Outcome Mapping Evaluation of an Intervention Programme for Intimate Partner Violence

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Pectora roborant cultus recti

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ABSTRACT

Background

Studies have found that between 42% and 66% of women who were killed by their intimate partner had recently used health care prior to their death but had not been identified as victims of intimate partner violence (IPV). IPV is the second highest contributor to the burden of disease affecting women after HIV and AIDS in South Africa. There is a growing need for women who are experiencing IPV to be identified and managed appropriately at our health facilities. However significant evidence is needed about comprehensive interventions for IPV to provide quality coordinated care to IPV survivors. Moreover, in order to receive institutional and governmental support (funding), evidence must be provided of a well-coordinated and structured IPV intervention programme. This study thus aimed to evaluate the implementation of an integrated comprehensive intervention programme for IPV using outcome mapping in the Macassar community.

Methods

The outcome mapping method was used to design, monitor and evaluate the implementation of a psychosocial and legal intervention for IPV. The method assists project teams to be specific about the organisations it targets, the changes it expects to see and the strategies it needs to implement to create change (Stage one). Ongoing monitoring of the IPV project according to the outcome mapping method enabled the project team to adapt strategies as needed and monitor the progress of boundary partners (Stage two). Stage three assisted the project team to identify what phenomena had to be studied in depth.

Results

The IPV intervention appeared to be of benefit for some IPV survivors. However collaboration and engagement with other stake holders (boundary partners) was problematic at times. IPV remains a stigmatised, hidden subject within healthcare while paradoxically being accepted as normative within the communities our health system serves. IPV remained under-identified even though staff attended and participated in onsite IPV training prior to the project onset.

Conclusion

There is still significant resistance to taking IPV seriously as a human right, health and societal issue. The complexities of IPV belie easy and simple solutions. A multi-faceted, comprehensive approach should become an integral part of primary health care

Key words: Intimate partner violence, IPV champion, IPV survivor, outcome mapping

Opsomming

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Agtergrond

Navorsing het bevind dat tussen 42% en 66% van vroue wat deur hulle intieme maat vermoor word voor hulle dood van gesondheid sorg gebruik gemaak maar hulle is nie as slagoffers van intieme geweld identifiseer was nie. In Suid Afrika is intieme geweldpleging (IGP) die tweede grootste bydraende faktor tot siektetoestande na HIV en VIGS in vroue. Daar is `n dringende behoefte om vroue in IPG by gesondheids fasiliteite te identifiseer en te bestuur. Navorsing en bewyse van omvattende intervensies word benodig om gekoordineerde en kwaliteits dienste aan IPG oorlewendes te lewer. Bewyse van gekoordineerde en gestrukteerde ingrypings moet gelewer word om institutionele en regerings ondersteuning (befondsing) te bekom.

Die doel van hierdie studie was om die implementering van `n integreerde omvattende intervensie program vir IPG in die gemeenskap van Macassar met behulp van die “outcome mapping” metode te evalueer.

Metode

Die “outcome mapping” metode was toegepas om die implementasie van `n bio-psigiese-sosiale intervensie te ontwerp, monitor en te evalueer. Hierdie metode help projek spanne om doelgerig te wees oor die organisies wat hulle eien, die verwagte veranderinge wat hulle wil sien en die strategiee wat toegepas moet word om die veranderinge te weeg te bring (Fase een). Deurlopende monitering van die projek volgens die “oucome mapping” metode het die projek span in staat om sommige strategiee te verander en aan te pas soos benodig (Fase twee). In fase drie identifiseer die projek span om `n spesifieke fenomena verder na te vors.

Resultate

Die IPG ingrypings program was voordelig vir sommige oorlewendes. Deurlopende samewerking en skakeling met sommige belanghebbendes was egter problematies met tye. In die gesondheidsisteem word intieme geweldspleging steeds gestigmatiseer en gekenmerk deur geheimhouding. Identifisering en sorg van IPG gevalle is steeds minimaal alhoewel omvattende voorafgaande opleiding en ondersteuning aan die primere gesondheids personeel verskaf was.

Slotsom

Daar is steeds weerstand om IPG as `n ernstige menseregte skending sowel as gemeenskaplike en gesondheids kwessies te beskou. Die komplekisiteit van IPG weerle eenvoudige en maklike oplossings dus moet `n omvattende en veelsydige benadering `n integrale deel van primere gesondheid sorg word.

Sleutelwoorde: intieme geweldpleging (IGP), IGP oorlewende

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ABBREVIATIONS

CCWs	-	Community carers workers
CHC	-	Community Health Centre
CNP	-	Clinical Nurse Practitioner
CV	-	Curriculum Vitae
IPV	-	Intimate Partner Violence
NGO	-	Non-Governmental Organisation
OM	-	Outcome Mapping
PHC	-	Primary Health Care
SAPS	-	South African Police Service
STI	-	Sexually Transmitted Infection
VEP	-	Victim Empowerment Unit

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TABLE OF CONTENTS

ABSTRACT ..... **II**

OPSOMMING ..... **II**

ACKNOWLEDGEMENTS ..... **III**

ABBREVIATIONS ..... **V**

CHAPTER ONE FOUNDATION OF THE STUDY **1**

1.1 INTRODUCTION 1
1.2 SIGNIFICANCE OF THE PROBLEM 1
1.3 RATIONALE 3
1.4 PROBLEM STATEMENT 4
1.5 RESEARCH AIM 4
1.6 RESEARCH OBJECTIVES 4
1.7 CONCEPTUAL FRAMEWORK 4
1.8 RESEARCH METHODOLOGY 6
1.8.1 Pilot study *7*
1.9 ETHICAL CONSIDERATIONS 7
1.10 DEFINITIONS 8
1.11 DURATION OF THE STUDY 9
1.12 CHAPTER OUTLINE 9
1.13 CONCLUSION 9

CHAPTER TWO LITERATURE REVIEW **10**

2.1 INTRODUCTION 10
2.2 BACKGROUND 10
2.3 CHALLENGES IN IDENTIFYING IPV 11
2.3.1 Failure to disclose IPV *11*
2.3.2 Health care providers' challenges *11*
2.3.3 Biomedical versus holistic healthcare *12*
2.4 IPV MODELS AND MANAGEMENT STRATEGIES 13
2.5 CONCLUSION 16

Stellenbosch University https://scholar.sun.ac.za

CHAPTER THREE RESEARCH METHODOLOGY 17

3.1 INTRODUCTION 17

3.2 STUDY DESIGN 17

3.2.1 People-centred development and behaviour change 18

3.2.2 Outcome mapping is a process of continuous learning and reflexivity 18

3.3 STUDY SETTING 18

3.4 STEPS OF OUTCOME MAPPING 18

3.5 STAGE ONE: INTENTIONAL DESIGN 20

3.5.1 Vision statement 21

3.5.2 Mission statement 21

3.5.3 Boundary Partners 21

3.5.4 Outcome challenge 21

3.5.5 Progress markers 22

3.5.6 Strategy map 22

3.5.7 Organisational practices 22

3.6 STAGE TWO: OUTCOMES AND PERFORMANCE MONITORING 22

3.6.1 Monitoring priorities 22

3.6.2 Outcome journal 23

3.6.3 Strategy journal 23

3.6.4 Organisational practices 24

3.7 STAGE THREE: EVALUATION PLANNING 26

3.8 QUALITATIVE EVALUATION: EXPLORATION OF PRIMARY HEALTH PROVIDERS` EXPERIENCE AND VIEWPOINTS REGARDING IDENTIFYING AND MANAGING IPV 26

3.8.1 Aim and objectives 26

3.8.2 Study design 27

3.8.3 Study population 27

3.8.4 Pilot interview 28

3.8.5 Trustworthiness 28

3.8.5.1 Credibility 28

3.8.5.2 Transferability 28

3.8.5.3 Dependability 29

3.8.5.4 Confirmability 29

3.8.6 Data collection 29

3.8.7 Data analysis 30

3.8.7.1 Familiarisation 30

3.8.7.2 Development of a key thematic index 30

3.8.7.3 Indexing 30

3.8.7.4 Charting 31

Stellenbosch University https://scholar.sun.ac.za

3.8.7.5 Interpretation 31
3.9 Ethical considerations 31
3.9.1 Confidentiality *31*
3.9.2 Autonomy *32*
3.9.3 Privacy *32*
3.9.4 The principle of beneficence *32*
3.10 Conclusion 32

CHAPTER FOUR FINDINGS 33

4.1 Introduction 33
4.2 Intentional Design 33
4.2.1 Vision statement *33*
4.2.2 Mission statement *33*
4.2.3 Boundary partners *34*
4.2.4 Outcome challenges *34*
4.2.5 Progress markers *36*
4.2.6 Strategy maps *38*
4.3 Monitoring and evaluation of strategies 40
4.3.1 Strategy monitoring tables *41*
4.4. Monitoring and EVALUATION of outcomes 45
4.5 Exploration of primary health carers` experience and viewpoints regarding identifying and managing IPV 50
4.5.1 Themes emerging from the interviews *51*
4.5.1.1 Primary health providers' understanding/opinion about IPV 51
4.5.1.2 Primary carer`s personal experience of IPV 54
4.5.1.3 Challenges in case finding and referral of IPV cases 55
4.5.1.4 IPV case finding strategies 58
4.5.2 The ideal IPV service *61*
4.6 Conclusion 62

CHAPTER FIVE DISCUSSION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS 63

5.1 Introduction 63
5.2 Discussion of findings 63
5.3 Addressing the research objectives 63
5.3.1 Objective: To implement a community-based service for IPV *63*
5.3.2 Evaluation of the strategies used and the outcomes set for implementation of the IPV service *64*
5.3.2.1 IPV survivors and their families 64
5.3.2.2 Facility-based primary health providers 66

Stellenbosch University https://scholar.sun.ac.za

5.3.2.3 Community based carers/workers 66
5.3.2.4 Police, legal and social services 67
5.3.2.5 Community leaders/activists 67
5.3.2.6 Department of Social Development 68
5.4 EXPLORATION OF PRIMARY HEALTH PROVIDERS` EXPERIENCE AND VIEWPOINTS REGARDING IDENTIFYING AND MANAGING IPV 68
5.4.1 Primary health providers' understanding/opinion about IPV 69
5.4.2 Primary health provider`s own experience of IPV 69
5.4.3 Challenges in case finding and referral of IPV cases 69
5.4.4 IPV case finding strategies 711
5.4.5 The ideal IPV service 712
5.5 LIMITATIONS 712
5.6. IMPLICATIONS AND RECOMMENDATIONS 722
5.6.1 Community structures/resources 722
5.6.2 The IPV service 733
5.6.3 Primary health providers 733
5.7 FUTURE RESEARCH 734
5.8 CONCLUSION 734

REFERENCES 755

APPENDICES 81

APPENDIX 1: ETHICAL APPROVAL FROM STELLENBOSCH UNIVERSITY 811
APPENDIX 2: PERMISSION OBTAINED FROM INSTITUTIONS / DEPARTMENT OF HEALTH 822
APPENDIX 3: PARTICIPANT INFORMATION LEAFLET 833
APPENDIX 4: INSTRUMENT / INTERVIEW GUIDE / DATA EXTRACTION FORMS 855
APPENDIX 5: CONFIDENTIALITY AGREEMENT WITH DATA TRANSCRIBER 866
APPENDIX 6: EXTRACT OF TRANSCRIBED INTERVIEW 877

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LIST OF TABLES

TABLE 3. 1: MONITORING WORKSHEET: OUTCOME JOURNAL (EARL ET AL., 2001: 94) 23
TABLE 3. 2: MONITORING WORKSHEET: STRATEGY JOURNAL DESCRIBING SOME OF THE STRATEGIES FOR THE IPV CLIENTS (EARL ET AL., 2001: 101) 24

TABLE 4. 1: THE OUTCOME CHALLENGES FOR EACH BOUNDARY PARTNER 35
TABLE 4. 2: PROGRESS MARKERS FOR EACH BOUNDARY PARTNER 36
TABLE 4. 3: STRATEGY MAP 38
TABLE 4. 4: IPV SURVIVORS AND THEIR FAMILIES 41
TABLE 4. 5: FACILITY-BASED PRIMARY HEALTH PROVIDERS 42
TABLE 4. 6: COMMUNITY CARE WORKERS (CCWS) 43
TABLE 4. 7: POLICE AND LEGAL SERVICE 43
TABLE 4. 8: COMMUNITY LEADERS 44
TABLE 4. 9: DEPARTMENT OF SOCIAL DEVELOPMENT 44
TABLE 4. 10: PV SURVIVORS AND THEIR FAMILIES 46
TABLE 4. 11: FACILITY BASED PRIMARY HEALTH PROVIDERS 47
TABLE 4. 12: COMMUNITY CARERS/WORKERS (CCWS) 48
TABLE 4. 13: POLICE AND LEGAL SERVICE 48
TABLE 4. 14: COMMUNITY LEADERS / ACTIVISTS 49
TABLE 4. 15: DEPARTMENT OF SOCIAL DEVELOPMENT 49
TABLE 4.16 THEMES AND SUBTHEMES 52

LIST OF FIGURES

FIGURE 1. 1: CONCEPTS EMBEDDED IN THE FRAMEWORK 5
FIGURE 1. 2: OUTCOME MAPPING METHOD 7

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CHAPTER ONE
FOUNDATION OF THE STUDY

1.1 Introduction

The Constitution of South Africa (1996:1247) states that “everyone has the right to be free from all forms of violence, regardless of whether from a public or private source”.

Saltzman, Fanslow, McMahon and Shelley (2002) describe intimate partner violence (IPV) as the intentional use of violence that may cause death, disability, and/or bodily harm. IPV also includes sexual violence which is the use of physical force to compel a person to engage in sexual acts against his or her will and/or indecent or abusive sexual contact. Thirdly it also includes psychological or emotional violence which is trauma to the person caused by “acts, threats of acts, or coercive tactics”. IPV also includes controlling behaviours such as isolating one`s partner from friends and family, stalking or restricting access to financial resources, employment, education and health care (Joyner, Rees & Honikman, 2015).

1.2 Significance of the problem

There is growing recognition of the association between IPV and increasing female morbidity and mortality rates globally. Abrahams, Jewkes, Martin, Matthews, Vetten, and Lombard (2009: 552) report that nationally IPV is directly linked to the high female homicide rate in South Africa. Their study reveals that the overall rate of female fatalities from IPV (24.7 per 100 000) in South Africa, is six times higher than the global rate (4.0 per 100 000). Norman, Bradshaw and Schneider (2007:653) state that IPV is the second highest contributor to the burden of disease affecting women after HIV and AIDS in South Africa.

Black, Basile, Breiding, Smith, Walters and Merrick (2011) report that IPV causes extensive long and short term disabilities such as; poor physical and mental health, substance abuse and posttraumatic stress disorder. Black et al., (2011: 430) reports that an estimated 67% of women who are treated in emergency rooms as a result of IPV have head injuries and one out of every three women has experienced loss of consciousness at least once as a result of IPV. Furthermore memories of past traumas

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can still cause stress responses thus continuing the impact of IPV well after the abuse itself has stopped.

Violence during pregnancy has been associated with an increased risk of miscarriage, premature delivery and low birth weight (Janssen, Holt, Sugg, Emanuel, Critchlow & Henderson, 2003:1341). Research in Cameroon and Kenya shows a relationship between physical and sexual IPV and the increased risk for induced abortions and terminations of pregnancy. In women of childbearing age (15-49 years) it was found that 38.7% of induced abortions were associated with physical violence, 30.7% with emotional violence and 14.8% with sexual violence (Alio, Salihu, Nana, Clayton, Mbah, & Marty 2010; Emineke, Lawoko & Dalal 2008: 99).

Kaye, Mirembe, Bantebya, Johansson, and Ekstrom, (2005; 581) report an association between IPV and induced abortions among women who received post abortion care in Kampala, Uganda. Moreover, the WHO (2013) analysis found that women who had been physically or sexually abused were 1.5 times more likely to have a sexually transmitted infection and HIV, compared to women who had not experienced partner violence.

In addition, IPV is also associated with harmful mental health effects such as: Post Traumatic Stress Disorder (PTSD), depression, anxiety, lowered self-esteem, psychosomatic complaints, substance abuse, self-harm, and suicidal ideation (Murray and Powell 2009:534; Bonomi, Thompson, Anderson, Reid, Carrell & Dimer 2006: 462).The relationship between IPV and postpartum depression is supported by studies in Brazil (Ludemir, Lewis, Valongueiro, de Arajuo & Araya 2010; Faisal-Cury, Menezes, d`Oliveira, Schraiber, & Lopes 2013:1230). Substance abuse, high HIV prevalence, poverty and unemployment are often intertwined with IPV (Joyner 2013:22). Women who reported physical and emotional IPV verbalised feelings of helplessness, resignation, isolation from friends, family, and lack of confidence in healthcare providers (Wittenberg, Joshi, Thomas & McCloskey 2007: 67). Data from the Perinatal Metal Health Project (PMHP) reveals women experiencing domestic violence are more likely to qualify for referral to a counsellor when screened for mental health (Meintjies, Field, Sanders, Van Heyningen & Honikman 2010:76).

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It is evident from research the need for evidence-based effective IPV interventions to decrease the public health burden of IPV and improve the health of those affected by it.

1.3 Rationale

There is growing evidence that women experiencing IPV are more likely to access health care services. Such visits appear to be the ideal time for detecting and intervening to provide further support. However evidence-based interventions are needed to provide quality and comprehensive care to IPV survivors. In addition, to receive institutional (protocols) and governmental support (funding), evidence must be provided of a well-coordinated and comprehensive IPV intervention programme that will benefit both IPV survivors and communities that so desperately need it.

The World Health Organization (2013) published its first ever policy and clinical guidelines for IPV. It recommends that a structured programme of advocacy, support and empowerment counselling should be offered to pregnant women and those who seek sheltered protection. Similarly Wathen and Macmillan (2005:589) provide evidence that those who received a specific programme of advocacy and counselling reported a decrease in the rate of re-abuse and an improved quality of life. Advocacy in this context constituted enabling survivors to access community resources and assisting with devising safety plans if needed.

Joyner and Mash (2012:399) state that extensive research has been done on the incidence, prevalence and health consequences of IPV but there is far less literature regarding comprehensive interventions for IPV. Similarly, Baldwin-Ragaven (2010:577) draws attention to the proliferation of peer-reviewed articles that measure the extent of the problem, document the consequences of non-intervention but fail to provide evidence - based interventions.

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1.4 Problem statement

IPV remains a hidden subject and women living with IPV are completely disregarded by society as well as the institutions (health sector included) that must assist them. There is a need for evidence-based IPV interventions to decrease the public health burden of IPV.

1.5 Research aim

To evaluate the implementation of an integrated comprehensive intervention programme for IPV using outcome mapping in the Macassar community of Cape Town.

1.6 Research objectives

- To evaluate the implementation of a community-based service for IPV
- To evaluate the strategies used to implement the service for IPV
- To evaluate the outcomes of the implementation of this IPV service

1.7 Conceptual framework

IPV is a complex phenomenon requiring a comprehensive intervention that includes clinical, psychological, social and legal components.

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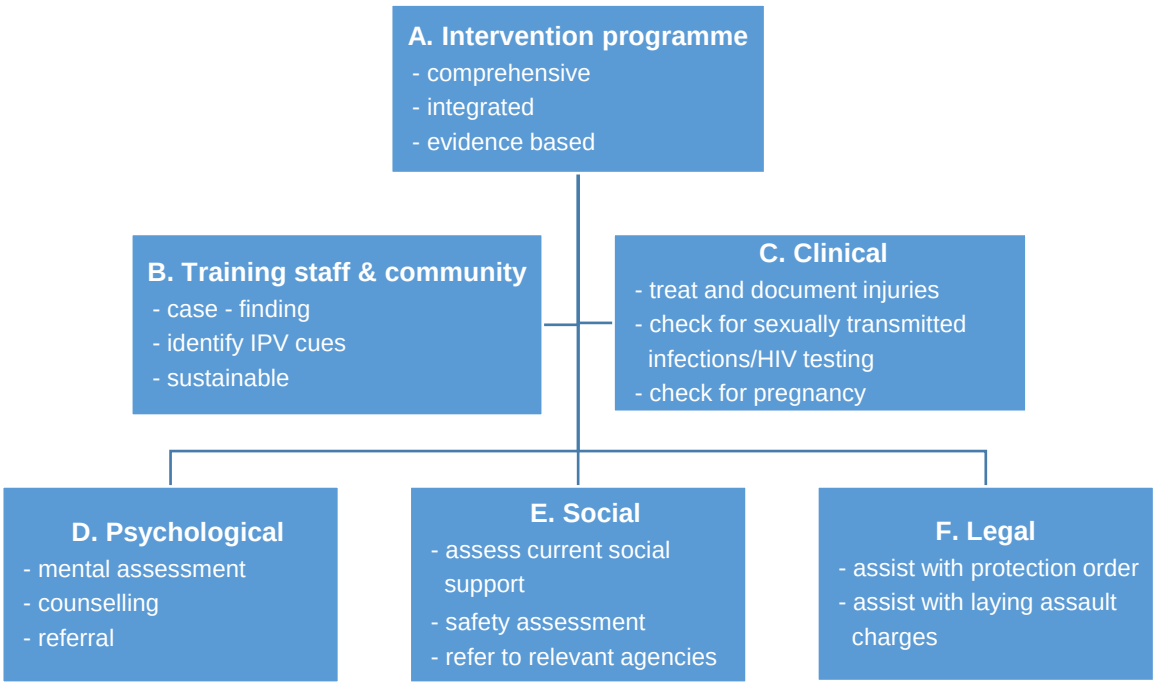
Figure 1. 1: Concepts embedded in the framework



(Source: Joyner and Mash`s IPV model: 2012)

A. Intervention programme

Joyner and Mash (2012b:399) recommend an intervention model for IPV that encompasses case-finding and comprehensive biopsychosocial and forensic care.

B. Training

Training for all primary care providers, allied workers and community carers in case finding, to promote identification of patients living with IPV. For example these might be scars or wounds due to assault, chronic pain syndromes, a history of mental illness (e.g. depression or substance abuse) or psychiatric medication. Joyner and Mash (2012:405) advises that on recognition of these cues the provider should ask *"Are you unhappy in your relationship?"* Further questions may be needed to elicit a history of IPV. If IPV is confirmed then the primary care provider can provide further clinical assessment and management. The patients can then be offered referral to an IPV champion for further more comprehensive assessment and counselling.

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C. The clinical component

On recognition of IPV the primary care provider can treat overt injuries, complete forensic documents if necessary, screen for and treat STI`s, including HIV, and provide advice on pregnancy or contraceptive options.

D. The psychological component

This includes screening for mental health problems such as depression, anxiety, post-traumatic stress disorder and substance/alcohol abuse by the IPV champion. Counselling is offered in an empathic manner, guiding the client towards making their own choices. Referrals can be made to a mental health nurse or doctor for formal diagnosis and treatment.

E. The social component

The IPV champion takes a detailed history regarding the abuse, the family, social support and assesses the degree of imminent risk from her intimate partner. If the client is in immediate danger of injury or death then she can be offered a shelter for her and her children. Other assistance such as planning for emergencies or procurement of maintenance payments can also be done.

F. The legal component

The IPV champion assesses previous engagement with the legal system, provides information about her legal rights and may assist in laying a charge or obtaining a protection order.

1.8 Research methodology

The research study followed the outcome mapping approach which is briefly outlined in the following diagram. A detailed description will follow in chapter three.

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Figure 1. 2: Outcome mapping method

(Source: Earl et al., 2001:4)

1.8.1 Pilot study

The IVP intervention was piloted in the Witzenberg sub-districts from 1 April 2012 to 31 March 2013. An urban pilot was also attempted at Elsies River Community Health Centre in the Tygerberg sub-district from November 2013 to April 2014 (Rees, Zweigenthal, Joyner, 2014).

1.9 Ethical considerations

The Western Cape Department of Health approved the study, reference number: 2014RP102. The Health Research Ethics Committee (HREC) at Stellenbosch University approved the study, reference number: N13/06/090. This study was built onto a previously approved study. An amendment was brought to the original application, detailing the specifics of this study

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1.10 Definitions

Allied service providers

These are additional support service providers such as physiotherapists and occupational therapists working at primary healthcare centres.

Intimate Partner Violence (IPV)

The intentional use of violence that may cause death, disability, bodily harm, it also includes sexual violence which is the use of physical force to compel a person to engage in sexual acts against his or her will and or indecent or abusive sexual contact and thirdly IPV also includes psychological or emotional violence which is trauma to the person caused by “acts, threats of acts, or coercive tactics” (Saltzman, Fanslow, McMahon and Shelley, 2002).

IPV survivors

Persons that are exposed to physical, psychological, emotional and financial abuse caused by their partners.

IPV champion

A skilled and expert generalist with the skills to assess a patient holistically and coordinates care between multiple role players involved in IPV management on an ongoing basis.

Outcomes

Outcomes are the ideal behavioural changes that occur as a result of intentional engagement with an individual or a group by a project team.

Primary care providers

An umbrella term that refers to the medical professionals, both doctors and nurses that provide primary healthcare at community health centres and clinics in the communities.

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Strategies

Activities the project team employs to support and assist boundary partners to achieve a specific goal (outcome challenge).

1.11 Duration of the study

Ethical approval	16 July 2014
Follow-up Data Collection	07 August 2015 – 18 August 2015
Data Analysis	30 September – 30 January 2016
Write up of MCur dissertation	February to November 2016

1.12 Chapter outline

Chapter one

Outlines the social value of the study and provides a brief introduction.

Chapter two

Presents the scientific value of the study based on the literature and the identified knowledge gap to be addressed.

Chapter three

Provides a detailed description of the research methodology used in the study.

Chapter four

Presents the results of the study.

Chapter five

Discusses the results and concludes with recommendations.

1.13 Conclusion

In Chapter 1, an introduction and rationale for the research study was provided. A brief overview of the aim, objectives, conceptual framework, research methodology, setting, ethical considerations and duration of the study was outlined. Chapter 2 discusses the scientific value of the study based on a review of the literature.

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CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

IPV is an ongoing health and social problem that profoundly impacts the lives of individuals, communities and the health sector. IPV encompasses physical, sexual, psychosocial, emotional, cultural, spiritual and financial abuse and since it has such a wide reaching effect, the management thereof also needs to be as comprehensive.
This literature review aims to summarise the scientific knowledge about the challenges in providing care for IPV survivors in relation to different intervention strategies that have been utilised for this purpose.

2.2 Background

Evidence on the widespread prevalence of IPV, resulting in adverse mortality and morbidity outcomes, underscores the need for health care programs and systems to respond to IPV (Chibber & Krishnan, 2011:1342). This opinion is shared by Elsberg, Jansen, Watts & Garcia-Moreno (2008:1165) who reports that IPV is associated with such serious public-health outcomes that it needs to be addressed by national and global health programs. Moreover, studies have found that between 42% and 66% of women who were killed by their intimate partner had recently used health care prior to their death but had not been identified as victims of IPV (Martin, Macy, Sullivan & Magee, 2007: 144, Sharps, Koziol-Mclain, Campbell, McFarlane, Sachs & Xu, 2001:377). There is thus a growing need for appropriate services for women presenting to the primary health care system who are experiencing IPV to be identified and managed appropriately.

While the causes and impact of IPV have been extensively studied, there is limited evidence-based research into the management of IPV. Jewkes (2013:190) argues for the development of new health sector approaches to IPV as well as more rigorous evaluations of IPV interventions particularly at primary care level. Black (2011:435) is of the opinion that IPV prevention and intervention should be prioritised to decrease the public health burden of IPV and improve the health of patients being seen in the medical system.

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The increasing utilisation of health care services among women, suggests that this may represent an important opportunity to engage in IPV prevention and management (Chibber & Krishnan 2011: 1342). The United Nations (2010) reports that women's visits to reproductive health i.e. family planning, maternal and child health services has been increasing globally, particularly in developing countries.

The World Health Organization's (2013) published policy guidelines for responding to IPV outlines requirements for an appropriate health sector response. It recommends clear policies and protocols, supportive management, financial resources and institutional support for primary health providers. Rees, Zweigenthal and Joyner (2014) concur with this recommendation advocating for clear policies and guidelines framing IPV as a health issue.

2.3 Challenges in identifying IPV

2.3.1 Failure to disclose IPV

Lutenbacher, Cohen and Mitzel (2003:55) are of the opinion that IPV survivors fear that disclosure of abuse will be ignored or not taken seriously by healthcare providers. Furthermore the perception that the survivor is to be blamed for the abuse and fear that she might lose her children or will have to leave partner were some of the reasons why IPV is not disclosed (Robinson & Spilsbury, 2008:28; Narula, Agarwal & McCarthy, 2012:597). Moreover survivors describe a non-judgemental, non-directive and empathetic approach by healthcare workers as key to disclosing IPV. According to Chang et al., (2005:30) characteristics of interventions that participants engage in include anonymity of the IPV survivor, presenting the participant with multiple options and respecting the autonomy of the participants. Lack of privacy in healthcare facilities and a fragmented service also contributes to non-disclosure.

2.3.2 Health care providers' challenges

A study in Zimbabwe found that identifying and responding to IPV in the antenatal setting is hampered by inadequate human, financial and infrastructural resources as well as lack of gender-based violence training for midwives. Moreover some midwives perceived IPV as a social and domestic rather than a health problem, therefore not requiring their attention (Shamua, Abrahams, Temmerman & Zarowsky 2013:524).

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Significantly, Joyner and Mash (2012a, 2012b) found that health providers feel unsupported and poorly equipped to handle the challenges of family violence. Moreover some are also exposed to similar incidents of IPV as their patients thus impeding their response to IPV. Subsequently the normalisation of IPV in the community is reflected in their disregard of IPV as a healthcare issue in their practice (Rees, Zweigenthal & Joyner, 2014: 6). Uthman, Moradi and Lawoko, (2011) using data from the 2008 Nigerian Demographic and Health survey (NDHS) demonstrated that community tolerance and acceptance of IPV is associated with increased spousal physical, sexual and emotional abuse.

Health professionals cite lack of time, feeling uncomfortable with the subject of partner violence and lack of training as the main reasons for failing to screen for IPV (Baig, Shadigian & Heisler, 2006). Similarly, Beynon, et al., (2012:9) report the top barriers in inquiry about IPV were lack of time, language/cultural barriers, lack of training and professional resources and protocols. Further, focusing on these barriers masks personal challenges such as feelings of frustration and futility regarding how to respond to such a complex issue.

2.3.3 Biomedical versus holistic healthcare

The overall clinical focus currently within South Africa care is biomedical and task-orientated care, stemming from a mind-set that equates effectiveness with speed (Gaede, Mahlobo, Shabalala, Moloi & Van Deventer 2006). Therefore clinical nurse practitioners struggle to provide holistic and patient-centred care (Joyner & Mash 2014:664). Moreover appropriate IPV management is geared towards continuity of care in contrast to acute episodic care encouraged by the practice of biomedical care (Rees, Zweigenthal & Joyner, 2014). This type of practice is further supported by evaluating nurses` daily performances according to records that focus on quantity over quality, diagnosis over understanding, and drugs administered over emotional care (Petersen, 2000:321).

A narrow focus on biomedical healthcare may also encourage a victim-blaming discourse. By conceptualising health problems as diseases, it fails to consider the psychosocial factors of ill health (Joyner & Mash, 2012). Furthermore by dismissing IPV as a social and legal issue, healthcare providers are not compelled to deliver

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comprehensive care to women affected by IPV. Beynon et al. (2012) sums it up by this remark:

"*it is possible that for those who operate from a results-driven model of care, where actions are expected to solve problems, the inability to control a situation or the outcome can be personally or professionally intimidating or frustrating".*

2.4 IPV models and management strategies

The World Health Organization's clinical and policy guidelines for IPV (2013) recommends that a structured programme of advocacy, support and empowerment counselling should be offered to all pregnant women and any others exposed to IPV. This entails aspects such as confidentiality, containment, helping the IPV survivor access information and resources, and assisting with safety by mobilising social support. It also recommends that health providers should specifically enquire about exposure to IPV when noticing symptoms that may indicate IPV in order to improve identification. This approach is supported by Joyner and Mash (2011:254). Similarly, Bonomi, Anderson, Rivara and Thompson (2009) advocate multi-faceted approaches that cover the clinical, mental, social and legal aspects of IPV in an integrated manner.

A systematic review by O'Campo, Kirst, Tsamis, Chambers and Ahmad (2011:855) reported that IPV intervention programs that incorporate multiple programme components were successful in increasing IPV screening and identification. The components of these programmes were institutional support, screening protocols, initial and ongoing training and immediate access or referrals to onsite or offsite support resources.

A Swedish study suggests engaging community structures such as schools, sports associations and workplaces as areas of influence for the prevention of IPV. Educational programmes directed at community leaders such as healthcare professionals, social workers, policemen, and politicians could help increase their awareness of IPV. However to really bring about change multilevel interventions are needed as discussed above (Jacobson, Von Bergstede, Krantz, Spak & Hensing, 2013: 339).

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Ambuel, Hamberger Guse, Melzer-Lange, Phelan M and Kistner (2013:833) implemented the Healthcare can Change from Within model (HCCW) to create sustainable system change to improve IPV screening and intervention. This encompasses development of an internal on-site IPV expert, training of all staff members working within a particular clinic or unit, development of clinic or unit-based policies and procedures, collaboration with local advocacy agencies and IPV experts as well as incorporation of continuous quality improvement and primary prevention strategies such as pamphlets that can be given out to literate patients.

According to Battaglia, Finley and Liebschutz (2003:621), survivors have indicated increased levels of trust when health professionals openly communicate about IPV in a caring and non-judgemental manner. Survivors also appreciate confidentiality and being included in decision making about their treatment plan. Nicolaidis (2002:122), Dienemann, Glass, and Hyman (2005:235) identified that key components of effective IPV interventions by healthcare providers are showing respect to the IPV survivor and displaying genuine concern. Survivors also valued information about other support services or if referrals were made to these services. Shamua, et al., (2013) advocated training and supporting nurses to pay attention to select cues and to then ask about IPV in a sensitive and caring way rather than promoting universal screening for all women.

A systematic review was conducted to explore the integration of IPV within the Spanish health system based on the WHO recommendations for health sector responses to violence against women. Key recommendations were that protocols or clinical guidelines must be developed and be in place to guide health providers on the management of IVP. Policies need also to be developed regarding the training of health providers to detect and manage IPV as they are considered the key role players in the successful implementation of IVP intervention (Goicolea, et al., 2013).

A study to determine the efficacy of a psycho-behavioural intervention in reducing IPV during pregnancy followed an integrated intervention approach model. This included the provision of information regarding types of abuses, recurrent cycles of violence, risks assessments and prevention options. The development of a plan of safety as well as supplying the participants with a list of community based resources, together

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with individual counselling sessions, was all included in the integrated approach. The study concluded that a specific intervention, although relatively brief had a discernible effect on IPV and pregnancy outcomes (Kielly, El-Mohandes, El-Khorazaty, Blake, & Gantz 2010).

In South Africa`s primary healthcare system there are no existing protocols for identifying IPV resulting in a poor and fragmented service for IPV clients which lacks continuity of care (Joyner & Mash, 2012a). In collaboration with the Department of Health, the Department of Social Development and the South African Police Service, an IVP intervention was piloted in the Witzenberg and Tygerberg sub districts between April 2012 and April 2014 (Rees, Zweigenthal & Joyner, 2014). The size of the sample were 75 women.

The recommended IPV care model covered four broad areas: clinical, social, psychological and legal. Primary providers were expected to case find by recognising specific cues suggestive of IPV. When IPV was identified, providers were to provide clinical care i.e. treating injuries, forensic documentation, reproductive health care, syndromic management of STIs and HIV testing. Social aspects includes, mobilisation of social support and planning for emergency situations. Survival issues such as procuring maintenance for children and disability grants were included.

The psychological component included identification of common mental health problems, counselling, and referral for diagnosis and treatment if needed. The legal component included a history of previous attempts to utilise the police or courts, information about legal rights and assistance to obtain a protection order or lay a charge. The study provided evidence that the IPV intervention was perceived to be of great benefit for most of the participants.

Joyner and Mash (2012b) suggest the concept of an “IPV champion” based on the chronic care policy in the Western Cape. It proposes that the IPV champion coordinates care between all the role players involved in IPV management. This person must have specific characteristics and qualities such as; exhibiting empathy and good listening skills, respect for client confidentiality and autonomy, effective in multidisciplinary teamwork and be able to foster inter-sectoral collaboration. If possible

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the IPV champion should be a staff member of the local primary health care facility who is interested to engage in IPV prevention and management. Following identification of IPV and provision of clinical care, the woman should be referred to the IPV champion for further management (Joyner & Mash, 2012b).

2.5 Conclusion

This chapter has summarised evidence on what is known about providing healthcare services for IPV survivors. The evidence clearly indicates that the implementation of a comprehensive IPV intervention programme in primary health care settings is long overdue. However the literature indicates that implementation of IPV intervention is challenging due to its complex nature. Therefore evidence of the implementation and evaluation of such services is of utmost importance to the health sector and the communities affected by IPV. Given the burden of disease IPV poses, along with its detrimental intergenerational effects, it is time our healthcare sector takes this challenge seriously. The next chapter will describe the methods used in this study.

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CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

Chapter three describes the research methodology that was used to design, monitor and evaluate an IPV intervention project using an outcome mapping approach. A biopsychosocial and legal intervention project for women affected by IPV was offered by Dr Kate Joyner at Macassar police station in the Victim Empowerment Unit (VEP) unit from September 2014 to April 2015.

3.2 Study design

Jones and Hearn (2009:2) argue that the choice of a planning, monitoring and evaluation framework for a project influences the values and practices embedded within the project. Consequently, the choice should be guided by an explicit focus on what is specifically needed for that project. They claim this decision is key to the efficacy of the project.

The IPV intervention followed the outcome mapping approach as a method to design, monitor and evaluate the project because it enables “an organisation to document, learn from, and report on the process of social and behavioural change that it embarked on” (Earl, Carden & Smutylo, 2001:17). Outcome mapping has been developed for organisations where monitoring and evaluation are primarily intended to help with project learning and improvement. Jones and Hearn (2009) states that outcome mapping is best suited when working in partnerships with different stakeholders as well as when promoting knowledge and influencing policy.

This methodology was developed by the International Development Research Centre in Canada to assist project teams in planning, monitoring and evaluation of programmes in various settings (Earl et al., 2001:21). It assists project teams to be specific about the individuals, groups or organisations it targets, the changes it expects to see and the strategies it needs to implement to create social change. Results are measured by the changes in behaviour, actions and relationships of the individuals, groups or organisations with whom the team interacts directly (Smutylo, 2005).

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The goal of this IPV intervention was to collaborate with the community of Macassar and through their participation create awareness and support IPV survivors to improve their quality of life. Twenty-three IPV survivors from ages 20 to 65 years attended the IPV service during the seven months of implementation.

Outcome mapping was chosen for the study design because it is based on the following principles which are in agreement with the goals of the IPV project:

3.2.1 People-centred development and behaviour change

Understanding and influencing change requires engaging with people by building relationships and investing in human capacity thereby bringing about social change (Jones & Hearn, 2009:2). The IPV intervention project intended to engage with a variety of role-players (boundary partners) in order to develop their skills to bring about social and behavioural change.

3.2.2 Outcome mapping is a process of continuous learning and reflexivity

Most effective planning, monitoring and evaluation activities are cyclical, repetitive and reflexive in nature to foster learning about the challenges involved in influencing social changes (Jones & Hearn, 2009:2). Regular monitoring and evaluation meetings will serve as opportunities for reflection and learning not only about partners and strategies, but also about the team`s own practices and challenges.

3.3 Study setting

The study was conducted in Macassar, a former township on the outskirts of the Cape Metropole near Somerset West. It has a population of approximately 46 000 Afrikaans speaking people. The community has basic amenities such as electricity, housing and tap water. It has three primary schools, two high schools, police station and a community health centre (CHC) including a maternity obstetrics unit (MOU). It lacks psychosocial and other community-based resources such adult social services. The IPV project was offered in a private room at the Victim Empowerment Centre (VEP) of Macassar police station. Women who had experienced IPV were mostly referred to the project from Macassar CHC, community-based carers and word of mouth.

3.4 Steps of outcome mapping

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Outcome mapping consists of 12 steps within three stages namely: intentional design, outcome and performance monitoring and evaluation planning.

The **intentional design** stage assisted the project team to articulate the macro level changes the project hoped to achieve. This included aspects such as the vision and mission statements, identification of the boundary partners to be engaged with, and the outcome challenge for each boundary partner. The intentional design stage also specified progress markers, which track the gradual progression of changed behaviour in the boundary partners as they engage in the project (Earl et al., 2001:31). Strategy maps identify different strategies for each boundary partner in order to reach their outcomes. The role and function of each member in the project team was defined.

The outcome and performance monitoring stage provided a framework to continuously monitor the progress of the boundary partners as well as the effectiveness of the implemented strategies. Monitoring was done using data collection tools such as outcome journals, strategy journals and performance journals. The outcome and performance monitoring process assisted the project team to ascertain what was happening at ground level with the project and to adjust their plans when required.

The third stage, **evaluation planning,** assisted the project team to identify what strategies, relationships, or issues arising from the evaluation process need to be studied in depth and the method of evaluation that must be followed.

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The three stages and twelve steps to Outcome Mapping are illustrated in **Figure 3.1** (Earl et al., 2001:4)

Figure 3.1: Outcome Mapping

The design, implementation and monitoring of the IPV service using the outcome mapping framework will now be explained in detail.

3.5 Stage One: Intentional Design

The project team consisted of Dr Kate Joyner, IPV champion, project coordinator and Masters student`s supervisor; Prof Bob Mash, co-researcher and co-supervisor; and co-researcher Winnifred Pienaar, the Masters' student.

The project team held their first meeting on the 22nd of August 2014 facilitated by Prof Mash to create the **Intentional Design**. Through a process of brain storming the following questions were addressed:

Why is the intervention necessary? (vision statement)

Who do we want to reach or influence? (boundary partners)

What is the long term goal? (outcome challenges and progress markers)

How do we reach the final outcome? (mission, strategy maps, organizational practices) (Earl et al., 2001: 3)

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Steps of the Intentional design stage are described further.

3.5.1 Vision statement

The vision statement articulated the ideal sustainable IPV intervention project the team wished to establish in the Macassar catchment area. It described broad behavioural changes in the boundary partners that the project hoped to help bring about. The vision statement was created by the facilitator asking the team members to verbalise what the ideal changes they envisaged the IPV project will achieve. A broad vision statement was refined through a process of deliberation within the team until the ideal vision statement was accepted by the team.

3.5.2 Mission statement

The mission statement described what the project must do to contribute to, and support, the vision. It briefly described the aspects the project would concentrate on and how this will be done. After every member`s input, a mission statement was developed as approved by all.

3.5.3 Boundary Partners

From April to August 2014 the IPV champion networked with individuals, groups and organisations in the catchment area of Macassar that had an interest in the project. A list of provisional candidates was identified by the project co-ordinator and the team selected those persons, groups and organisations it could influence and engage directly about IPV. In turn, it was hoped the boundary partners would influence the community to increase awareness of IPV so as to promote the sustainability of this IPV service.

3.5.4 Outcome challenge

An outcome challenge was created for each boundary partner that described the ultimate change anticipated for that partner. Team members had to describe what the ideal behavioural change (outcome) for each boundary partner, aligned with the vision and mission, would be in the long term. An outcome challenge was then drawn up for each boundary partner describing the desired behavioural or social change.

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3.5.5 Progress markers

These specify progressive changes that measure the boundary partners' interaction with the project. These are aligned to the ultimate achievement of the outcome challenges. Progress markers are stepping stones that require increasing engagement with, and transformation of, the boundary partner. The specific progress markers were defined at three levels:

i. What the project team *expect to see* i.e. small changes in the boundary partners as they start engaging in the project.
ii. What project team *would like to see* i.e. real engagement of boundary partners with the intended changes
iii. What project team *would love to see* i.e. deeper and more meaningful changes in values and behaviour of the boundary partners.

3.5.6 Strategy map

Different strategies/activities were identified by the project team to assist and support the boundary partners to achieve the desired changes. These were individualised according to the unique challenges facing each boundary partner.

3.5.7 Organisational practices

These were the internal practices that the project team had to identify and consider for the successful implementation of the IPV service. It addressed the *when* and *by whom* aspects such as the role definition of each project team member, dates and venues for meetings, data collection responsibilities, facilitation of meetings and any other tasks that enabled the project team to function optimally.

3.6 Stage Two: Outcomes and Performance monitoring

3.6.1 Monitoring priorities

Meetings were held two monthly to monitor and reflect on the progress of boundary partners, implemented strategies and organisational practices. This was done to assess progress and to adapt implementation approaches when necessary. The team also prioritised what should be monitored on an ongoing basis and what would need to be evaluated in depth in future.

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3.6.2 Outcome journal

An outcome journal was used to record the level of change by rating the achievement of each progress marker. The progress of each boundary partner was monitored and recorded at each meeting. Evidence of change was collected from the IPV champion`s observations and field notes.

Table 3. 1: Monitoring worksheet: outcome journal (Earl et al., 2001: 94)

MONITORING WORKSHEET 2: OUTCOME JOURNAL		
Work Dating from/to: 01 September 2014 – 30 April 2015		
Contributors to Monitoring Update: Dr K Joyner		
Boundary Partner: IPV survivors and their families Outcome: Display coping skills and improved quality of life		
EXPECT TO SEE		
OOO 1	• Identify crisis situations	
OOO 2	• Dealing with imminent danger	
LIKE TO SEE		
OOO 5	• Display coping skills	
OOO 6	• Awareness of resources	
LOVE TO SEE		
OOO 13	• Improved quality of life	

3.6.3 Strategy journal

Data on strategies that were implemented to encourage change in the boundary partners were discussed in depth at team meetings, recorded and transcribed. These documents comprised a key component of the strategy journal. It included detailed information on the effectiveness of strategies, if and where changes were needed, and follow-ups required. Information was obtained from the number of referrals made from the CHC, inquiries and appointments made at the police station about the IPV service. The IPV champion`s own field notes regarding interactions with boundary partners as

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well as interventions implemented with IPV clients served as a source of information for monitoring strategies.

Table 3. 2: Monitoring worksheet: strategy journal describing some of the strategies for the IPV clients (Earl et al., 2001: 101)

MONITORING WORKSHEET 3: STRATEGY JOURNAL
Work dating from/to: 01 September 2014 – 30 April 2015
Contributors to Monitoring Update: Project team
Strategy to be Monitored Provision of psycho-, social- and legal support to IPV clients.
Description of Activities Assessments done with all IPV survivors on scale of abuse. P 021 Burn victim provided a huge amount of support, home visits and liaising with Helderberg hospital social worker and finally handed over to a person whom Dr. Joyner had identified as a potential community-based IPV champion. Liaised with social worker and family physician at Helderberg hospital regarding client`s burn wounds and circumstances. P 05 Assisted with obtaining protection orders from Magistrate court. P 011 Wrote referral letters to mental health nurses at CHC and continued to follow up. P 014 Provided counselling and referred to mental health unit at CHC for further assessment and care.
Effectiveness This varied from case to case. Some clients only needed supportive counselling, other were assisted in getting employment by drawing up CVs and applying for jobs. Still others felt empowered to make changes such as starting divorce proceedings.
Required Program Follow-up or Changes Identification of IPV champion within the community.
Lessons Interviews with IPV survivors revealed the invisibility, as well as the lack of acknowledgement of IPV in the community and support services e.g. magistrate's court, and social services.

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3.6.4 Organisational practices

Meetings were held two monthly where the progress of the project were monitored. Data collected by the IPV champion were recorded in the outcomes and strategy journals. The project team reflected on their internal practices at the regular meetings. These practices were monitored for effectiveness, relevancy and sustainability with regard to the achievement of outcomes. They were modified as needed.

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3.7 Stage Three: Evaluation planning

The third stage, evaluation planning, assisted the project team to identify what strategies, relationships, or phenomena arising from the evaluation process need to be studied in depth and the method of evaluation that must be followed.

A key issue that emerged from the monitoring and evaluation phase was that relatively few primary care providers, with the exception of the doctors, identified and referred patients with IPV to the service during its implementation. This was despite the fact that the majority of the staff attended and actively participated in the training on identification and referral of IPV cases. The referrals clearly indicated that doctors made many more referrals than nurses. One doctor attended the training from the four due to the high number of consultations. The Masters student was keen to evaluate this phenomenon through a descriptive qualitative exploration of primary care providers' experiences and viewpoints regarding identifying and managing IPV. The project team supported this as an appropriate evaluative component within the outcome mapping design.

3.8 Qualitative evaluation: Exploration of primary health providers` experience and viewpoints regarding identifying and managing IPV

3.8.1 Aim and objectives

The aim of this qualitative component was to explore the experience and viewpoint of primary health providers towards identifying and managing patients with IPV

Specific objectives for this evaluation included:

- To explore primary health providers understanding about IPV
- To identify challenges that may have interfered with the identification and referral of IPV cases to the service
- To explore the management strategies that primary health providers implement when confronted with IPV cases
- To explore primary health providers opinion regarding the IPV service
- To explore primary health providers personal experiences of IPV

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3.8.2 Study design

Interviews were guided by a semi-structured interview guide (Appendix 4). These were conducted with members of the multi-disciplinary healthcare team at Macassar CHC after completion of the IPV intervention project. The researcher used in-depth interviews to gain understanding of participants` perspectives on identifying and managing patients with IPV. This furnished insight into their lived experiences in dealing with the topic (Botma, Greeff, Malaudzi, and Wright: 2010: 190).

3.8.3 Study population

Inclusion criteria

The inclusion criteria included all primary health providers who consulted women at Macassar CHC including the allied service providers.

Exclusion criteria

Auxiliary and enrolled nursing staff was excluded because they did not consult patients.

Participants were chosen by means of purposive sampling. Purposive sampling is the deliberate selection of specific participants, meeting the inclusion criteria, in order to provide rich detail about the information needed to address the objectives of the study (Grove, Burns & Gray, 2013: 268).

After obtaining permission from the Department of Health to conduct the study, the researcher first arranged a meeting with the facility manager to explain the details of the research and how it will impact the facility. A date and time was set by the facility manager for the researcher to have an information session with the staff. It was attended by different members of the multi-disciplinary team where details of the research were disseminated. Participation information leaflets (Appendix 3) were also given to the facility and operational managers for staff who could not attend the information session. The names of staff members who volunteered and met the inclusion criteria were taken and appointments were made with them.

Eight participants were purposely chosen to represent the different categories of the multi-disciplinary team to illicit varied information from them.

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- Two medical officers
- Two clinical nurse practitioners
- Two midwives
- A physiotherapist
- An occupational therapist

Prior to the interviews, the researcher visited the health facility to familiarise herself with its daily routines, and to check and arrange data collection venues.

3.8.4 Pilot interview

A pilot interview was conducted with one of the participants to test the proposed questions and to ensure that the researcher was adequately prepared. The pilot interview was analysed with the assistance of the co-supervisor to identify if the proposed questions were in agreement with the stated objectives and if the participants understood them. Changes were made to questions that did not illicit adequate information. Data from the pilot interview was included in the study.

3.8.5 Trustworthiness

Lincoln and Guba's principles of credibility, transferability, dependability and confirmability, as described in De Vos et al., (2009:346) were applied to assure trustworthiness.

3.8.5.1 Credibility

The researcher made use of audio recordings with the permission of the participants to assist with this process. To ensure confidentiality interviews were held in the participants consulting rooms after work. Codes were used in place of their names during data analysis. Credibility was assured by utilising the supervisor and co-supervisor to review the data objectively.

3.8.5.2 Transferability

Qualitative research does not aim at generalising the information to other situations therefore transferability of knowledge in this study have been ensured through detailed descriptions of the participants' experiences with the phenomenon studied.

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Demographic data…..

3.8.5.3 Dependability

Dependability is achieved through providing a detailed description of the methodology used to source, collect and analyse the data (Terre Blanche et al., 2006:94). This is discussed under data collection. Furthermore the methodology and collection of data was peer reviewed by the co-supervisor.

3.8.5.4 Confirmability

To eliminate biases from the researcher and ensure confirmability the researcher had to carefully reflect on her own perceptions and assumptions about IPV to remain as objective as possible. Therefore, the researcher explored and reflected on her own opinions and experiences regarding IPV from the outset during contact sessions with her supervisor.

The researcher received her training as a professional nurse at a public institution and worked a few years in the emergency unit of a public hospital. Here the researcher dealt with numerous IPV cases. The researcher remembers her absolute frustration to deal efficiently in assisting clients exposed to IPV due to lack of training and policy guidelines.

3.8.6 Data collection

Interviews took place daily depending on the busyness of the facility and the availability of the participants. Participants were given an information letter to read through and then were requested to complete and sign the consent form
(Appendix 3).

A semi-structured interview guide consisting of open-ended questions based on the study objectives was used to elicit information about the phenomenon under study (Appendix 4). The literature review was used to guide the interview and understand the interviewee`s perception about their experiences in caring for patients exposed to IPV.

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Interviews were conducted in English or Afrikaans according to each participant's preference as Afrikaans is the dominant language in the area. Both researcher and transcriber are bilingual in English and Afrikaans. The interviews were audio-recorded and transcribed verbatim (Appendix 6). Interviews took place in participants' consulting rooms at the facility. Demographic information about each participant was collected at the start of each interview. This was done to establish rapport between the researcher and the participants and to understand the participants` frame of reference.

3.8.7 Data analysis

Transcripts were checked for accuracy and if any mistakes occurred these were corrected according to the original recording. Data was coded and analysed according to the framework method (Ritchie & Spencer, 1994) and the Atlasti programme. The framework method involved five steps namely familiarisation, developing a thematic framework, indexing, charting, mapping and interpretation.

3.8.7.1 Familiarisation

This process entailed reading the transcripts and observations notes or listen to the audio recordings to get familiar with the content. From this process key ideas and recurrent themes were noted as they emerged (Elo, Kynga, 2008).

3.8.7.2 Development of a key thematic index

Codes and categories were developed from the content based on the aims and objectives of the study. Codes and categories were refined until a final list was developed called a thematic index. Each code had a short descriptive label to enable the correct data to be placed under the code. This process enabled the researcher to divide the data into smaller sections for easier interpretation (Attridge-Stirling, 2001).

3.8.7.3 Indexing

The codes identified in the thematic index were applied to all the data by highlighting specific passages and linking it to specific codes in the margin (Pope, Ziebland & Mays, 2000).

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3.8.7.4 Charting

The thematic index`s framework was used to re-arrange the data into a series of charts so that all the data of the same code are together. (Mabuza, Govender, Giwhala, Ogunbanjo & Mash; 2014).

3.8.7.5 Interpretation

By reading each chart the data was interpreted to establish the range and nature of the phenomenon being studied. Other interpretations included characteristics of key concepts, typology of emerging themes and patterns of associations or explanations in the data. Attention was also paid to deviations and contradictions in the data as this serves as a rich source of information to increase understanding of the phenomenon (Elo et al, 2008).

3.9 Ethical considerations

The Health Research Ethics Committee (HREC) at Stellenbosch University approved the study, reference number: N13/06/090. This study was built onto a previously approved study. An amendment was brought to the original application, detailing the specifics of this study (Appendix 1).

Permission was obtained from the Department of Health, reference number 2014RP102 and the facility manager. Prior to the interview sessions, permission for participation, and to electronically record the interview, was obtained from each participant (see Appendix 2).

3.9.1 Confidentiality

Assurances were given to participants that the information shared during the interviews would be kept in confidence and that there would be no unauthorised access to the data. The recordings and transcripts will be stored in a locked and secure area, for a minimum of five years. Access is limited to the people who were directly involved in the study, namely, the researcher, her supervisor and co-supervisor.

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3.9.2 Autonomy

Participation in the research was completely voluntarily and the participants were informed that they were free to withdraw from the study at any stage without prejudice. Written, informed consent was obtained from each participant for both the participation in the research study and for the interviews to be audio-recorded.

3.9.3 Privacy

Privacy was assured by the use of pseudonyms instead of participants' real names. The transcriptions and recordings were coded and no personal details of a participant were revealed.

3.9.4 The principle of beneficence

The principle of beneficence entails doing no harm, removing harm and promoting all that is good (Pera & Van Tonder, 2011:54). The researcher was cognisant of the sensitivity of the research topic and if an interviewee indicated discomfort the interview would be discontinued or postponed to another date.

3.10 Conclusion

This chapter discussed the use of an outcome mapping method to design, monitor and evaluate a community-based intervention for IPV. As part of the evaluation stage an emerging finding regarding primary care providers' experiences in managing patients exposed to IPV was further explored using qualitative research. The next chapter presents the main results.

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CHAPTER FOUR
FINDINGS

4.1 Introduction

This chapter presents the findings of evaluating an intervention programme for IPV using the outcome mapping method. The findings of the research study that followed from the evaluation process are also presented.

4.2 Intentional Design

4.2.1 Vision statement

This was decided upon by input from the team who conceptualised the ideal changes the project hoped to achieve. The following statement was endorsed by all team members:

We envisage the development of a sustainable IPV model of care based on the right expertise and in collaboration with community resources in Macassar. It should provide evidence on what is the best model for IPV care for decision-makers. There will be less IPV and better quality of life for IPV survivors and their children within the Macassar catchment area. IPV survivors will have equipped themselves with skills and improved their resilience.

4.2.2 Mission statement

The team brainstormed what they thought the project must do to accomplish the vision. Their mission statement follows:

We aim to establish a comprehensive (clinical-psycho-social-legal) counselling service for women living with IPV, their partners and family. Concurrently, we will network with community resources around the IPV issue, as well as with the community at large, raising awareness. In this way we hope to contribute to an improved quality of life amongst families resident in Macassar. The intention is that the service will be sustainable beyond the initial seven months.

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4.2.3 Boundary partners

The project team identified the following individuals, groups and organisations as boundary partners. The project interacted directly with them:

- IPV survivors and their families
- Facility-based primary health providers
- Community based primary carers/activists
- Police and legal services
- Community leaders
- Department of Social Development

4.2.4 Outcome challenges

These are statements that describe the change in the behaviour, activities and actions of the boundary partners with whom the project interacts directly. The outcome challenges are presented in Table 4.1.

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Table 4. 1: The outcome challenges for each boundary partner

Boundary Partner	Outcomes
IPV survivors and their families	The intervention intends to see IPV survivors and their families display coping skills and with ongoing social support improve their quality of life.
Facility-based primary health providers	Improved case finding for IPV by Primary Healthcare Providers (including, Maternity Obstetrics Unit (MOU), and allied services. Improved record keeping of IPV clients will result in effective and appropriate referral to the IPV service. Appropriate clinical, including mental health and forensic, care of women will become standard practice. There will be ongoing collaboration and open communication with the IPV champion and support from Department of Health managers.
Community carers/workers	Case finding in the community and referral to the IPV champion. Change in their consciousness regarding IPV i.e. more awareness and sensitivity around the issue. Follow-up with clients in the community when needed. Accompanies IPV champion on home visits.
Police and legal services	Refer clients to IPV champion. Collaborate with IPV champion regarding protection orders and laying charges. Victim empowerment volunteers attend court to support. participants and assist with follow up / home visits.
Community leaders	To be aware of IPV service and make appropriate referrals. Changing their own as well as society`s attitude towards IPV from acceptance as normative to zero tolerance.
Department of Social Development	Assist with social grants. Team work, collaboration and open communication. Referral for ongoing cases/Regular feedback on clients.

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4.2.5 Progress markers

These are statements that describe the anticipated progression of change in boundary partners' behaviour that will ultimately lead to the outcomes (Table 4.2). They guide the team on how to monitor progress towards achieving the desired outcomes.

Table 4. 2: Progress markers for each boundary partner

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Boundary partner	Expect to see	Like to see	Love to see
IPV survivors and their families	• Identify crisis situations where improved coping mechanisms are needed. • Deal with imminent danger such as being able to assess and respond appropriately to dangerous situations at home.	• Display coping skills such as asking for assistance, applying for protection order. • Aware of resources such as NGO`s, mental health clinics.	• Improved quality of life i.e. being able to take care of herself and her children.
Facility-based primary health providers	• Attend training courses to identify IPV cases and provide clinical care. • Make appropriate referrals. • Involvement of facility manager.	• Improved recordkeeping, documentation of injuries. • Improved consultation skills with IPV survivors.	• Facility manager facilitating and supporting an independent community IPV service. • All PHC staff identifying, attending to and referring IPV cases.
Community carers/workers	• Attend training on IPV. • Identify and referring cases.	• Follow up on “call-backs”. • Accompany IPV champion on home visits.	• Change in understanding and sensitivity towards IPV. • Become IPV champions.
Police and legal services	• VEP volunteers to attend training. • Refer clients.	• Work in collaboration with IPV champion.	• Assist with follow up cases.
Community leaders/ activists	• Closer interaction between them and IPV champion.	• Refer suspected cases	• Greater awareness of IPV
Department of Social Development	• Assist with social grants and community liaison.	• Refer clients to IPV champion.	• Ongoing case management.

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4.2.6 Strategy maps

A strategy map for each outcome challenge was designed. Different strategies were identified by the project team to assist each boundary partner to achieve their outcomes (Table 4.3). These were individualised according to the unique challenge each boundary partner was facing.

Table 4. 3: Strategy map

Boundary Partner	Outcomes	Strategies
IPV survivors and their families	IPV survivors and their families display coping skills. Where possible, they access ongoing social support to improve their quality of life.	Provide comprehensive assessment and counselling through individual and group sessions. Assist with procurement of maintenance, protection orders and divorce proceedings as necessary.
Facility-based primary health providers	Improvement in case finding and clinical care for IPV by primary care providers.	Provide training workshops in IPV case finding and management.
	Improved record keeping of IPV cases to provide appropriate clinical, legal and mental health care of women.	Provide training regarding IPV and attend regular meetings with the staff to address any challenges they may experience regarding IPV.
	Ongoing collaboration and open communication with the IPV champion and support from Department of Health managers.	Meeting and liaising with facility manager, other sub-district managers, family physician, and leadership of the CHC.
	Referral of IPV clients to the IPV service effectively	Identify motivated persons to be trained as IPV champions in order to sustain the service and extend it to other areas.
Community carers/ workers (CCWs)	Change in their consciousness and attitude regarding IPV by creating more awareness and sensitivity around it.	Identify NGOs in the community and invite them to become involved.
	Case finding at home or in the community and referring these women to the IPV champion.	Provide training to CCWs on case finding and appropriate interaction with IPV clients when doing follow ups.
	Assist in following - up clients in the community or accompany the IPV champion on home visits if and when necessary.	Ongoing liaison as required – IPV champion available for meetings as necessary on Fridays during field work period.

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Boundary Partner	Outcomes	Strategies
Police and legal services	Refer clients to IPV champion when they come to lay charges.	Identify key allies in South African Police Service (SAPS) to liaise with as necessary.
	Assist IPV clients with obtaining protection orders and laying of charges. Accompany or help with follow up / home visits when needed.	Create strategies for improved accountability and responsiveness in assisting clients.
Community leaders	To be aware of service and refer clients if necessary.	Meet with them and attend their meetings to build relationships and collaboration.
	Changing their own as well as society`s attitude and behaviour towards IPV.	Outreach to schools, religious leaders/ organisations and sport clubs.
Department of Social Development	Open communication, team work, collaboration through professional feedback on clients.	Identify and meet with them (including social worker at Helderberg Hospital).
	Referral for ongoing case management. Assist clients to obtain social grants.	Build relationships and get to know their system for referrals.

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4.3 Monitoring and evaluation of strategies

Outcomes and performance monitoring of the IPV intervention study by the project team took place on an ongoing basis at scheduled meetings. This process assisted the project team to identify where changes were needed to help improve performance. The IPV champion gathered data on a weekly basis about her interactions with all the main actors. These were in the form of field notes and included information such as bookings made by primary health carers, attendance and therapy sessions with IPV clients and other interactions with other role-players. The information was recorded in strategy and outcome journals.

The evaluation of the strategies and outcome results of the boundary partners are discussed below based on information obtained from the outcome and strategy journals.

4.3.1 Strategy monitoring tables

Tables 4.4 to **4.9** reflects the evaluation of the planned strategies for each boundary partner. The tables are divided into the planned strategies, description of the activity that took place and the effectiveness thereof. These were rated low, medium or high according to the effectiveness of the strategy.

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Table 4. 4: IPV survivors and their families

Planned strategy	Description of activity	Effectiveness
Psychological support		
In depth assessments were done with all survivors by means of a comprehensive interview at their first appointment. This covered a full history of abuse, case-finding for mental disorders and referral to appropriate resources.	Three survivors were referred to the mental health clinic, one for a STI check at the family planning clinic, and another for a medical condition and which was subsequently referred to the district hospital.	High
Provide counselling through individual and group sessions.	Support groups were abandoned because survivors were very resistant, preferring individual counselling.	Low
Social support		
The IPV champion provided varied social support such as safety assessment and development of a safety plan.	Home visits were done to assess survivors` home circumstances, provide support and refer to community resources when needed. Assisted survivors with administrative tasks such as writing a CV and applying for employment. She accompanied a survivor to rescue her child from a drug house.	High
Legal support		
Assist with procurement of maintenance, protection orders and divorce proceedings as necessary	Four IPV survivors were assisted with obtaining protection orders and two with information regarding divorce proceedings as well as accompaniment to the magistrate and divorce court was given.	High

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Table 4. 5: Facility-based primary health providers

Meeting and liaising with facility manager, other sub-district managers, family physician, and leadership of the CHC	Regular meetings with the facility manager occurred initially but these stopped due a rapid deterioration in the manager`s health. Meetings with other leadership structures such as the district manager did not materialise due to busy schedules and failure to keep appointments from their side.	Medium
Provide training workshops in IPV case finding and management.	Two training workshops were held at Macassar CHC with 27 staff members that included the following categories of staff: one doctor, 12 clinical nursing practitioners, three enrolled nurses, two health promotors, one physio and occupational therapist as well as four administrative staff and three general workers. Training covered case finding, management and referrals of IPV clients to the IPV champion for assessment, counselling and further psychosocial and legal care.	Medium.
Have regular meetings with the staff to address any challenges they might be experiencing regarding IPV case management.	No formal meetings were held with the staff due to the high workload of the facility but ongoing monitoring and support occurred weekly. The IPV champion visited the facility every Friday to check the referral book and to liaise with staff regarding challenges with IPV cases.	High
Identify motivated persons to be trained as IPV champions in order to sustain the service and extend it to other areas.	Originally one of the doctors was earmarked but this could not materialise due to their placements at other CHC and their high workload at the facility.	Low

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Table 4. 6: Community care workers (CCWs)

Identify other services in the community and invite them to become involved.	Contact was made with the organisation “Network of Care” a community based volunteer organisation. The IPV champion attended community-based meetings and had follow-up meetings with community volunteers in Macassar.	High
Provide training to CCWs on case finding and appropriate interaction with IPV clients when doing follow ups.	Training was provided to the volunteers regarding identifying and referring IPV cases. The strategy on follow ups was changed due to the sensitivity and the potential risks this could cause to IPV survivors.	Medium
Ongoing liaison and connecting by having regular onsite meetings	Lack of support and cooperation from the leader of the community liaison forum presented major challenges in the ongoing liaison with community structures.	Low

Table 4. 7: Police and legal service

Identify key allies in South African Police Service (SAPS) and meet with them regularly.	Meetings were held with the key personnel at the local police station to introduce and explain the purpose of the IPV project and the importance of their support and cooperation with it. A follow up meeting with the Colonel and the leader of the community policing forum proved the Colonel’s support for the IPV service, but he was removed from this position within two months.	High
Create strategies for improved accountability and responsiveness in assisting clients	Follow-up strategies were difficult to implement because key scheduled meetings were cancelled at short notice due to operational requirements.	Low

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Table 4. 8: Community leaders

Meet with them and attend their meetings to build relationships and collaboration	Meetings were first held with the facility manager at Macassar CHC and thereafter she introduced the IPV champion to the leaders of the community policing forum as well as the police force management.	High
Outreach to schools, religious leaders/ organisations and sport clubs.	Lack of cooperation from the leader and coordinator of the community policing forum sabotaged outreaches to other organisations because of the influence this person had in the community.	Low

Table 4. 9: Department of Social Development

Identify and meet with them (including social worker at Helderberg Hospital who was appointed towards the end of field work period).	The IPV champion met with Patch social worker to inform about the IPV service and to refer clients if need be. At Helderberg district hospital there was no social worker available until the end of the intervention period.	Medium
Build relationships and get to know their system for referrals.	The social workers in Macassar specified that they only deal with child-related cases.	Low

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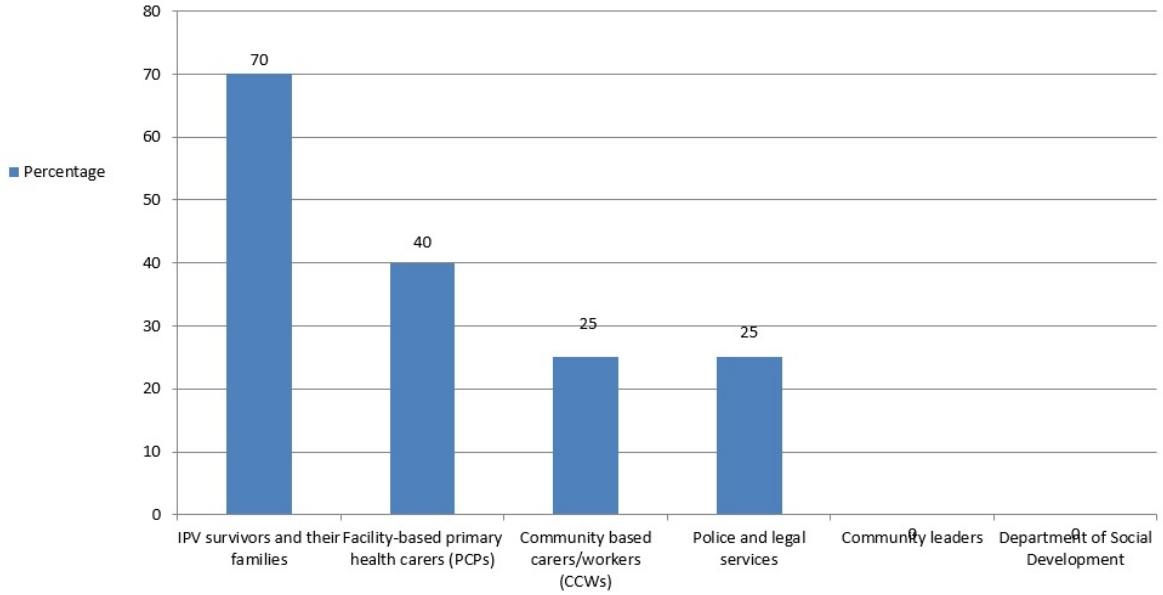
4.4. Monitoring and evaluation of outcomes

Figure 4.1 shows the extent to which the outcomes were achieved by each boundary partner. A numerical value was attached to each graduation of the progress marker. The scoring was zero (0) if no progress was made, one (1) if partial progress was made and two (2) if the progress was achieved. The score was expressed as a percentage of the total score, if all progress markers were fully achieved

Figure 4. 1: Overall rating of progress with boundary partners



The following tables' present the evaluation of each boundary partners` progress marker, a description of the evidence and the extent the outcome was achieved, partially achieved or not achieved. Some progress markers are combined.

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Table 4.10: PV survivors and their families

Progress marker	Extent of achievement	Description of the evidence
Identify crisis situations	Partially achieved	Four IPV survivors requested assistance in applying for protection orders. Letters were written to the magistrate of the family court and a survivor was accompanied to the magistrate court.
Dealing with imminent danger	Partially achieved	An IPV survivor was assisted in rescuing her son from drug abusing ex-partner.
Display coping skills	Achieved	During supportive counselling sessions, attempts were made to enhance coping mechanisms by focusing on the client's strengths. This resulted in survivors requesting assistance for applying for jobs. By end of project, four had found work .
Awareness of resources	Partially achieved	Referrals to state provided legal services to procure divorces and/or protection orders and to medical services such as the mental health and family planning clinic for STI treatment increased awareness of available resources.
Improved quality of life	Partially achieved	Of the survivors that made use of the IPV service, seven expressed appreciation for the supportive counselling that was offered to them, three verbalised improvement in their domestic situation and three managed to find work. Two were referred to the mental health clinic and two to clinical nurse practitioners for physical complaints. One was subsequently referred to the district hospital and follow-up. However the relative dysfunctionality of legal and social services created major frustrations and delays for survivors dealing with their challenges

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Table 4. 11: Facility based primary health providers

Attend training workshops to identify IPV cases	Achieved	The following categories of staff at Macassar CHC attended two training workshops: one doctor, 12 clinical nursing practitioners, three enrolled nurses, two health promotors, one physio and occupational therapist as well as four administrative staff and three domestic workers. However the pharmacists, mental health nurses and most Midwife Obstetric Unit nurses did not attend the training.
Make appropriate referrals to the IPV champion for further assessment.	Partially achieved	This was partially achieved because over a period of seven months from the 23 attendees at the IPV service, 37 referrals were from the CHC of which 13 attended.
Improved consultation together with good recordkeeping and documentation of injuries	Not achieved.	The recordings in the folders of the referrals were checked. There were no detailed descriptions of injuries and reference to the patient`s mental state was poor. Most entries were about patients requesting the doctors to complete J88 forms. No reference to other clinical screenings such as HIV, STI`s and pregnancy were made.
Facility manager facilitating and supporting a sustainable and independent community IPV service	Not achieved	The establishment of an independent, sustainable IPV service was not achieved as the facilitation and support of the facility manager for this failed at a critical juncture due to serious ill-health.
All PHC staff identifies and refers IPV cases	Partially achieved	The profile of staff who made referrals were: Doctors 28, clinical nurse practitioners seven, the occupational therapist and the psychologist one each.

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Table 4. 12: Community carers/workers (CCWs)

Attend training regarding IPV in order to identify and refer cases.	Achieved	Training was provided to two community care volunteers and 25-30 community-based care workers from Masincendane, the NGO which provides the service for the CHCs.
Follow up on “call backs” and accompaniment on home visits	Abandoned	Both these progress markers were abandoned after discussion with the project team due to the safety concerns for IPV survivors if the “call back” slip was given to the wrong person. The IPV champion carried out home visits on her own.
Change in the understanding and the sensitivity of IPV.	Not achieved	Comments such as agreeing that an IPV survivor`s child should be taken away from her or blaming her still showed lack of understanding about the complexity of IPV.
Identify future IPV champion	Not achieved	This was not achieved due to aforementioned reasons.

Table 4. 13: Police and legal service

VEP volunteers to attend training in order to identify and refer clients	Achieved	Training was given VEP volunteers who referred two IPV survivors to the service.
Work in collaboration with the IPV champion	Not achieved	Collaboration could not occur because senior police management was changed frequently making it difficult to build effective working relationships.
Assist IPV clients with obtaining protection orders, laying charges and follow up	Not achieved	This was still a major hurdle in the court system and led to a lot of frustration. Clients were either given wrong information or there was a lack of urgency in processing the orders.

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Table 4. 14: Community leaders / activists

Closer interaction between community leaders and the IPV champion	Not achieved	The deterioration of the relationship between the IPV champion and the chairlady of the Community Policing Forum was pivotal as she was an influential link between the certain components of the community, police and IPV project.
Greater awareness of the IPV service and referral of suspected cases.	Not achieved	A campaign like the‘16 days of activism` was the ideal platform to reach the community and create greater awareness of IPV and the available service but the IPV champion was not included in the planning, nor was she given an opportunity to speak at the event.

Table 4. 15: Department of Social Development

Assists IPV survivors with obtaining social grants. Referral of clients to IPV service.	Not achieved	No service available in the community
Ongoing case management	Not achieved	The IPV coordinator referred one case to them but it was poorly handled causing more trauma and problems for the mother and the child.

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4.5 Exploration of primary health carers` experience and viewpoints regarding identifying and managing IPV

A key issue that emerged from the monitoring phase was that relatively few nurses identified and referred patients with IPV to the service. Doctors referred 28 of the cases whilst the nurses referred seven and the allied services referred one each. The project team decided to evaluate this phenomenon in more depth through a qualitative exploration of primary care provider's experience and viewpoints regarding identifying and managing IPV.

Eight participants were interviewed representing the different categories of the multi-disciplinary team.

- Two medical officers
- Two clinical nurse practitioners
- Two midwives
- A physiotherapist
- An occupational therapist

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4.5.1 Themes emerging from the interviews

Five broad themes and subthemes emerged from the interviews

Table 4.16 Themes and sub-themes

Themes	Sub-themes
Primary health carers' understanding/opinion about IPV	• Culture • Class stereotypes • Gender role stereotypes • Substance abuse • Male infidelity
Primary care providers' personal experiences of IPV.	• The invisibility of IPV • Loneliness caused by IPV
Challenges in case finding and referral of IPV cases	• Health system challenges • Psychosocial challenges • Emotional detachment
IPV case finding strategies	• Direct versus indirect enquiry • Destigmatising IPV • Provide options • Patient and staff education • Holistic versus fragmented care
The ideal IPV service	

4.5.1.1 Primary health providers' understanding/opinion about IPV

It was important to hear primary care providers' opinions and understandings of IPV. The majority related IPV to physical abuse but when probed further other forms abuse came forth. Some participants acknowledged that they never really thought about it and so when reflecting about it they realised that their understanding of IPV was influenced by multiple factors.

Culture

One such aspect is the type of culture one grows up in. They thought certain types of abuse tend to occur more in a specific culture or race. One participant opined that physical IPV occurred more in the traditional African culture where there is a strong patriarchal system and women are required to be extremely submissive. By contrast,

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in the affluent, westernised culture, emotional and verbal abuse seemed more prevalent. The abuse is more subtle but just as devastating:

> *"But I think in lots of African cultures there`s the perception that the man is the boss and the wife must be submissive….and if she won`t then the man may discipline his wife to get her in line."* **P3**

> *"And in other communities, the white community you will find more emotional abuse."***P2**

Class stereotypes

Some participants were of the opinion that due to constant exposure to violent crime in predominantly working class communities, IPV is accepted as normal behaviour and this subsequently influences participants` own view about IPV. Persistent exposure to violence numbs the whole psyche to it:

> *"And I think, I don't know… it's a cultural thing to some extent that they see it as acceptable for this to happen."* **P8**
> *"You know…..they get so used to the abuse, it becomes the norm."* **P4**

The shame factor of IPV was also brought up by participants. It appears that IPV is regarded as normal behaviour in the community but when it occurs among the more affluent or involves a professional person it becomes stigmatised. The IPV survivor is then regarded with shame and the stigma results in the non-disclosure of abuse which in return contributes to the hidden nature of IPV.

> *"You know, it's almost like they want to hide it and they are…I don't know…ashamed"* **P8**
> *"And especially in the middle-class, because we think we are better and it cannot happen to us. What will they say about me? I have status, my husband is a lawyer".* **P4**

> *"It's almost like it's going to be made public as soon as they go and see the doctor. So I think it's because they don't want it to be known"* **P12**

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Gender-role stereotypes

Interviewees were of the opinion that women accept IPV because of financial dependence as a result of the high number of children at a young age. Inference was that women's acceptance of this "*dependency role"* results in further exploitation thus perpetuating IPV. They are forced to stay with the partner and are resigned to their fate which in turn normalises the acceptance of IPV:

> *"Most of the times when women are not in the position to look after themselves financially, they become financially dependent on the men and so you are financially and emotionally dependent"* **P4**

> *"For instance, when a woman is dependent on this man, then they sort of allow it and accept it as their fate. Because they think, no, I'm dependent on him for giving me money and he's supporting me, I won't have another place to stay, so I'm going to not leave and I must stay in this situation that I am in".* **P11**

> *"We had a young girl, she was nineteen, and she had two children already and then she delivered twins"* **P8**

> *"Because that's what they do, they make you dependent on them with all these children"* **P11**

However an interesting observation of another participant was that due to the increase in male unemployment there is a reversal in the traditional gender roles. Whereas men were the providers traditionally, females are now the breadwinners. This has led to an increase in female independence and male insecurity resulting in higher rates of IPV due to the reluctance of the men in accepting this inferior role:

> *"Because she said when she was studying, he also used to threaten and tear up her notes and accuse her of trying to be better now"*

> *"I am going to be a nurse. I'm going to educate myself so I won't be dependent on this man's money any more".***P11**

> *"…she's got her own house. She's got her own money. She bought her own car….So he can go"* **P12**

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Substance abuse

Another factor that perpetuates the occurrence of IPV according to interviewees is the high level of drug and alcohol abuse in the community. Substance abuse leads to partners becoming more violent and abusive especially with the long term use of drugs such as methamphetamine (tik) which substantially increases the occurrence of IPV:

> *"Yes I think it`s becoming worse in the community due to the drugs and the alcohol which is increasing more and more"* **P6**

> *"Alcohol abuse is one of the major role-players that causes there to be violent behaviour towards each other"* **P8.**

Male infidelity

Women experiencing IPV are most vulnerable during pregnancy as informed by the two midwives in the interviews. Pregnant women are fearful of informing their partners when diagnosed with a sexually transmitted infection (STI) because both have to come for treatment. The mother tends to get re-infected numerous times implying infidelity on the part of her partner. This emotional abuse puts both mother and child`s mental and physical health at risk:

> *"…and also when partners are having a lot of other partners. I treat a lot of STIs here. So they know their partners are sleeping around".* **P12**

> *"But we give them contact slips for the partner to come for treatment, so what they do, they basically just treat themselves but then they get re-infected all the time at home".* **P11**

4.5.1.2 Primary carers` personal experience of IPV

This was the more challenging part of the interview as the participants were not keen to share their experiences or denied ever experiencing IPV. However one participant was willing to share her story. Another participant strongly denied ever experiencing IPV and spoke about a friend of hers that experienced IPV with a cheating husband. But she came quite agitated while telling the story and towards the end of the interview she acknowledged it as her story. The question was then posed if they were aware of any next of kin or close friends that were exposed to IPV and some were more forthcoming.

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The invisibility of IPV

The interviewees verbalised their shock at discovering IPV taking place with family members or close friends. It is often a secret in families and it is only when the survivor reaches out for help that it is recognised or when they end up in hospital. One participant said that she suspected something, but respected the person's privacy and did not probe further. The following responses regarding family members exposed to IPV were:

> *"And you are not aware of it until you actually hear about it and see the signs, or until they approach you for help. But I think that's the starting point: how do you get them aware of it"* **P5**

> *"And we wondered at one time if she`s unhappy, is she depressed or just the shy type…Then it came out and she told us she has left her husband. He abused her physically and emotionally"* **P2**

Loneliness caused by IPV

One participant shared her experience as an IPV survivor. She verbalised that although she was qualified as a professional nurse she still allowed her partner to intimidate her through threats and feelings of shame. She recounted how she felt isolated and lonely because although she shared it with friends they would not believe her. She empathises with IPV survivors for not disclosing abuse as it took her years to break out of that stranglehold:

> *"And you know, in the beginning you think it's your entire fault and you deserve to be treated like that. But because you are already weak, you doubt yourself already because of that, and now he comes along and says, look at you, nobody will believe you da-da-da".* **P11**

> *"So I think it's also about you'll deny it until you are blue in the face, until somebody obviously sees things happening and you can't deny it, then you are more ashamed but I think that people need to be aware of this…"* **P5***.*

> *"It's a lonely place because you have to keep up a front and smile. Because with this guy, I told all our friends and they said, never, how could he have? They said, never."* **P11**

4.5.1.3 Challenges in case finding and referral of IPV cases

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Primary healthcare facilities are often the first point of contact the IPV survivor makes in order to get help. To deliver quality service health carers must be able to identify (diagnose) and treat or refer appropriately. The low number of referrals to the IPV service over seven months alludes to major challenges with this important task.

Health system challenges

Both doctors and nurses were in agreement that time constraints during consultations gave rise to superficial consultations. The clinical nurse practitioners (CNPs) are expected, and constantly reminded, to consult their patient within ten minutes. Doctors voiced their frustration with the ever increasing number of patients with minor ailments that are referred to them. This result in superficial consultations and the deeper or underlying issues such as IPV gets missed. The participants felt that IPV is not always identified easily as some patients find it difficult to divulge such traumatic experiences and open themselves to potentially judgmental health providers. The concern was also that if IPV was identified and the patient becomes emotional then more time needs to be spend with her while there are still lots of other patients to be seen:

> *"I was called in yesterday and told I can only handle one complaint at a time and I cannot spend more than ten minutes with a patient"* **P2 (Nurse)**
>
> *"I think it`s pressure, work pressure and the time, the time allowed. I managed to get away with it thus far but not anymore…"* **P2**
>
> *"And there isn`t always time for consultations ….that extra time for consultations and those types of things…because if she has a breakdown and they`re banging on my door… "* **P3 (Doctor)**
>
> *"So that is a big problem, it's the fact that we don't have the time to do in-depth consultation about this problem, or to specifically with every lady inquire about it,……."* **P8 (Doctor)**
>
> *" it's that we end up sort of carrying the larger burden at the moment in terms of literally the amount of patients that we work through a day compared to what they see (nurses) a day."* ***P3***
>
> *"And I think we also have issues with patients who insist on seeing a doctor, which is not…they're not supposed to sort of have the luxury to do that, but then*

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> *they end up complaining. The outcome is that they come to us in the end anyway" **P8***

Doctors complained of constant interruptions during consultations by colleagues which eroded rapport with the patient and the likelihood of disclosure. Lack of privacy in trauma was also an issue as that was where the IPV cases were sometimes first seen:

> *"If you are a doctor you get interrupted a lot, because in one consultation you will often have at least two interruptions where sisters or nurses come in to discuss patients with you and so you've lost her…". **P3***

> *"But let's say in trauma, there is absolutely no chance of privacy". **P8***

Another challenge that was highlighted by the occupational therapist was the lack of continuity of care due to constant staff turnover. This was problematic because the relationship of trust between the therapist and the IPV survivor develops over time and gets discontinued when one is transferred:

> *"But it's also different when therapists change, because then you have to build that relationship all over again."* **P5**

Psychosocial challenges

Both doctors and nurses expressed and displayed their exasperation in dealing with the complexities of IPV. Because IPV is a psychosocial issue they found it difficult to manage as they saw this being beyond their control and scope of practice. The perceived lack of managerial support due to the absence of the facility manager because of serious ill-health compounded the issue:

> *"So you identify the problem but there`s nothing that they can do about it. And for a health worker it is very frustrating because you want to resolve people`s problems…"* **P3**

> *"Because I mean, it doesn't even help if we identify them and we still don't have anywhere to send them for further counselling or to be followed up. It's a big frustration."***P8**

Emotional detachment

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The high number of patients attending the CHC daily leads to emotional exhaustion and consequent compassion fatigue. In order to protect themselves from burnout they detached themselves from emotionally charged problems such as IPV. However, another participant regarded this type of response as non-caring because these self-preservation measures ultimately results in the unwillingness to identify IPV:

> *"Because I think a lot of people are just professionally exhausted working in primary care".* **P8**

> *"The person comes in and they've got an injury, and they are not mentioning specifically that they were abused or beaten, and if you are stressed and under pressure, it's sort of just easier to attend to the medical complaint and not inquire about the cause for that. Which is sad and is not right, but it's a reality."* **P8**
>
> *"Today, they do nothing because it's a job and it's convenient. And they don't have empathy – they don't have heart."* **P11**

One participant, a previous IPV survivor, expressed that denying IPV was a way of protecting herself from re-traumatising herself:

> *"It is as though you turn your back upon it and you build a wall so that no-one can see through it."* **P4**

4.5.1.4 IPV case finding strategies

The diversity of opinions regarding recognition of IPV matched those regarding management strategies for IPV cases. The participants that struggled with identifying IPV subsequently failed to provide adequate care.

Direct versus indirect enquiry

The IPV training model recommended that direct enquiries be made after recognition of specific clues in the consultation that suggested the possibility of IPV. The more experienced nursing participants stated that they enquired directly about IPV in comparison with their younger colleagues. The limited time they had for consultation prompted them to focus their efforts on recognising specific clues, causing them to enquire about and identify IPV early:

> *"…Or I ask directly if there`s abuse…"*

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> *"After examining her I could not find anything physical wrong. So I asked her do you have stress? She started to unpack about her husband…."* **P8**

> *"Ja, I counsel them by the way I talk and ask them, just to find out to what degree is this abuse and who else is involved".* **P12**

However, the doctors do not have to limit their consultation time so strictly. The strategy they mostly applied was to enquire indirectly about IPV in a more subtle manner as they first wanted to build up trust and put the patient at ease:

> *"But if you chat in general…what I usually do is that I don`t speak about IPV but I just speak in general."* **P2**

> *"If I suspect something like that, I will come around a bit of a bend. I will ask them something like, are you married. Or I will ask them, do you have kids? Okay, then they will be more willing to talk about that."* **P8**

Destigmatising IPV

An interesting strategy that two of the participants applied was to use their own experience of IPV as a means of connecting with their clients. This also assisted in displaying a non-judgemental attitude towards IPV thus putting the clients at ease:

> *"I take it from myself and I tell them that if I am arguing with my husband, what is acceptable or what not."* **P11**

> *"I usually use my own experience and tell them I went to see a psychologist myself…"* **P4**

Provide options

Another participant stated that because IPV is so complex she suggests different options to her IPV clients according to their current situation. Providing different options respected the client`s autonomy and made them co-partners in their management:

> *"Options and guidelines and how it is done ,,, It is totally…totally voluntary, you cannot force anyone"* **P4**

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> *"And apart from the psychologist I would suggest support groups….and then you bring in the immediate family. With support I meant only for the abused persons."* **P4**

Patient and staff education

Different teaching strategies were suggested by both doctors and nurses as a management strategy to educate the patients about IPV. One suggestion was that patients in the waiting area be targeted by the health promoters at the CHC to create awareness of IPV. The other suggestion was that an individual with a problem with IPV be educated during consultations to assist them to deal with it. The more awareness of IPV is created the less it will be accepted as normal.

> *"I don't know, I just think it's education and education. You must follow up to see whether they have implemented it, or did she go for help or did she speak to someone?"* **P11**

> *"For example, at the day hospital or the community day centre, then maybe involving the health promoters to advertise and to explain to them what it actually is. So what is intimate partner violence and what is violence in general, and when is it a problem?"* **P8**

A suggestion was that peer learning could occur during staff meetings where IPV cases could be discussed. Specific cases could be discussed and management strategies shared. IPV cannot be treated in isolation and best practices must be shared:

> *"But if they make a point of maybe once every month or once every three months to mention this at a meeting…Remember to look out for this, or maybe to discuss a case…. just to sort of keep it upfront in people's minds".* **P8**

Holistic care vs fragmented care

The occupational and physiotherapists understood that in order to treat an injury or impairment they had to manage their clients holistically because emotions such as anxiety and fear prolong the recovery process. IPV manifests in various symptoms and therefore an injury cannot be treated in isolation but the cause of the injury needs to be examined:

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> *"But I think the thing is also, when you think about occupational therapy, it's not only about looking at a certain aspect but looking at the client holistically."* **P5**

> *"So you have to go deeper into the cause of their stress… if someone comes complaining of neck muscle spasms then you have to look at what could have caused it in order to first rule that out, so that the patient does not return with the same problem."* **P6**.

Both these therapists believed in a multi-disciplinary approach when providing care for their clients. When there was a suggestion of IPV they consulted with their colleagues, or referred the case to the doctors with their patients' consent:

> *"So…they first have to be sorted out medically before they`re sent to mental health nurses"* **P6**

> *"I think at the end of the day you work in a team, so you need to look at the other team members to help. So it's about the importance of the multidisciplinary team. And also finding out what steps were taken previously because normally the doctors will refer them if they need to go to the police station or if they need to go to social services".* **P5**

4.5.2 The ideal IPV service

The question was posed in reference to the outcome results that indicated 37 referrals to the IPV service from Macassar CHC was made over a seven month period. Two participants were not part of the CHC staff IPV training expressed their wish to receive the type of training.

The participants all realised in hindsight the need for a dedicated IPV service. Challenges such as time constraints with consultations due to the huge number of patients has made them realise it was a great benefit to them and the IPV survivor to have a dedicated IPV champion:

> *"Yes, this is how you pick it up, this is what you do, this is how you can help or this is who you can refer to. You know, just channels that we can have as support as nursing sisters"* **P12**

> *"But I think that there is a great need for a service where women can speak… so that they can get counselling on how to cope with this problem"* **P6**

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> *"My ideal would be for that person to get out of that situation. But in order for that to happen there must be places where they could go, you know, somewhere safe…"* **P11**

The IPV service should ideally be situated in Macassar somewhere. Both the police station and the health centre pose the considerable risk to the IPV survivor of being seen attending the IPV service and subsequently stigmatised by other community members. Yet health providers seemed unaware of the sensitivity of this issue.

> *"If there could be a separate place for the person to provide counselling at the clinic perhaps"* **P6**

> *"Do they walk out of here when you've given them a phone number…and people don't really want to go and get help from (there)…. So the ideal would be if it's in the community centre"* **P12**

4.6 Conclusion

This chapter presented the findings of the outcome mapping process in terms of the project design as well as the monitoring of strategies and outcomes. The outcome mapping method allowed the project team to monitor and evaluate an IPV intervention in-depth. A more in depth evaluation of the primary care providers' experiences and opinions of the services for IPV was also presented. The next chapter will discuss the key findings in relation to the literature and the implications for health services and future researchers.

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CHAPTER FIVE
DISCUSSION, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

The chapter discusses the key findings about an evaluation of an intervention programme for IPV using the outcome mapping method. The research objectives, the limitations of the study and recommendations are discussed.

5.2 Discussion of findings

An IPV service was implemented in Macassar based on Joyner and Mash`s (2012b:399) IPV model of care. The model advocates a comprehensive biopsychosocial and legal approach for IPV that includes case-finding and continuity of care by primary health carers. The findings of this study have highlighted both positive and negative aspects of implementing the IPV service. The experiences and viewpoints of primary health carers at Macassar CHC regarding identifying and managing IPV revealed varied responses.

5.3 Addressing the research objectives

The research objectives were:

- To evaluate the implementation of a community-based service for IPV
- To evaluate the strategies used to implement the service for IPV
- To evaluate the outcomes set for implementation of the IPV service

A brief discussion of the findings of the research study as it relates to the study objectives' follows. The second and third objective will be addressed simultaneously for each boundary partner.

5.3.1 Objective: To evaluate the implementation of a community-based service for IPV

The implementation of the IPV service followed the intentional design phase of the outcome mapping method. The service envisaged creating awareness of IPV through collaboration with community organisations in the Macassar catchment area, 48to

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implement a sustainable comprehensive IPV service for women affected by IPV. This entailed articulating vision and mission statements, identifying strategic community organisations as boundary partners with whom the project team interacted during implementation of the IPV service. Outcome challenges for each boundary partner were set that described desired behavioural changes to be displayed by the end of the project. Strategies to assist boundary partners to achieve the desired outcomes were plotted. Monitoring of both the strategies and outcomes continued at scheduled meetings throughout the intervention period by the project team. Some strategies were changed as appropriate. Choosing the outcome mapping approach as a method to design, monitor and evaluate the IPV project enabled the project team to document, learn from, and report on the process of social and behavioural change that occurred during implementation. A recommendation of the outcome mapping method is that all boundary partners must engage in the initial planning of a project to encourage co-ownership of, and cooperation with, the project (Nwanze & Mash 2012:238). Their exclusion at the inception of the study could have contributed to the uncooperative approach experienced with certain boundary partners.

5.3.2 Evaluation of the strategies used and the outcomes set for implementation of the IPV service.

5.3.2.1 IPV survivors and their families

Twenty three survivors accessed the IPV service over a seven month implementation period. The biopsychosocial and legal components of the intervention model were implemented effectively. It provided practical assistance to IPV survivors in diverse situations. The IPV champion developed certain participants' skills with regard to formulating curriculum vitaes and applying for jobs to improve their quality of life. In addition to counselling, the IPV champion accompanied and supported participants to navigate their way through local institutions such as the magistrate and divorce courts. This empowered them to make positive changes for themselves and their children. Referrals for further mental health support and clinical care were made after in depth assessments.

The IPV model is in agreement with The World Health Organisation`s (2013) recommendation that a structured programme of advocacy, support and

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empowerment counselling should be offered to all women exposed to IPV. The IPV model evaluated by Ambuel et al (2013:833) incorporated most of the components of Joyner and Mash`s IPV model. They reported sustained change two years after implementation. Although the current study was much shorter the progress rating of 70% indicates an improvement in the quality of life of some survivors.

The only strategy that had to be adapted in the IPV model was to replace support groups with individual follow-up sessions in response to requests from IPV clients to protect their privacy. This decision was made as IPV interventions should accommodate participants' needs. This also shows respect for the patient`s autonomy (Chang et al., 2005:33).

However utilisation and follow up attendance of the IPV service were sporadic. From the 37 referrals made by primary health providers, only 13 patients attended the IPV service. This might be due to various reasons. Attendance may have been impacted by the convenience of the time or date for the survivors. Furthermore the location of the service at the police station turned out to be problematic in a number of ways. On the one hand, if seen accessing this service by other members of the community, they could risk retaliation by their intimate partner. On the other, during the seven months of her service at the police station, the IPV champion noticed that a fundamentally disrespectful attitude was often displayed towards clients by the police. This was often compounded by poor communication causing potential negative associations with any encounter with the police service. Misperceptions about the service itself, may also have affected attendance. Moreover Kielly et al., (2010) reports that some IPV survivors only need a brief encounter with health carers that listen and acknowledge the difficulties of their situation.

The degree of shared decision making on further management by the survivor and the primary care provider is of utmost importance. Battaglia et al (2003:621) reported that survivors appreciated being included in decision making about their further management. Nicolaidis (2002:122), Dienemann, Glass, and Hyman (2005:235) agree that a key component of effective IPV interventions are showing respect to the IPV survivor`s autonomy. Therefore if the referral was made in a directive manner (as

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is sometimes the norm in health services) the patient may have expressed their autonomy passively by not attending the appointment.

5.3.2.2 Facility-based primary health providers

Strategies designed for primary health carers were less effective as indicated by an outcomes rating of 40% overall. Meetings with leadership structures such as the district manager, police investigative team, and the family physician failed to materialise due to busy schedules and failure to keep appointments from their side. Training workshops in case finding, care and referrals for IPV were attended by the majority of the CHC staff. However a suitable person to be trained as an IPV champion could not transpire as no one emerged to take on this role, perhaps due primarily to the work pressures in the facility and the realities of staff rotation. A key issue that came out of the monitoring phase of the outcome mapping process was that relatively few clinical nurse practitioners identified and referred patients with IPV to the service during its implementation. Ironically however, when the study was over they recommended that they needed exactly the service that they had not made use of while it was available to them for a full seven months.

Referral numbers indicated that doctors made 28 referrals compared to the seven by the nurses. Yet only one doctor had attended the training. The project team decided to evaluate this phenomenon through a descriptive qualitative exploration of primary health carers' experiences and viewpoints regarding the identification and management of IPV. The discussion of the findings of this research study follows later.

5.3.2.3 Community based carers/workers

Community based carers are pivotal for any community orientated intervention because they serve as an important link between the various groups in the community. They tend to be well known in the community because of the services they provide. Jacobson et al., (2013:339) encourages engagement with community structures such as volunteers to influence the prevention of IPV. However they may pose a significant confidentiality risk especially in a small community like Macassar, which is exactly what these IPV survivors made clear that they do not want. Ideally therefore, they

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should be guided and managed by an IPV champion with regards to the complexities and sensitivity about IPV.
Their ongoing training in identification and referral of IPV cases can assist in creating and sustaining awareness of IPV in the community. During the intervention period two IPV cases were referred from the community based carers and one carer approached the IPV champion for assistance with her own IPV situation.

5.3.2.4 Police, legal and social services

The turnover of staff, irregular shift patterns, and minimal interest in, or commitment to, the IPV service made collaboration with the police difficult. This hindered attempts to improve the quality of their response to IPV survivors. Ongoing liaison and communication became very challenging with constant disruptions due to their operational activities.

The IPV service was offered at Macassar police station in a separate room, the Victim Empowerment Unit. The need for an IPV service might be understood by the protection and legal services but there is still significant resistance to taking IPV seriously as a human right's issue. This lack of appreciating the seriousness of IPV was apparent when more than one IPV client was turned away by police officers when enquiring about the service. Subsequently, a few months after the IPV service was discontinued a police officer from the Macassar unit shot and killed his wife in a domestic violence incident, suggesting that some police officers had private reasons for their resistance to this service.

5.3.2.5 Community leaders/activists

Coordinated community support and partnerships are pivotal for meaningful engagement with a contentious issue such as IPV intervention. The VEP co-ordinator held a key position in the network between police, community groups and health services. A close working relationship between the IPV champion and VEP co-ordinator was needed to enable engagement with community structures and organisations. However, despite the IPV champion's efforts to achieve this, genuine cooperation and commitment to the value of this service was not forthcoming from the

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VEP co-ordinator. This IPV service and champion might have been perceived as an intrusion on her jurisdiction as VEP co-ordinator, resulting in this reaction. However Gonzalez-Guarda et al., (2013) and Jacobson et al., (2013:339) recommend that community leaders and organisations such as churches, sports and recreation facilities must be utilised to create and sustain IPV programmes aimed at young people.

5.3.2.6 Department of Social Development

There were no social work services to deal with adults in the area and therefore collaboration with the IPV service was not possible. Yet part of the mandate of the Department of Social Development is to be strategic partners with health and police services to address IPV. The absence of social services failed to address the critical issues of domestic violence and IPV which in return failed the community of Macassar.

5.4 Exploration of primary health providers` experience and viewpoints regarding identifying and managing IPV.

5.4.1 Primary health providers' understanding/opinion about IPV.

It was important for the primary health providers to articulate their opinions about IPV because it revealed their underlying misconceptions. Their opinions about IPV exposed stereotyping, generalisations and stigmatising attitudes. The dangers of such inferences are that they result in a discourse which blames the IPV survivor for her situation. Disregard for the gravity of their situation diminishes the quality of care survivors receive. The directive approach which is status quo for health providers in contemporary primary care undermines the right to self-determination of the survivor and the healing opportunities that being treated respectfully and being allowed autonomy could offer her.

Furthermore, the social problems contributing to IPV such as substance abuse and unemployment causes the primary carers to feel overwhelmed because these are seen as beyond their areas of influence. Echoing this finding, Shamu et al (2013: 524),

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inform that midwives perceived IPV as a social and domestic problem and not really health related. This attitude leads to the fragmented approach of managing IPV or disregarding the problem completely.

5.4.2 Primary health provider`s own experience of IPV

The psychological effects of IPV can still be experienced years after such incidents occurred (Rees et al., 2011). Some health providers expressed that when dealing with an IPV survivor, it brought back the feelings of fear and intimidation that they had repressed. Consequently the patient`s disclosure of IPV may be ignored due to the provider's unresolved personal issues regarding IPV. These lived experiences tend to impact the clinical capability of managing IPV, more especially when they have not been worked through at an intrapsychic level. The danger of judging or even blaming the survivor, as well as potential hopelessness about solutions, can filter through non-verbally in their attempt to dismiss the reality of IPV. Conversely, providers who have resolved their own IPV-related issues can, and often do, make a significant contribution to the care of IPV survivors, and the field of gender-based violence at large.

5.4.3 Challenges in case finding and referral of IPV cases.

Due to the high levels of interpersonal violence in the area, the research team expected that women exposed to IPV would be readily identified. This proved unrealistic, because case-finding of IPV by primary care nurses was minimal. Doctors referred far more survivors than the higher number of clinical practitioners. This may well be because doctors had to complete the J88 (forensic evidence form) for the police in cases of physical or sexual assault. These women were therefore unavoidably identified as survivors of IPV. IPV identification needs to be part of ongoing clinical governance and quality improvement activities if it is to be embedded into the service (Goicolea, Briones-Vozmediano, Ohman, Edin, Minvielle & Vives-Cases, 2013).

Primary care providers cited health system challenges such as limited consultation time together with high volumes of patients, lack of privacy and inadequate human

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and infrastructural resources as daily realities. Literature supports the authenticity of such challenges (Baig, Shadigian & Heisler, 2006; Uthman, Moradi & Lawoko, 2011; Joyner and Mash 2012a, 2012b). Due to these ongoing challenges, and their biomedical oriented training, they find it easier to focus on clinical complaints and neglect the psychosocial aspects of patient care. (Shamu, et al., 2013:524). Changing clinical practice in primary care requires strong managerial support. Peterson (2000:321) observed that current nursing management focuses on "*quantity over quality, diagnosis over understanding, and drugs administered over emotional care".* In the absence of sustained managerial support, the ongoing implementation of a new protocol soon loses its impetus and falls away. This opinion is supported by O`Campo, et al (2011:855) who allude to the need for strong institutional support for successful IPV disclosure and consequent improvement in identification rate.

Moreover the high workload results in mental and physical exhaustion leading to emotional detachment and consequent resistance to dealing with a complex phenomenon such as IPV (Joyner & Mash, 2014: 665). Jacobson et al (2013) concur with these sentiments as health professionals in their study experienced IPV as a difficult emotional and recurrent social problem. However, Beynon et al (2012) remark that focusing on these barriers may mask feelings of frustration and a sense of helplessness about how to respond effectively to such a complex issue as IPV.

The need for a generalist with the skills to attend to a patient holistically and to co-ordinate care on an ongoing basis was highlighted in the study, and confirmed by the clinical recommendations of the WHO (2013). IPV in particular requires practitioners to take a holistic approach that includes clinical, psychological, social, forensic and legal issues. Unfortunately competencies around holistic care are underdeveloped amongst SA primary care providers. This may because both doctors and nurses are trained within a functionally biomedical model, hampering the development of biopsychosocial care skills required in providing care for IPV (Joyner & Mash, 2012a, Joyner & Mash, 2014: 664). Moreover IPV care requires multiple role players such as doctors, nurses, psychologists, psychiatrists physio- and occupational therapists as well as the police, social workers and community activists. A good generalist would have the skills to provide patient-centred holistic care and provide coordinated care between the multiple role players. Therefore the need for training an IPV champion

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who is a skilled and expert generalist to help coordinate care on an ongoing basis with good relational continuity is recommended.

5.4.4 IPV case finding strategies

The two more experienced CNPs had, through previous consultations with IPV survivors, developed the skill to directly inquire about IPV. By so doing they optimised the efficiency (and humanity) of their service. The doctors' advocated a more subtle approach of first building up trust before enquiring about IPV. Both these approaches are supported by the literature as long as the enquiry is done in a caring and non-judgemental manner and survivors are part of the decision–making process (Battaglia, Finley & Liebschutz. 2003: 620, Joyner and Mash 2011:254).

By contrast, the physiotherapist and occupational therapist emphasise a holistic approach to case finding. Patients that are injured and display emotions such as anxiety and fear are never treated in isolation. Instead these injuries are investigated and the emotions are explored as they could indicate that the patient is living with IPV. Destigmatising IPV through sharing personal experiences during consultations may provide a safe environment for the survivor to disclose IPV. Sharing information about IPV by health promoters at the CHC can assist in creating greater awareness of IPV. By providing IPV survivors with different options on how to address their situation, the survivors` autonomy is respected. These all serve as positive reinforcements to assist in IPV case finding.

5.4.5 The ideal IPV service

In retrospect all the participants were in agreement that there is a need for a dedicated IPV service or a person that can deal with IPV cases independently. However when this service was available to them they made very poor use of it. The absence of a social worker to deal with adult social issues underscores the need for such a service.

5.5 Limitations

- The outcome mapping method's recommendation that boundary partners be part of planning a project from the start to facilitate co-ownership was not adhered to due to practical and logistical complications.

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- Due to the sensitive nature of the topic, there is the possibility of giving socially acceptable responses to questions in order to protect oneself. The researcher attempted to avoid this problem by guaranteeing complete anonymity and by emphasising the importance of honest answers to the questions.
- Interviews were not held until saturation of data was reached because no new volunteers were willing to participate and no new themes emerged from the eight participants.
- Potential bias from the research student as a result of her supervisor also performing the role of IPV champion and intervention coordinator.
- Equally, the complex interplay of roles required of the supervisor, IPV champion and project manager was difficult to manage at times causing strain for both student and supervisor.

5.6. Implications and recommendations

5.6.1 Community structures/resources

- IPV interventions are complex and require strong relationships between multiple sectors such as health, social, legal and community-based services. These collaborations seem to occur on national and policy level but commitment is lacking at local level.
- Community organisations such as churches, sports and recreation facilities must be utilised for developing programmes aimed at young people to create awareness of IPV at an early age.
- Community carers/workers and other relevant role players should be trained about IPV identification and care to sustain ongoing awareness of IPV in the community and encourage appropriate referrals of such cases. Further research is needed on how to effectively network with community resources around the IPV issue.
- The legal system and the South African Police Service (SAPS) should play an integral part in the fight against the scourge of ongoing IPV. Therefore strategies for improved accountability and responsiveness in assisting clients must be developed.

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- There is a big need for a competent social worker to provide assistance for adults in the community of Macassar.

5.6.2 The IPV service

- Location of the IPV service should be in a neutral, safe and private venue that survivors will find accessible and acceptable to enable utilisation of the service preferably at a CHC complex. Unfortunately, this ideal setting could not be found in Macassar at the time of setting up the service.
- Due to our highly racialised society in post-apartheid South Africa, utilisation of the service may have been better enabled by a champion who matched the predominant class, race and mother tongue of the population served.

5.6.3 Primary health providers

- Attention needs to be given to the training of primary health carers to perform as generalists using a holistic biopsychosocial and legal approach that supports coordination and continuity of care. Training needs to be embedded more consciously in a system that prioritises recognition and management of IPV in its routine reporting and quality improvement processes.

5.7 Future research

IPV care requires multiple role players such as the public health sector, the police, social workers and community activists. Therefore future research should focus on how to better collaborate and engage with these structures to address IPV.

5.8 Conclusion

Joyner`s IPV model of care was implemented and evaluated according to the outcome mapping method in the Macassar community of the Cape metropole. The IPV intervention provided a comprehensive (bio-psycho-social-legal) service for women living with IPV. The IPV intervention programme attempted to engage with a variety of role-players (boundary partners) in the community to bring about social and behavioural change. Findings indicate that the IPV intervention was of varying benefit for IPV survivors. However collaboration with other stake holders became problematic

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as the study ran its course, displaying ongoing resistance to taking IPV seriously as a human right's and health issue and a social scourge.

IPV still remains a hidden subject as women living with IPV are still not adequately identified and managed within healthcare even when training is provided. It appears that only a few health providers are prepared to engage with the IPV survivor while the others presented a myriad of excuses for non-engagement. The complexities of IPV do not lend themselves to easy and simple solutions. Therefore a multi-faceted, comprehensive approach to IPV should be embedded within all health providers training, and actively prioritised as a key component of clinical governance within primary health care.

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APPENDICES

Appendix 1: Ethical approval from Stellenbosch University

UNIVERSITEIT·STELLENBOSCH·UNIVERSITY
jou kennisvennoot · your knowledge partner

Ethics Letter

16-Jul-2014

Ethics Reference #: N13/06/090
Clinical Trial Reference #:
Title: An evaluation of potential benefits and/or disadvantaged of a biopsychosocial and forensic intervention for intimate partner violence.

Dear Doctor Kate Joyner,

Your application for a major protocol amendment to the abovementioned research study dated 4 June 2014 refers.

The HREC has approved the amendment which incorporates a change in the study title as well as the study setting which will now be Macassar.

If you have any queries or need further assistance, please contact the HREC Office 0219389657.

Sincerely,

REC Coordinator
Franklin Weber
Health Research Ethics Committee 1

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Appendix 2: Permission obtained from institutions / department of health

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House., 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: 2014RP102
ENQUIRIES: Ms Charlene Roderick

Division of Nursing
P O Box 19063
Tygerberg
7505

For attention: **Dr Kate Joyner, Prof Bob Mash, Ms Winnifred Pienaar and Ms Tonya Esterhuizen**

Re: AN EVALUATION OF POTENTIAL BENEFITS AND/OR DISADVANTAGES OF A BIOPSYCHOSOCIAL AND FORENSIC INTERVENTION FOR INTIMATE PARTNER VIOLENCE.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries in accessing the following sites:

Macassar CHC	**C Alexander**	**Contact No, 021 857-2330**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 06/11/14

CC **A HAWKRIDGE** **DIRECTOR: KHAELITSHA / EASTERN**

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Appendix 3: Participant information leaflet

TITLE OF THE RESEARCH PROJECT:

Outcome Mapping Evaluation of an Intervention Programme for Intimate Partner Violence

REFERENCE NUMBER: N13/06/090

CO-INVESTIGATOR: Winnifred Pienaar

ADDRESS: Nursing Division, FMHS, Francie Van Zijl Ave, Parow

CONTACT NUMBER: 021 904 9135 / 0837810509

Dear Participant

My name is Winnifred Pienaar and I would like to invite you to participate in a research project that aims to explore the experiences of primary healthcare providers in managing IPV patients.

Please take some time to read the information presented here, which will explain the details of this project and contact me if you require further explanation or clarification of any aspect of the study. Your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee (HREC) at Stellenbosch University** and will be conducted according to accepted and applicable National and International ethical guidelines and principles, including those of the international Declaration of Helsinki October 2008.

Currently there are no existing guidelines on how to care for intimate partner violence (IPV) in primary healthcare setting within South African, despite the problems it poses. In order to draw up these guidelines, it is important to hear from the people that are in the forefront of dealing and managing this complex condition. Therefore the aim of the study is to explore the experience of primary care providers in the daily managing patients with IPV.

By agreeing to participate in this study, you will take part in a study that will provide a service for women experiencing intimate partner violence that has been developed in the Western Cape. This research study is relevant for the needs and interests of surrounding communities given the unusually high rates of gender-based violence in South Africa.

Individual interviews will be conducted privately, audio-recorded and transcribed confidentially. Your views will be regarded and treated with the utmost respect. All information collected during interviews will be treated as confidential. The identity of the participant will remain anonymous at all times. All data will be locked up in a safe for a period of five years and will only be made available to the supervisor, co-supervisor and research ethics committee upon request

If you are willing to participate in this study please sign the attached Declaration of Consent and hand it to the investigator.

Yours sincerely

Winnifred Pienaar
Principal Investigator

Stellenbosch University https://scholar.sun.ac.za

Declaration by participant

By signing below, I …….…….. agree to take part in a research study entitled: **AN EVALUATION OF AN INTEGRATED COMPREHENSIVE INTERVENTION PROGRAMME FOR INTIMATE PARTNER VIOLENCE USING THE OUTCOME MAPPING METHOD**
.

I declare that:

- I have read the attached information leaflet and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....……. On (*date*) ……..…….. 2015.

.....

Signature of participant

Declaration by investigator

I (name) ……Winnifred Pienaar…….…… declare that:

• I explained the information in this document to ……..

• I encouraged him/her to ask questions and took adequate time to answer them.

• I am satisfied that he/she adequately understands all aspects of the research, as discussed above.

• I did not use an interpreter.

Signed at (place)……...on (date) ……2015.

Signature of investigator ……

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Appendix 4: Instrument / interview guide / data extraction forms

TITLE: Exploration of primary health carers` experience and viewpoints regarding identifying and managing IPV.

The following open-ended questions will be posed to the participants:

a) What are your views/opinion regarding intimate partner violence?

b) What were the challenges in identifying women with IPV?

c) What are the management strategies that you implement when consulting IPV clients?

d) Were you ever personally or a significant other exposed to IPV?

e) What are your views regarding the IPV service that was implemented?

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Appendix 5: Confidentiality agreement with data transcriber

To whom it may concern

Letter of declaration Winnifred Babara Pienaar

Student number: 15555534 - Stellenbosch University

I hereby confirm that audio transcriber services were provided to my client, Winnifred Babara Pienaar, a student at Stellenbosch University.

I assure that all the transcribed information will remain confidential between me and my client.

Yours sincerely

L. van Wyk

Leon Van Wyk

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Appendix 6: Extract of transcribed interview

WP: Tell me, with the intimate partner violence, do you see it a lot? Was it part of your training?
R: I think we were exposed to it as students. I wouldn't say that it was a specific module or that it received attention in itself specifically. But we were exposed to it, and also when we were rotating at different clinics as part of our practical training. Ja, so we are familiar with it.
WP: So tell me, was it easy for you to identify then with patients? The patients that were referred, were they referred from the sisters? Or was it something you picked up while you were examining this patient?
R: So what usually happens in our setting when we do pick them up, it's that they come with a J88 where they actually want to report what's happening and then want to make a case. That is more often how it happens. I have had cases where a lady came in, for example, with a painful arm and where it was also due to intimate partner violence, the husband had abused her, and where I urged her to go and open a case and she was unwilling. And I think, I don't know, it's a cultural thing to some extent that they see it as acceptable for this to happen. But more often it's via the J88s.
WP: So the majority of the cases were the J88 where the patient comes…
R: The patient actually comes to seek help.
WP: An in order to lay a case they must have this J88.
R: Yes.
WP: Talking about this experience of a patient that tells you, does the patient just say…you know, if you inquire, what are their reactions? Do they hide it?
R: So it almost feels like you've got two sets of patients. You have those who come forward and they want to make a case. They'll come forward with it. And then you get others that you pick up during the consultation. They come in because their arm is painful or whatever reason, and when you ask them about what happened, it comes out that they were abused by a partner. And in that group of patients, they are not forthcoming. You know, it's almost like they want to hide it and they are…I don't know…ashamed.
WP: Ja, because the literature shows that the majority of our clients that suffer with that and who get violently attacked, their problem is that they don't know how to…
R: How to communicate it, ja. Maybe they don't know that they can bring that up at the clinic. You know, maybe they think they're just coming for the medical issue and they don't realise that they can come to us with this problem.
WP: What do you think are the challenges associated with primary health care workers to diagnose…not to diagnose, actually, but just to identify, listen, this could be a candidate?
R: Time. We are so pushed for time. We are barely coping at the moment just getting through all of the patients that we're supposed to see within a day, and just sort of dealing with the specific problem that they are coming with. And I mean, especially patients who are not forthcoming about this issue, you need to sit down with them and take time and build rapport and win their trust to get them to talk to you.