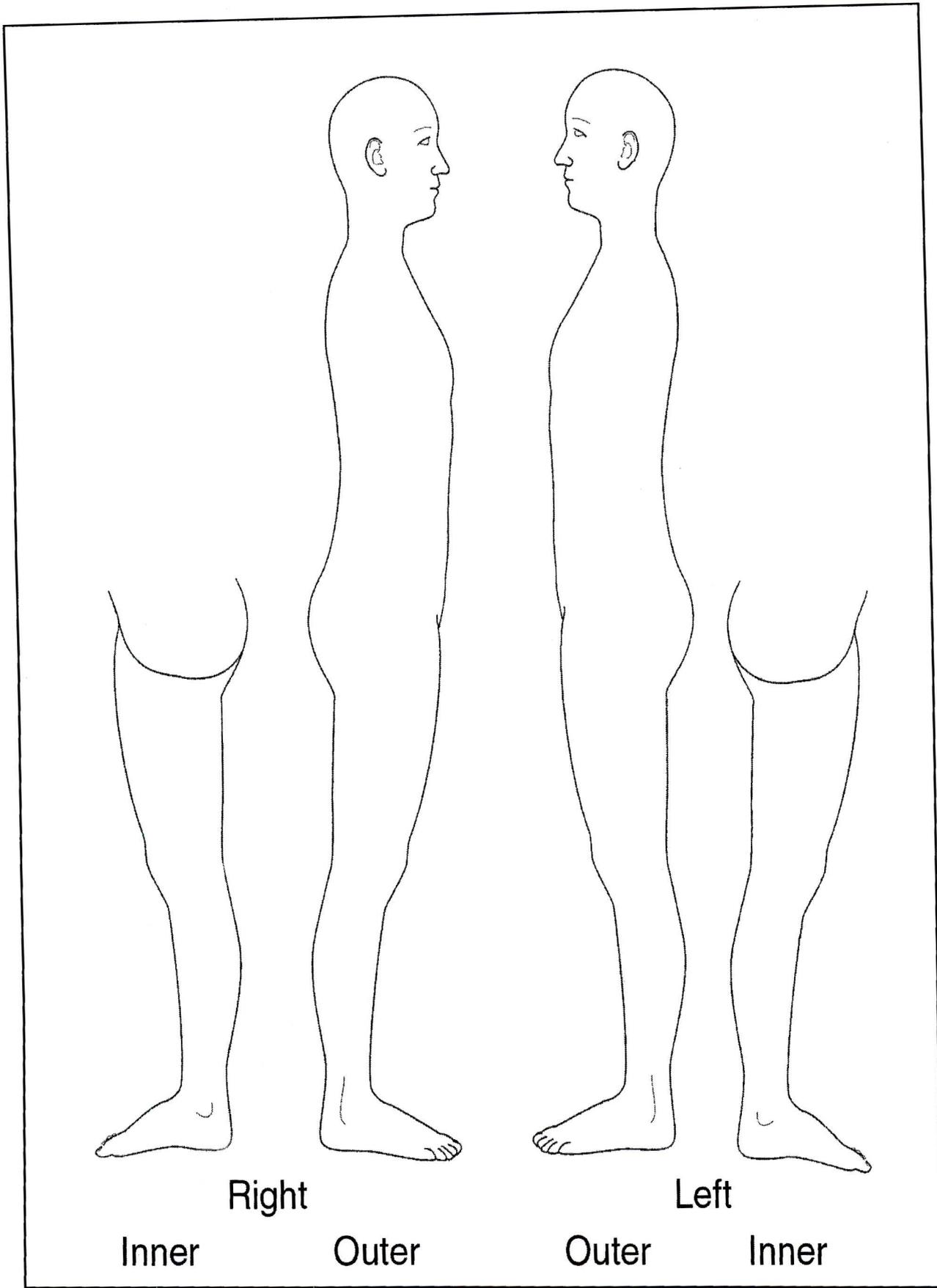
Patient Name: _____ Folder No. _____

Left

Right



Patient Name: _____ Folder No. _____



Patient Name: _____ Folder No. _____

SPECIAL INVESTIGATIONS:

	RESULTS			
HIV Testing:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
STI Screening:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pregnancy Test:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative
X-rays:	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

TREATMENT PLAN/GIVEN:

Injuries: _____

Emergency Contraception: _____

STI's: _____

PEP: _____

SAFETY ASSESSMENT:

A woman's safety is very important, and her danger is the highest if she lives with the abuser or continues to see him at regular intervals. Health workers need to be especially aware of this, specifically if she verbalises that she feels unsafe. Health workers are not experts in this area and referral to SAPS or an appropriate agency may be the best course of action at this time. If this is not acceptable to the patient, then the health worker can perform a preliminary safety check, strongly advising the patient to consider the short and long-term outcomes.

A safety assessment must be done for all patients who disclose domestic violence. The following needs to be established:

Has the violence increased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the perpetrator use alcohol and drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the perpetrator threatened to kill her?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there weapons at home/does the perpetrator have access to weapons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the client afraid to go home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has she thought about killing herself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Name: _____ Folder No. _____

Record answers to the following questions. The answers to the questions can be assigned a value for risk assessment. Assign a value for the answers as follows:

Add up the total to provide a risk rating: **No = 0** **Yes = 1**
0 - 3 ← **Caution**
4 - 7 ← **High Risk**
8 - 11 ← **Severe Risk**

- Has he threatened you with physical violence? Yes No
- Has he threatened the children with physical violence? Yes No
- Is there a firearm in the house? Yes No
- Has he threatened to kill you? Yes No
- Has he threatened to kill the children? Yes No
- Does the patient think he is capable of killing her? Yes No
- Were alcohol and/or drugs consumed prior to the last incident of abuse? Yes No
- Was SAPS intervention necessary? Yes No
- Is he presently in the home? Yes No
- Has the abuse escalated in either frequency or severity? Yes No
- Have you ever received medical treatment for injuries sustained as a result of abuse? Yes No

TOTAL RATING

SAFETY PLAN:

A short-term safety plan is a set of strategies that can assist the immediate safety of your patient and help her to be prepared for further violence. A safety plan must be discussed with all patients who disclose domestic violence. Knowing the level of danger will help the health worker and client to think through what the options are. An initial safety plan worked out at the health facility will probably only deal with the immediate situation. There is no formula for safety planning, but the health worker can help the client think and plan the following:

- ? What will you do when you leave the health facility?
- ? Will you seek help from SAPS and/or courts?
- ? How will you ensure your children's safety?
- ? Where can you go if you need to leave home?
- ? Who can you trust to tell about the domestic violence?
- ? Where can you leave money, clothing, copies of documents and valuables if necessary?
- ? Will you accept a list of important telephone numbers referrals to help with longer-term safety planning?

Patient Name: _____ Folder No. _____

REFERRAL:

Have you referred your patient to an appropriate agency?

Yes No

OPTION 1:

OPTION 2:

OPTION 3:

INFORMATION:

Is it safe to give your patient written literature?

Yes No

If not how have you conveyed the information to your patient?

Have you given your patient appropriate information with regard to domestic violence, referral agencies, safety plans, and shelters?

Yes No

FOLLOW UP:

Date for follow up appointment with patient in your outpatient clinic or at the designated health care facility where/when you will be in attendance

Was your patient satisfied with the referrals you made for her?

Yes No

Signature:

Print Name:

Qualifications:

Health Facility:

Date:

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LEGISLATION

Domestic Violence Act, 116 of 1998.

THE DOMESTIC VIOLENCE EXAMINATION FORM HAS BEEN ADAPTED FROM THE FOLLOWING MATERIALS:

Metro Women Abuse Council (Toronto), Ontario Hospital Association. *Best Practice Guidelines For Health Care Providers Working With Women Who Have Been Abused*. Ontario Hospital Association #401, Canada.

Osattin A, Short LM. Intimate partner violence and sexual assault: A guide to training materials and programs for health care providers. Atlanta. Centre for Disease Control and Prevention, National Centre for Injury Prevention and Control, 1998.

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