Intimate partner violence at a tertiary institution

Kalli Spencer

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of

Master of Medicine in Urology

Johannesburg, 2017

Declaration

I, Kalli Spencer declare that this research is my own work.

It is being submitted for the degree of Master of Medicine in the branch of Urology at the University of the Witwatersrand, Johannesburg. It has never been submitted before for any degree or examination at this or any other University.

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23rd Day of August, 2017

Abstract

Background. Intimate partner violence (IPV) is actual or threatened physical, sexual, psychological, emotional or stalking abuse by an intimate partner. Despite the high prevalence of IPV in South Africa (SA), there is a paucity of data on university students training in fields where they are likely to have to manage such events in the future.

Objectives. To ascertain the prevalence of IPV in an SA tertiary institution population with a diverse demographic profile.

Methods. Students from the faculty of health sciences and the faculty of humanities, social work department completed an anonymous questionnaire. Students were made aware of psychological counselling available to them.

Results. Responses were obtained from 1 354 of 1 593 students (85.0%) (67.8% female, 45.9% black, 32.7% white, 16.6% Indian, 4.8% coloured). Of the respondents, 53.0% indicated that they were in a relationship. The prevalence of any type of IPV (sexual, physical or emotional abuse) among all respondents was 42.6%. Emotional abuse was reported by 54.9% of respondents, physical abuse by 20.0% and sexual abuse by 8.9%. Thirty-five females (6.5% of respondents who had suffered IPV) indicated that they had been emotionally, physically and sexually abused. Fourteen percent identified themselves as perpetrators of abuse, but only three perpetrators of sexual abuse reported having also been victims of sexual abuse. Most respondents (58.7%) knew where to get help.

Conclusion. The extent of IPV among the medical and social work students sampled was found to be unacceptably high, both as victims and as perpetrators. As a result of their exposure to IPV, these individuals may have difficulty in managing patients who have been subjected to abuse.

Acknowledgements

I would like to acknowledge the following people and institutions for their invaluable input and assistance:

Professor Haffejee

Professor Geoffrey Candy

Professor Edwell Kaseke

Ms Amitha Betchan

Ms Natashya Bennett

Miss Magali de la Kethulle de Ryhove

Dr Deirdre Kruger

Ms Deidre Pretorius

Mr Michel de Abreu

Mrs Kuschke

Ms Maria Wanyane

Ms Twinette Bradley

Department of Urology at the University of the Witwatersrand

Department of Surgery at the University of the Witwatersrand

Department of Social Work at the University of the Witwatersrand

Department of Family Medicine at the University of the Witwatersrand

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CCDU – Counselling careers and development unit

CDC – Centers for Disease Control and Prevention

CNS – Central nervous system

GIT - Gastrointestinal

HIV – Human immunodeficiency virus

IBS – Irritable bowel syndrome

IPV – Intimate partner violence

MCQ – Multiple Choice Question

POWA – People Opposing Women Abuse

PREMIS – Physician readiness to manage intimate partner violence

PTSD – Post-traumatic stress disorder

SA – South Africa

SD- Standard deviation

STI – Sexually transmitted infection

USA – United states of America

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Section 4: Appendices

Section 1: Literature Review

This literature review will begin by defining interpersonal violence and intimate partner violence. The reasons behind perpetration are then explored. International and local prevalence statistics are then reviewed. Some of the reasons unique to the high prevalence in South Africa is then explained. The relevance of IPV to health care practitioners is then expanded upon through a comprehensive description of the physical, emotional and psychological effects that may be detected during a consultation. The review then explores what data is available to suggest whether this group of practitioners could be victims or perpetrators themselves and the impact on clinical practice. Assessment of undergraduate curricular and training is briefly reviewed but is beyond the scope of this MMed report and will be published in two future publications.

1.1 Definition of interpersonal and intimate partner violence

The World Report on Violence and Health (WRVH) 2002 defines interpersonal violence as violence between individuals, subdivided into family and intimate partner violence and community violence (1).

Intimate partner violence (IPV) is defined as actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner. An intimate partner can be a current or former spouse or non-marital partner, such as a boyfriend, girlfriend, or dating partner. Intimate partners can be of the same or opposite sex (2).

1.2 Risk factors for perpetration

Most problems related to intimate partner violence have centred on men being the perpetrators of domestic violence, but men can be victims too. Some of these male victims may present to the urologists office. The refusal of many boys and men to report domestic violence makes assessment of its global prevalence difficult. ‘Shared living arrangements’, ‘reduced earnings’ and ‘early- and adult-onset affective disorders’ are the risk factors more commonly associated with male perpetration, whereas risk factors for female perpetration include ‘low educational attainment’ and ‘early-onset alcohol abuse/dependence’ (3).

Within the South African Context particular instigators of perpetration have been studied. Abrahams et al noted that the risk of being violent was linked to the use of violence to solve problems in other settings; having more than one current partner; and verbally abusing a partner (4). Perpetration of IPV is also related to a larger percentage of lifetime and past year sexual partners, more recent intercourse, a higher probability of reporting casual sex partners both ever and in the past year, transactional sex, and a greater chance of reporting sexual violence against women other than girlfriends (5). Santana et al added that this sex is most often performed unprotected (6).

Perpetration is strongly linked to alcohol abuse. With early use and exposure to alcohol abuse as children within the family a cycle of alochol related violence is perpetuated. Unemployment then also aggravates this cycle (7). A phenomenon known as “liquid courage” has been coined as bravado that develops after alocholo consumption which shifts aside innerhibitions further allowing for engagemnent of risky behaviour (7).

Male rapists are often exposed to childhood abuse or adversity and more likely to have a pattern of ideation that enables them to justify rape (8). These men view gender inequitably and have ‘adversarial’ and ‘hostile ideas’ about their victims (8). Narratives of masculinites that justify and celebrate ‘toughness’, ‘heterosexual performance’, and male dominance over women also play a role (9).

Given the high rates of poverty, current food insecurity and poor education can result in perpetration amongst South African men (9).

1.3 The prevalence of IPV

1.3.1 The global prevalence of intimate partner violence

It has been indicated that internationally between 10 and 52% of woman experienced physical abuse at the hands of an intimate partner during their lifetime, and that sexual violence had been inflicted upon 10-30% of respondents. These findings were the result of a review of 50 population-based studies canvassing respondents in 35 countries prior to 1999 (10).

A population based study by C. Garcia-Moreno et al in 2006, studying 15 different countries, reported a lifetime prevalence of physical or sexual partner violence, or both, varying from 15% to 71% (10). Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in the past year (10).

In sub-Saharan Africa the true prevalence is thought to be underestimated due to lack of standardisation of research methodology and under-reporting. The estimated IPV prevalence is between 20-71% (11).

1.3.2 The South African prevalence of IPV

South Africa has one of the highest rates of IPV in the world. A SA study found a lifetime prevalence of victimisation among female respondents to be 19%. Another national study on physical violence amongst men found the perpetration rate of violence in their most recent or their current partnership to be 27.5% (3). Another study showed the prevalence of forced sex was 7.1%. 80.9% of the men who reported sexual violence also reported both physical and emotional against partners (4). The South African Police Service estimate that one female is raped every 36 seconds and over half of female homicide victims are murdered by their

intimate partners (3). A national study in South Africa on female homicide indicated that a woman is killed by her intimate partner every six hours (12).

In a South African IPV study across three provinces it was noted that the prevalence of ever having been physically abused by a current or ex-partner was 26.8% in the Eastern Cape, 28.4% in Mpumalanga and 19.1% in the Northern Province (13).

A separate South African study conducted in Gauteng, the same province as this study, found that 50% of the women had experienced gender-based violence over their lifetime, and 18.1% in the last year (14). A quarter of women in the province had experienced sexual violence in their lifetime and 7.8% in the prior year (14). Emotional violence was the most common form of abuse reported by women and disclosed by men, with 43.7% of women having experienced these on one or more occasions (14). Physical violence was detected in 33.1% of women with 13.2% in the last year (14). Perpetration of sexual violence was disclosed by 37.4% of men and emotional violence in 65.2% of men (14).

1.4 Background of intimate partner violence in South Africa

The threat of intimate partner violence is at its maximum in violent societies where such behaviour is socially acceptable. A 'culture of violence' is an all-encompassing aspect of post-apartheid South Africa, and as such constitutes a foundation for abuse against women (12). The almost exclusive media focus on "political violence" in SA before 1994 and on "crime related violence" since, deflected attention away from the high levels of interpersonal violence (15).

Specific causes for intimate violence have been noted in South Africa, with poverty being most influential (16). Disparities in income lead to power plays and disempowerment of woman (16). It has been noted that conflict levels were lower in relationships where women received their household resources mainly from a third party (16). Education is another driving factor and is protective against having ever been abused (16). As mentioned previously a national culture of violence may explain why levels of marital conflict often precede domestic violence (16). These conflicts are often fueled by alcohol consumption. Alcohol consumption by both sexes is strongly associated with domestic violence (16). Cultural norms often dictate male dominance and legitimise the need to discipline a woman (16). Isolation of partners by preventing them from seeing family and friends, or working and speaking with other men is a form of abuse (13). Another alarming trend is physical violence during pregnancy and its associated morbidity (13). Restricting access to essentials needed to care for a baby is also considered abusive (13). Woman are denied equal access to education, employment and political roles and often don't feel empowered to seek help or even know where to find it (16).

1.5 Physical, mental and emotional effects of intimate partner violence

The effects of intimate partner violence influence the victim's health. The health consequences can be divided into physical, sexual and mental effects. Findings show that

a greater percentage of women who were the victims of battery in the preceding year (12-17%) presented to casualty departments than women with severe abuse trauma/injuries (2-3%) (17).

The trauma, anguish and anxiety associated with IPV can lead to persistent/recurrent health issues such as pain (e.g. back pain or headaches) or chronic CNS symptoms including syncope or fits. For example female victims often (10–44%) report choking—'incomplete strangulation'—and head injuries resulting in altered levels of consciousness which can present with acute neurological sequelae (17). Victims of abuse may experience functional GIT syndromes (e.g., IBS) as result of recurrent anxiety compared to non-abused woman. These woman complain of more GIT symptoms (e.g., eating disorders and reduced appetite) (17).The functional damage to the intestines can have a lifelong impact. High blood pressure and chest pain are commonly reported self-reported cardiac symptoms of victims (17).

Gynaecological conditions are the greatest physical health differentiator between women who have been battered and those who haven't (17). Common illnesses include STI's, urinary tract infections, vaginal infection or bleeding, fibroids, lowered libido, genital discomfort, tenderness during intercourse and recurring pelvic pain (17).

The health issues stemming from sexual abuse (40-45% of abused females) is significantly worse than those experiencing physical abuse only (17).

Possible processes of increased risk is the shame and anxiety experienced with forced intercourse exhibiting as increased levels of stress and depression which lower the immune system. Anal, urethral and vaginal injury from forced intercourse (due to no lubrication or the direct pressure) can result in transmission of pathogens through direct inoculation into the circulatory system or retrograde passage of urethral microorganisms. These perpetrators also have unprotected sex with other partners thus increasing the infection risk to their intimate partner (17).

Women who try to safeguard themselves against HIV – for example, by insisting on condoms or rejecting condomless sex – experience increased rates of intimate partner violence (11). The link between HIV, STI's unplanned pregnancy and IPV may in part be explained by these issues (18). IPV may be the result of relationship stress created over a partner's HIV status. Furthermore, the noteworthy correlation between having numerous sexual partners and experiencing IPV implies that a partner's conception of a woman's sexual relations outside the confines of the relationship may spark IPV, or, inversely, that a woman's exposure to IPV may cause her to partake in additional relationships (19).

Intimate partner violence is linked to various psychological problems, with rates of 50-75% for PTSD and 54–68% for major depressive disorders and 50–75% in woman who are victims (17). Regardless of the aetiology, when IPV is treated, there is a reduction in depressive symptoms. Alcohol abuse is associated with IPV: 20% for females and 45% for males (17). Women exposed to post-traumatic stress disorder may turn to narcotics or liquor to soothe or manage the effects of PTSD: avoidance, hyperarousal and intrusive thoughts (20).

1.6 The effect of IPV on employment

Abused women tend to use medical services more frequently than non-abused women which is directly proportional to the gravity of the physical attack (17). Women exposed to IPV were more likely to be late for work or depart early, call in ill or miss days of work as a result of an abusive partner (21). Alsaker et al found this had physical and psychological impacts on the worker's quality of life. In the same study a significant rate of unemployment was noted with lower scores or improvement in the domains of pain and physical wellbeing (21).

Victims of IPV often present to hospital before visiting a police station or the justice system. It is therefore imperative for healthcare personnel to know how to recognise and manage a victim of IPV.

1.7 Intimate partner violence curricular at academic institutions

Studies in the USA have assessed the adequacy of health science and humanity curricula. Connor et al have used a modified version of the PREMIS (Readiness to Manage Intimate Partner Violence Survey) tool for their assessment of learners which measures the, attitudes, beliefs, knowledge and self-reported behaviours amongst students by means of a four part (Background, Intimate Partner Violence Knowledge, Opinions, and Practice Issues), 67-item survey that requires approximately fifteen minutes to complete (22). Any IPV education that students receive could be effective in increasing confidence and perceived preparedness to address IPV with patients (23).

1.8 Implication of IPV for Medical and Social Work students

University students are considered an elite sector of society and one could assume that attending a tertiary institution would consequently render them less likely to be perpetrators or victims of IPV (24). Some of these students are studying toward degrees which would see them dealing with the victims of IPV. There is a paucity of data relating to South African university students to understand how many are victims of IPV, particularly in the fields of medicine and social work where they may, in future, be treating patients with IPV related conditions.

IPV is also detrimental to a student's academic success and ultimate career advancement. Many students struggle due to missed classes, interruptions in learning, poor concentration and lowered self-esteem (25). As a result they may fail examinations and eventually drop out of their university programme (26).

The study aims to ascertain the prevalence of intimate partner violence within a South African tertiary institution population which has a diverse demographic profile. It also aims

to assess whether personal experience of IPV in final year students changes perceived or actual IPV knowledge.

The outcomes of the study may be used to improve the current curricula of professional degrees which may better equip future healthcare providers with the information and tools needed to provide an IPV victim with excellent quality of care. It may also help universities to develop appropriate support structures for health care providers who themselves have been victims of intimate partner violence.

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- Please make your article concise, even if it is below the word limit.
- Qualifications, ***full*** affiliation (department, school/faculty, institution, city, country) and contact details of ALL authors must be provided in the manuscript and in the online submission process.
- Abbreviations should be spelt out when first used and thereafter used consistently, e.g. 'intravenous (IV)' or 'Department of Health (DoH)'.
- Scientific measurements must be expressed in SI units except: blood pressure (mmHg) and haemoglobin (g/dL).
- Litres is denoted with an uppercase L e.g. 'mL' for millilitres).
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- Main results with (for quantitative studies) 95% confidence intervals and, where appropriate, the exact level of statistical significance and the number need to treat/harm. Whenever possible, state absolute rather than relative risks.
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- Contribution to the body of knowledge
- Strengths and weaknesses in relation to other studies
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- *Journal references:* Price NC, Jacobs NN, Roberts DA, et al. Importance of asking about glaucoma. Stat Med 1998;289(1):350-355. DOI:10.1000/hgjr.182
- *Book references:* Jeffcoate N. Principles of Gynaecology. 4th ed. London: Butterworth, 1975:96-101.
- *Chapter/section in a book:* Weinstein L, Swartz MN. Pathogenic Properties of Invading Microorganisms. In: Sodeman WA, Sodeman WA, eds. Pathologic Physiology: Mechanisms of Disease. Philadelphia: WB Saunders, 1974:457-472.
- *Internet references:* World Health Organization. The World Health Report 2002 – Reducing Risks, Promoting Healthy Life. Geneva: WHO, 2002. http://www.who.int/whr/2002 (accessed 16 January 2010).
- Legal references

  • Government Gazettes:

  National Department of Health, South Africa. National Policy for Health Act, 1990 (Act No. 116 of 1990). Free primary health care services. Government Gazette No. 17507:1514. 1996.

  In this example, 17507 is the Gazette Number. This is followed by :1514 – this is the notice number in this Gazette.

  • Provincial Gazettes:

  Gauteng Province, South Africa; Department of Agriculture, Conservation, Environment and Land Affairs. Publication of the Gauteng health care waste management draft regulations. Gauteng Provincial Gazette No. 373:3003, 2003.

  • Acts:

  South Africa. National Health Act No. 61 of 2003.

  • Regulations to an Act:

  South Africa. National Health Act of 2003. Regulations: Rendering of clinical forensic medicine services. Government Gazette No. 35099, 2012. (Published under Government Notice R176).

  • Bills:

South Africa. Traditional Health Practitioners Bill, No. B66B-2003, 2006.

- Green/white papers:

South Africa. Department of Health Green Paper: National Health Insurance in South Africa. 2011.

- Case law:

Rex v Jopp and Another 1949 (4) SA 11 (N)

Rex v Jopp and Another: Name of the parties concerned

1949: Date of decision (or when the case was heard)

(4): Volume number

SA: SA Law Reports

11: Page or section number

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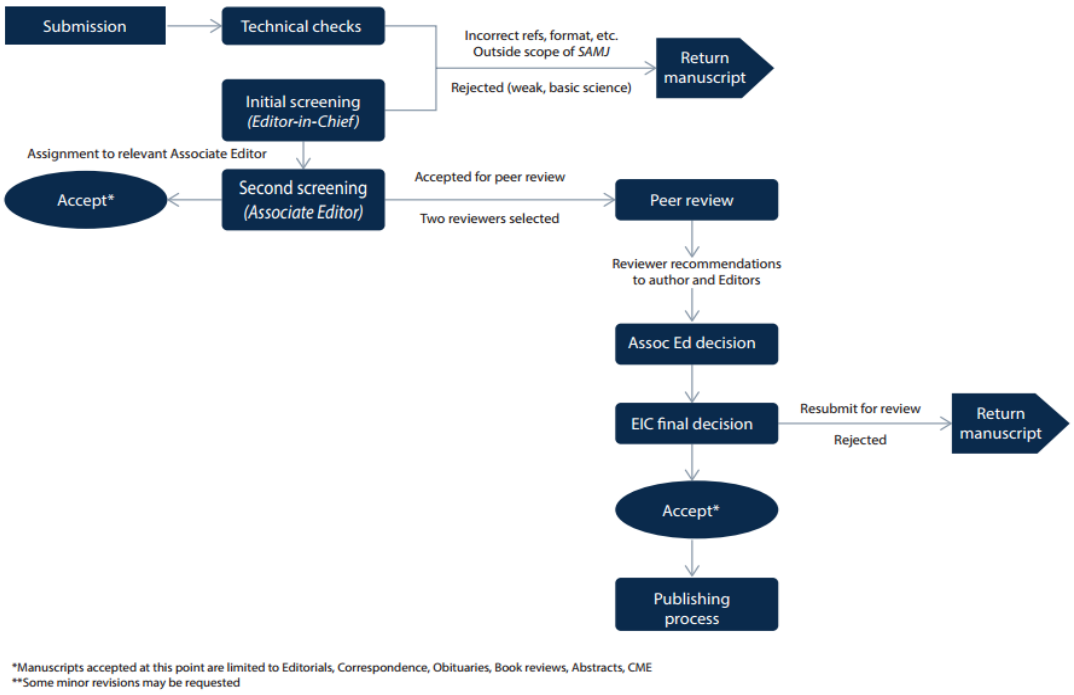

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Section 3: Draft Article to the South African Medical Journal

Cover letter to the editor

01/09/16

Dear Sir/Madam

I thank you in advance for kindly considering our research entitled “Intimate partner violence at a Tertiary Institution”.

South Africa has one of the highest rates of IPV in the world. A SA study found a lifetime prevalence of victimisation among female respondents to be 19%. Another national study on physical violence amongst men found the perpetration rate of violence in their most recent or their current partnership to be 27.5%.

Health care professionals should be adept at managing patients who are victims and dealing with perpetrators.

University students are considered an elite sector of society and one could assume that attending a tertiary institution would consequently render them less likely to be perpetrators or victims of IPV. There is a paucity of data relating to South African university students to understand how many are victims of IPV, particularly in the fields of medicine and social work where they may, in future, be treating patients with IPV related conditions.

The study aims to ascertain the prevalence of intimate partner violence within a South African tertiary institution population which has a diverse demographic profile.

The outcomes of the study may be used to improve the current curricula of professional degrees which may better equip future healthcare providers with the information and tools needed to provide an IPV victim with excellent quality of care. It may also help universities to develop appropriate support structures for health care providers who themselves have been victims of intimate partner violence.

The SAMJ is the first journal this manuscript has been submitted to. This is also the first study we have conducted on the subject of IPV.

Thank you for your time and consideration

Sincerely

Kalli Spencer

MBBCh

Department of Urology, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg.

Intimate partner violence at a tertiary institution

K Spencer,[1] MB BCh; **M Haffejee,**[1] MB BCh, FCS (Urol); **G Candy,**[2] MSc, PhD; **E Kaseke,**[3] BA, PhD

[1] *Department of Urology, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

[2] *Department of Surgery, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

[3] *Department of Social Work, Faculty of Humanities, University of the Witwatersrand, Johannesburg, South Africa*

Corresponding author: *K Spencer (doctorkspencer@gmail.com)*

Key words: Intimate, partner, violence, university, students

Word count: 3319 (Abstract: 267)

S Afr Med J. 2016 Nov 2;106(11):1129-1133. doi: 10.7196/SAMJ.2016.v106i11.12013.

ABSTRACT

Background. Intimate partner violence (IPV) is actual or threatened physical, sexual, psychological, emotional or stalking abuse by an intimate partner. Despite the high prevalence of IPV in South Africa (SA), there is a paucity of data on university students training in fields where they are likely to have to manage such events in the future.
Objectives. To ascertain the prevalence of IPV in an SA tertiary institution population with a diverse demographic profile.
Methods. Students from the faculty of health sciences and the faculty of humanities, social work department completed an anonymous questionnaire. Students were made aware of psychological counselling available to them.
Results. Responses were obtained from 1 354 of 1 593 students (85.0%) (67.8% female, 45.9% black, 32.7% white, 16.6% Indian, 4.8% coloured). Of the respondents, 53.0% indicated that they were in a relationship. The prevalence of any type of IPV (sexual, physical or emotional abuse) among all respondents was 42.6%. Emotional abuse was reported by 54.9% of respondents, physical abuse by 20.0% and sexual abuse by 8.9%. Thirty-five females (6.5% of respondents who had suffered IPV) indicated that they had been emotionally, physically and sexually abused. Fourteen percent identified themselves as perpetrators of abuse, but only three perpetrators of sexual abuse reported having also been victims of sexual abuse. Most respondents (58.7%) knew where to get help.
Conclusion. The extent of IPV among the medical and social work students sampled was found to be unacceptably high, both as victims and as perpetrators. As a result of their exposure to IPV, these individuals may have difficulty in managing patients who have been subjected to abuse.

BACKGROUND

Victims of intimate partner violence (IPV) may experience numerous physical, sexual, psychological, behavioural and even fatal consequences (Table 1).[1] These include an increased number of visits to emergency departments, and an increased risk of gastrointestinal, cardiovascular, gynaecological and psychiatric disorders, including depression, substance abuse and post-traumatic stress disorder.[1] Women who refuse to have sex without a condom have an increased likelihood of becoming IPV victims, and if forced to do so have the additional problems of sexually transmitted infections, including HIV, and unplanned pregnancies.[1] The effects of IPV may not be immediately apparent, and may only manifest with targeted questioning or after an examination. It is precisely because of the complexity of these implications that it is important for the clinician to know how to screen for and manage these individuals.

Table 1. Effects of intimate partner violence[1]

Physical
Abdominal/thoracic injuries
Bruises and welts
Chronic pain syndromes
Disability
Fibromyalgia
Fractures
Gastrointestinal disorders
Irritable bowel syndrome
Lacerations and abrasions
Ocular damage
Reduced physical functioning
Sexual and reproductive
Gynaecological disorders
Infertility
Pelvic inflammatory disease
Pregnancy complications/miscarriage
Sexual dysfunction
Sexually transmitted diseases (HIV)
Unsafe abortion
Unwanted pregnancy
Psychological and behavioural
Alcohol and drug abuse
Depression and anxiety
Eating and sleep disorders
Feelings of shame and guilt
Phobias and panic disorder
Physical inactivity
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders

Smoking
Suicidal behaviour and self-harm
Unsafe sexual behaviour
Fatal health consequences
AIDS-related mortality
Maternal mortality
Homicide or suicide

The World Report on Violence and Health[1] defines IPV as 'actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner'. An intimate partner can be a current or former spouse or a non-marital partner, such as a boyfriend, girlfriend or dating partner, and can be someone of the same or the opposite sex. The South African (SA) Domestic Violence Act 116 of 1998[2] expands on this definition and speaks of a 'complainant' as any person who is or has been in a domestic relationship and has been or allegedly has been subjected to an act of domestic violence. The term domestic relationship is all-encompassing and includes customary marriages, various types of relationships and even flatmates. The definition of domestic violence is further expanded to include economic abuse, intimidation, harassment, stalking, damage to property, entry into the complainant's residence without consent, and controlling behaviour.[2]
Looking at the global prevalence rates, a review of more than 50 population-based studies from 35 nations found that 10 – 52% of females reported that they had been physically abused, and 10 – 30% had experienced sexual violence from an intimate partner at some point in their lives.[3] The reported IPV prevalence of 20 – 71% in sub-Saharan Africa has been thought to be an underestimate due to under-reporting and poor standardisation of methods.[3]
A SA study found a lifetime prevalence of victimisation among female respondents to be 19%. Another national study on physical violence amongst men found the perpetration rate of violence in their most recent or their current partnership to be 27.5%. [4] More than 50% of female homicide victims are murdered by their intimate partners. [4] Furthermore, an SA study on female homicide indicated that a woman was killed by her intimate partner every six hours.[5]

University students are considered an elite sector of society, and it could be assumed that attending a tertiary institution would render individuals less likely to be perpetrators or victims of IPV.[6] Some of these students study towards careers in which they will need to deal with the victims of IPV. There is a paucity of data relating to SA students who are victims of IPV, particularly in the fields of medicine and social work. The objective of this study was to ascertain the prevalence of and gender differences in IPV in a group of students studying to be healthcare workers in an SA tertiary institution.

Methods

Approval to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (ref. no. M120670).

Study participants

A sample of male and female students from the medical school and department of social work at a university in Gauteng Province, SA, were asked to complete a quantitative anonymous questionnaire. The sample consisted of all 1st- to 6th-year medical students and all

1st- to 4th-year social work students. These two faculties comprised 1 593 students, and the decision was made to use the entire group as a sample. Connor *et al*.[7] found that students who received education about IPV while at medical school reported having greater confidence and perceived preparedness to deal with IPV victims. We therefore selected this population because they would be exposed to IPV and would be likely to screen for it.

Data collection process

The consent process consisted of a brief presentation by the first author (KS) detailing the study prior to handing out the questionnaire. The information sheets, consent forms and questionnaires were handed out after lectures or exam sessions. Participation in the study was voluntary, and students were told they could leave questions unanswered if necessary. An electronic marking sheet was used, and the questionnaires were anonymous with no name or student number reflected anywhere on the response sheet. Completed questionnaires were then placed into a sealed box. After the survey, each student was given a form with the contact details of a dedicated psychological counselling service available to them if they experienced discomfort as a result of the survey process.

Data collection tool

Two recommended screening tools from the US Centers for Disease Control and Prevention (CDC) were combined to create 25 multiple-choice questions, which were adapted to the SA context. These tools were the computer-based IPV Questionnaire and the Women Abuse Screening Tool (WAST). The WAST had a Cronbach's alpha of 0.75 estimated for the reliability of the tool and a correlation with the construct validity of the Abuse Risk Inventory of 0.69.[8]

The data collection tool comprised four domains, of which this article covers only two – demographics and the prevalence of the different types of abuse.

The first six questions requested demographic information from the participants, including the degree for which they were enrolled (medicine or social work), year of study, age group, gender, racial group and relationship status.

Questions 14, 15 and 16 were about relationships and were derived from the Women Abuse Screening Tool (Table 2).[8] Questions 11 – 13 and 17 – 22 were derived from the questions on the computer-based IPV questionnaire listed in Table 3.[8] Two questions involving handguns from the original IPV questionnaire were not included in this questionnaire. Questions 24 and 25 were original questions (Table 4).

Table 2. Components of the WAST[8]

Question	Response			
In general, how would you describe your current relationship?	A lot of tension	Some tension	No tension	Not applicable
How do you and your current partner work out arguments?	Great difficulty	Some difficulty	No difficulty	Not applicable
Do arguments ever result in you feeling bad about yourself?	Often	Sometimes	Never	Not applicable

Table 3. Components of the computer-based IPV Questionnaire[8]

Question	Response		
Have you ever had a partner or spouse who gets very jealous or tries to control your life?	Yes	No	
Does someone close to you sometimes say insulting things or threaten you?	Yes	No	
Is there someone you are afraid to disagree with because they might hurt you or other family members?	Yes	No	
Has someone close to you pushed, kicked, or otherwise physically hurt you?	Yes	No	
Has someone close to you abused you emotionally?	Yes	No	
Have you ever been made to have sex (oral, anal, vaginal) when you didn't want to?	Yes	No	
Have you ever physically hurt someone close to you?	Yes	No	
Are you worried that you might hurt someone physically close to you?	Yes	No	
Have you ever had a partner or spouse try to keep you away from family or friends?	Often	Sometimes	Never
In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide as a result of being an IPV victim?	Often	Sometimes	Never

Table 4. Additional original questions

Question	Response	
If you were sexually abused, were you able to negotiate safe sex?	Yes	No
If you were to be a victim of IPV, do you know where to get help?	Yes	No

Statistical analysis

The results of each sheet were tallied electronically per question. Data were recorded on an Excel 2013 spreadsheet (Microsoft, USA), and Statistica version 12 (Statsoft, USA) was used for all statistical procedures. Descriptive statistics were reported as totals and percentages for categorical data. Comparative statistics were done using a χ^2 test or Fisher's exact test as appropriate, with a *p*-value of <0.05 being considered statistically significant.

For the purposes of definition, participants were deemed to have been victims of physical abuse if they answered in the affirmative to the questions referring to being pushed, kicked, or otherwise physically hurt, victims of sexual abuse if they had been made to have sex (oral, anal vaginal) when they did not want to, and victims of emotional abuse if they answered in the affirmative to the question directly asking the respondent whether he/she had been emotionally abused. The definition of emotional abuse was further expanded to include whether a partner gets very jealous or tries to control the respondent's life, tries to keep them away from family or friends, says insulting things or threatens them, is disagreeable, or may try to hurt them or other family members.

Results

Responses were obtained from 1 354 of the 1 593 students (85.0%). The responses collected were similar for each year of study. Most respondents were aged 20 – 24 years (61.9%) and were female (67.8%); 45.9% were black, 32.7% white, 16.6% Indian and 4.8% coloured (Table 5).

Table 5. Demographic information on the respondents

Demographic variables	**%**
Age (years)	
17 – 19	25.1
20 – 24	61.9
≥25	13.0
Gender	
Female	67.8
Male	32.2
Ethnic group	
Black	46.0
White	32.7
Indian	16.6
Coloured	4.8
Study year	
1	23.8
2	17.1
3	20.2
4	16.1
5	13.3
6	9.5
Relationship status	
Single	47.0
Relationship/engaged/married	53.0

Fifty-three percent of the respondents were in a relationship, engaged or married. Of the 718 respondents who reported that they were in a relationship, 123 (17.1%) indicated that they had a jealous partner. Of the remaining 636 respondents who indicated they were not currently in a relationship, a very similar proportion (*n*=127; 19.9%) indicated that they had had a jealous partner in the past. The following responses pertain to respondents in a relationship (*n*=718): 40 (5.6%) often and 250 (34.8%) sometimes felt that their partner tried to keep them away from family and friends, while 250 (34.8%) reported that their partner was sometimes insulting or threatening towards them and 123 (17.1%) afraid to disagree with their partner because they might harm them or their family. Two hundred and three respondents (28.3%) felt that there was some tension in their current relationship, 310 (43.2%) experienced some difficulty when settling arguments with their partners, 555 (77.3%) sometimes felt lowered self-esteem after settling an argument, and 124 (17.3%) were afraid not to agree with their partner.

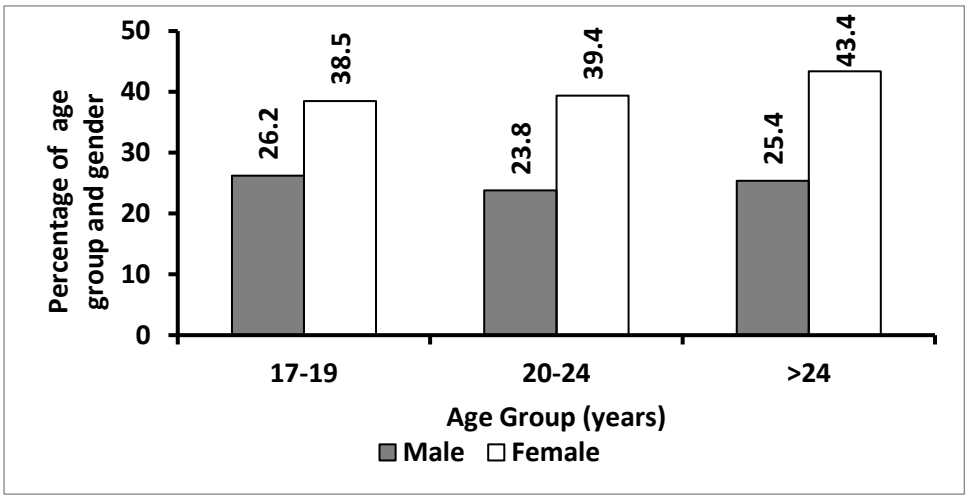
The prevalence of any type of IPV (sexual, physical, emotional abuse) among all the respondents was 42.6% (577/1 354). Emotional abuse was the most common type of abuse (35.0% of respondents). With the expanded definition of emotional abuse (as above) the prevalence increased to 54.9%. Physical abuse (20.0%) and sexual abuse (8.9%) were reported less often. Thirty-five females (6.5% of respondents who had suffered IPV) indicated that they had been emotionally, physically and sexually abused. Most of these females (28/35, 80.0%) indicated they were not currently in a relationship.

With sexual abuse, although no trend with age was apparent among male students, the percentage of females reporting sexual abuse increased by 6.1% between the 17 – 19 year-old

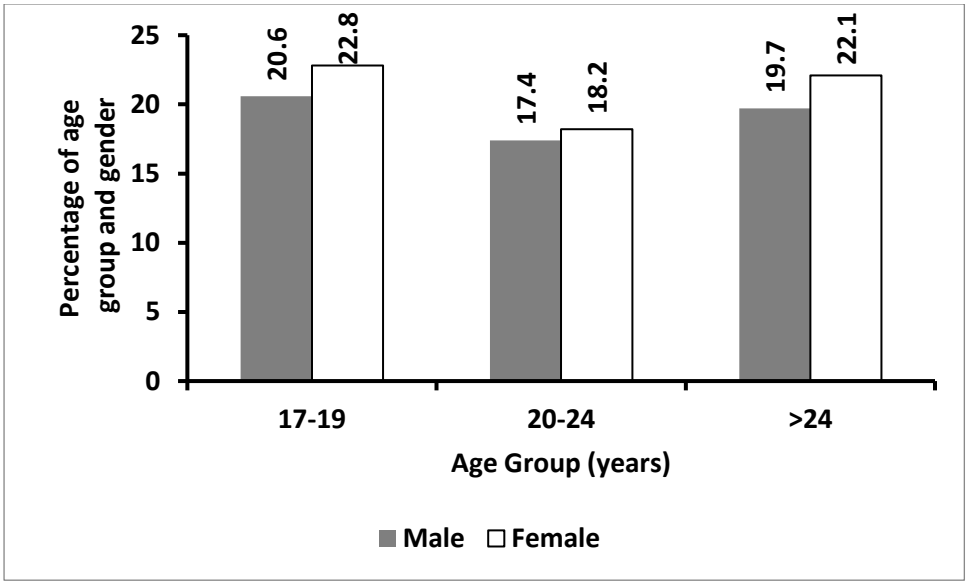
(9.8%) and >24-year-old (15.9%) age groups. Older females (>24 years) appeared more vulnerable to emotional (43.4%) and sexual abuse (15.9%) (Fig. 1).

Fig. 1. Types of abuse by age group and gender: A: Emotional; B: Physical; C: Sexual.

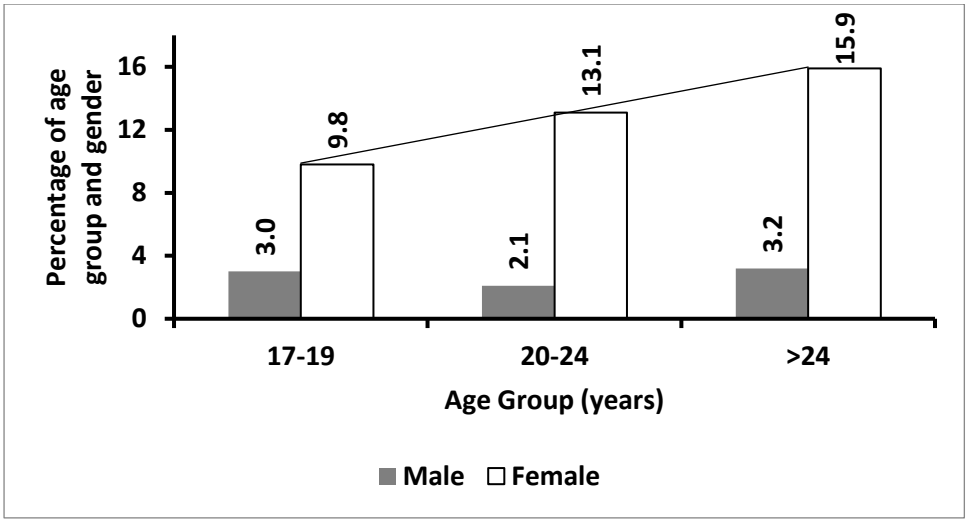
A



B



C



Responses of females relating to questions pertaining to whether the partner was isolating or insulting, to whether there was tension in the relationship, and to settling of arguments and disagreeing with a partner did not appear to indicate a major problem, with less than half of the respondents reporting that these were issues. However, overall 59.5% of female respondents in a relationship aged <25 years indicated they had a jealous partner. Furthermore, overall 68.0% had arguments resulting in the individual 'feeling bad' often (14.4%) or sometimes (55.2%). This response was also more common in the two younger age groups. Of all the victims of sexual abuse, 45.0% were at least able to negotiate protected sex. Overall, 58.7% of the respondents knew where they could get help and counselling as victims of abuse.

The perpetrators (14.0% of total respondents) of IPV tended to be males in the white and Asian ethnic groups, females among coloured respondents, and without an apparent gender difference (p=0.55) among black respondents. There were no age-related differences (males p=0.87 and females p=0.69) among the perpetrators, although younger males were more often perpetrators in the 17 – 19-year age group. Only three perpetrators of sexual abuse indicated that they themselves had been sexually abused.

Discussion

Healthcare workers tend to provide superior management to victims of IPV when they seek assistance for themselves first. Christofides and Silo[9] found that practitioners who reported their own, a friend's or a family member's experience with IPV had an increased 'quality of care score'. This could be the result of their ability to identify and empathise with victims. Kim and Motsei[6] stated that healthcare workers who were victims of IPV tended to have the same cultural values as the victims they treated and counselled, underlining the 'gender-bound constructs' within which they operated, which extended from their personal to their professional capacities. Sugg and Inui,[10] however, reported that doctors were 'emotionally inactivated' and therefore not able to manage patients with similar experiences, and might experience personal distress.

This study determined the prevalence of IPV in an SA tertiary institution population, representative of the ethnic makeup of the national population. The study is unusual as it obtained responses from medical and social work students in all years of study and from respondents of both genders. These students, whose future professions include counselling of victims of abuse, would be expected to be aware of this problem.

The total prevalence of IPV at the institution in question was 42.6%, comparable to a study from China that found a prevalence of 37.1%.[11] The university with the highest reported prevalence of IPV victims was in Nigeria, with a figure of 58.8% for female students.[12] Studies at other universities found varying prevalences (in descending order) from 28.7% (Tennessee), 22% (Wisconsin) and 10% (Vanderbilt) in the USA, to 7% (Ontario, Canada).[13-16] A study at numerous institutions in the UK found an overall prevalence of 14.2%.[17]

In line with previous studies, the present study found a higher prevalence of female (particularly in the older age groups) than male IPV victims. A report from the Office of Justice in the USA[18] stated that female students in full-time education were at a higher risk of sexual violence than the general female population. Several risk factors were noted: 'living on campus, being unmarried, getting drunk frequently, and experiencing prior sexual victimization'.[19]

In an SA study by Gass *et al*.[4] it was found that the single common risk factor for IPV victims of both genders was witnessing parental violence. Specific risk factors pertaining to male victims included reduced income and lack of proximity to a primary female care provider, whereas, whereas risk factors for female victims included low standard of education, physical violence during childhood, and 'intermittent explosive disorder' and adult-onset alcoholism'.[4] There is a strong correlation between IPV and cross-generational cycles of abuse and susceptibility to risk during the life course [4].

An interesting observation in our study was the low use of condoms. Peltzer[19] had similar findings, and reported that 29.2% of SA students never, 35.4% always, 19.8% regularly and 8.5% irregularly used condoms over a 3-month period. This is concerning given the high national HIV incidence and that this was a well-educated group of individuals who should be aware of the risks of unprotected sexual intercourse.

An interesting and unexpected finding was the high rate of female perpetrators, particularly amongst black and coloured students. The National Intimate Partner and Sexual Violence Survey by the CDC expanded the definition of IPV to include rape while under the influence of illicit drugs, undesirable touching, expressive aggression, conceiving by coercion, refusing to use a condom, and stalking.[20] With the new definition they found an equal rate of perpetration between the genders. Female aggressors are also at increased risk of becoming a victim later on.[21] Gass *et al*.[4] reported that shared living arrangements, reduced income and early- and adult-onset affective disorders are the risk factors most commonly associated with male perpetrators, whereas risk factors for female perpetration include low levels of education and early-onset alcohol abuse/dependence.

Medical schools need to have appropriate support mechanisms in place for victims and potential victims of IPV, and students should be given a list of local resources. According to Ambuel *et al*.,[14] students need to be allowed to process their feelings and experiences within their academic spaces. There should be a safe environment that fosters open, respectful sharing of experiences and ideas, appropriate supervision, and encouragement of responsible self-care including access to psychotherapy and support groups. To this end, our institution has dedicated psychology and counselling services available. Broader institutional and policy changes should also be implemented in academic programmes to enable early detection and management.[14]

Study limitations

Concepts such as physical, sexual or emotional abuse could have been better defined, as the questions assumed that students had prior knowledge or understood the scope of abuse as defined by current legislation. This may have affected their ability to answer the questions. Certain components of emotional abuse as defined by the SA Domestic Violence Act were

not specifically included, such as economic abuse, intimidation, harassment, stalking, damage to property, and entry into the complainant's residence without consent. The participants may also have had different perceptions of what defines sexual abuse, and the fact that a person did not agree with the statement does not mean it did not happen. If the data collection tools had covered these various other forms of IPV, labelled domestic violence under the Domestic Violence Act, the prevalence rate might have differed.

Conclusion

The extent of emotional, physical and sexual abuse among university medical and social science students sampled was unacceptably high, both as victims and as perpetrators. As a consequence of their own abuse, these individuals may have difficulty in managing patients who have been subjected to abuse. To determine possible regional differences in this unacceptable practice, it is recommended that similar surveys be undertaken at other centres of higher learning.

Acknowledgements. The authors acknowledge Amitha Betchan and Magali de la Kethulle de Ryhove for their administrative assistance, and Deidre Pretorius for her advice.

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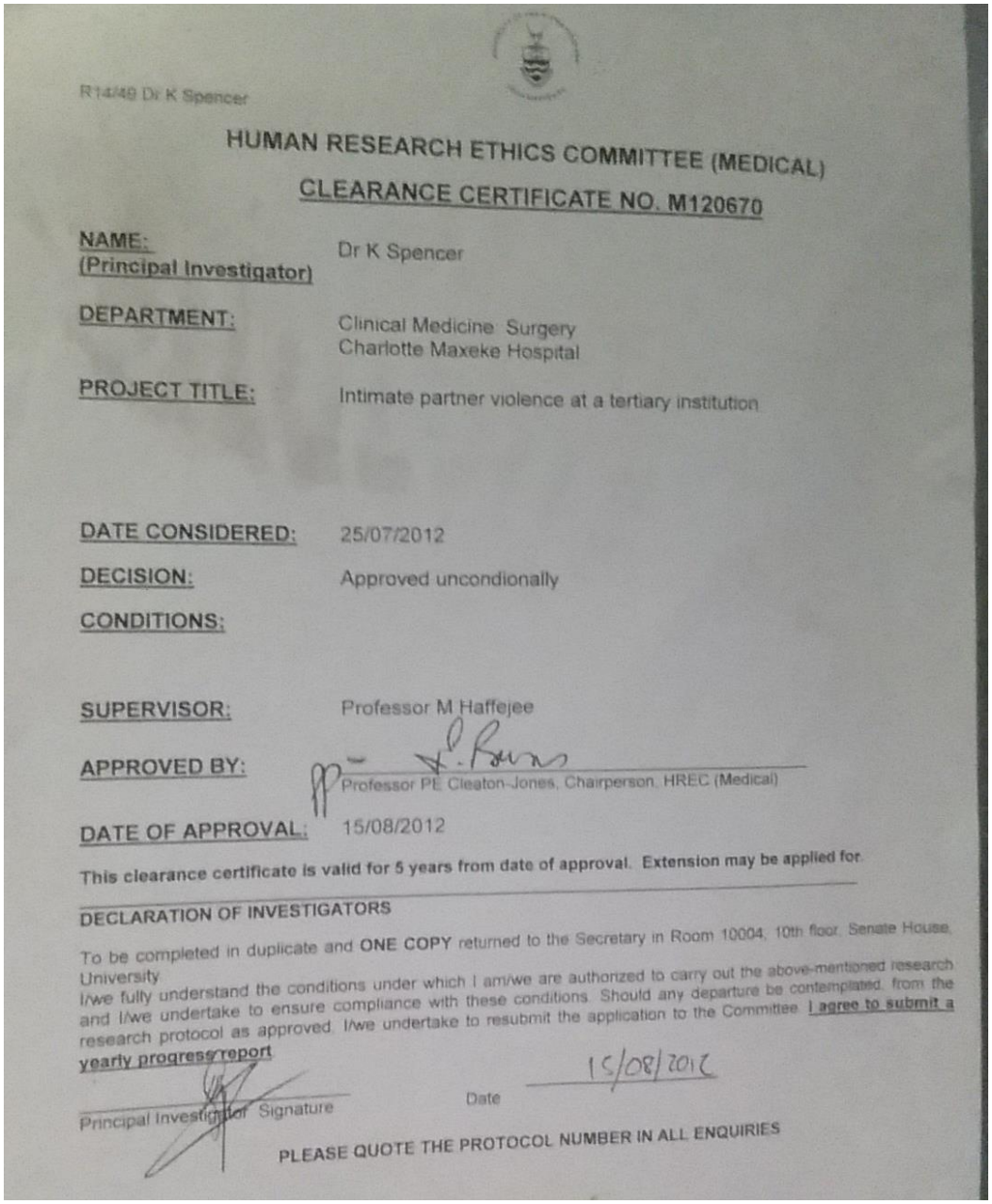
Accepted 19 September 2016

Section 4: Appendices
4.1 Ethics approval



R14/49 Dr K Spencer

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M120670

NAME: (Principal Investigator)	Dr K Spencer
DEPARTMENT:	Clinical Medicine Surgery Charlotte Maxeke Hospital
PROJECT TITLE:	Intimate partner violence at a tertiary institution
DATE CONSIDERED:	25/07/2012
DECISION:	Approved uncondionally
CONDITIONS:	
SUPERVISOR:	Professor M Haffejee
APPROVED BY:	Professor PE Cleaton-Jones, Chairperson, HREC (Medical)
DATE OF APPROVAL:	15/08/2012

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Secretary in Room 10004, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report.**

Principal Investigator Signature

Date 15/08/2012

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

4.2 Postgraduate approval

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

Private Bag 3 Wits, 2050
Fax: 027117172119
Tel: 02711 7172076

Reference: Mrs Sandra Benn
E-mail: sandra.benn@wits.ac.za

01 November 2016
Person No: 0300820K
PAG

Dr K Spencer
Po Box 198
Highlands North
2037
South Africa

Dear Dr Spencer

Master of Medicine: Approval of Title

We have pleasure in advising that your proposal entitled *Intimate partner violence at a tertiary institution* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Section 5: Annexure – Protocol

5.1 Background

The World Report on Violence and Health (WRVH) 2002 defines interpersonal violence as violence between individuals, subdivided into family and intimate partner violence and community violence (1).

Intimate partner violence (IPV) is defined as actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner. An intimate partner can be a current or former spouse or non-marital partner, such as a boyfriend, girlfriend, or dating partner. Intimate partners can be of the same or opposite sex (2).

Most issues of gender based domestic violence have been centred on men as the perpetrators of domestic violence, however, men can be victims of domestic violence. Some of these male victims may present to the urologists office. The great reluctance of many men and boys to report domestic violence makes it very difficult to accurately assess its global prevalence. 'Shared living arrangements', 'reduced earnings' and 'early- and adult-onset affective disorders' are the risk factors more commonly associated with male perpetration, whereas risk factors for female perpetration include 'low educational attainment' and 'early-onset alcohol abuse/dependence' (3).

Intimate partner violence is quite common throughout the world. A review of over 50 population- based studies in 35 countries before 1999 indicated that between 10% and 52% of women from around the world reported that they had been physically abused by an intimate partner at some point in their lives, and between 10% and 30% had experienced sexual violence by an intimate partner (4).

A population based study by C. Garcia-Moreno et al in 2006, studying 15 different countries, reported a lifetime prevalence of physical or sexual partner violence, or both, varying from 15% to 71% (4). Between 4% and 54% of respondents reported physical or sexual partner violence, or both, in the past year (4).

In sub-Saharan Africa, the reported prevalence of intimate partner violence ranges from 20% to 71%. However, the prevalence of intimate partner violence is believed to be under-estimated because of under-reporting and lack of standardization of methods (5).

South Africa has one of the highest rates of IPV in the world. A national study found a 19% lifetime prevalence of victimisation among female respondents and a study on physical violence among South African men found that 27.5% reported perpetration of violence in their current or most recent partnership (3). The South African Police estimate that one woman is raped every 36 seconds and over half of female homicide victims are killed by their intimate partners (3). A national study in South Africa on female homicide indicated that a woman is killed by her intimate partner every six hours (6). The risk of IPV is highest in societies where violence is a socially sanctioned norm. In South Africa, a 'culture of violence' is a pervasive feature of post-apartheid legacy, which forms a backdrop for violence against women (6). The almost exclusive media focus on "political violence" in SA before 1994 and on "crime related violence" since, deflected attention away from the high levels of interpersonal violence (7).

The effects of intimate partner violence influence the victim's health. The health consequences can be divided into physical, sexual and mental effects. Findings show that a greater percentage of women who were the victims of battery in the preceding year (12-17%) presented to casualty departments than women with severe abuse trauma/injuries (2-3%) (8).

The trauma, anguish and anxiety associated with IPV can lead to persistent/recurrent health issues such as pain (e.g. headaches/back pain) or chronic central nervous system symptoms including syncope and fits. For example abused women frequently (10–44%) report choking—'incomplete strangulation'—and blows to the head resulting in loss of consciousness. Both of these can result in acute medical conditions including neurological sequelae (8). Battered women are diagnosed with functional gastrointestinal disorders (e.g., chronic irritable bowel syndrome) linked to recurrent anxiety more than women who have not suffered abuse, and have significantly above average self-reported gastrointestinal symptoms (e.g., eating disorders and reduced appetite) (8). The consequent functional damage to the bowel can last far longer than the violent relationship. Correlations also exist between self-reported cardiac symptoms such as hypertension and chest discomfort and intimate partner violence (8).

Gynaecological conditions are the most constant, enduring and substantial physical health differentiator between women who have been battered and those who haven't. Common illnesses include sexually-transmitted infections, urinary tract infections, vaginal infection or bleeding, fibroids, lowered libido, genital discomfort, tenderness during intercourse and recurring pelvic pain (8).

Sexual abuse that characterises the experience of at least 40–45% of abused women places these women in even greater jeopardy of health problems than women who have been physically assaulted only (8).

Possible processes of elevated risk include the humiliation and anxiety reported with forced intercourse exhibiting as increased levels of stress and depression known to lower the immune system; vaginal, anal and urethral injury from forcible intercourse (direct pressure or absence of lubrication) leading to increased transmission of microorganisms through direct transmission into the circulatory system or back flow of urethral bacteria; and men forcing sex on partners as well as having unprotected sex with other partners thus increasing the infection risk to their intimate partner (8).

Women who try to safeguard themselves against HIV - for example, by insisting on condoms or rejecting condomless sex - experience increased rates of intimate partner violence (5). These issues might partly explain links between intimate partner violence and sexually transmitted infections, HIV, and unplanned pregnancy (9). IPV may be the result of relationship stress created over a partner's HIV status. Furthermore, the noteworthy correlation between having numerous sexual partners and experiencing IPV implies that a partner's conception of a woman's sexual relations outside the confines of the relationship may spark IPV, or, inversely, that a woman's exposure to IPV may cause her to partake in additional relationships (10).

Intimate partner violence is associated with individual psychopathology, with rates of 54–68% for major depressive disorders and 50–75% for post-traumatic stress disorder in female

victims (8). Regardless of the aetiology, when IPV is treated, there is a reduction in depressive symptoms. Alcohol abuse is associated with IPV: with rates of 45% for men and 20% for women (8). Women exposed to post-traumatic stress disorder may turn to narcotics or liquor to soothe or manage the particular groups of symptoms concomitant with post-traumatic stress disorder: intrusive thoughts, avoidance, and hyperarousal (11).

Abused women tend to use medical services more frequently than non-abused women and use of healthcare services increases with the gravity of the physical attack (8). Women exposed to IPV more frequently skip work, come late or leave early and report sickness more than other women, due to living with an abusive partner (12). Alsaker et al (2009) found that bodily and psychological problems may make life as an employee quite difficult. This may explain the higher rates of unemployment as well as less improvement and lower scores in physical health and pain domains among the unemployed found in their study (12).

Victims of IPV often present to hospital before visiting a police station or the justice system. It is therefore imperative for healthcare personnel to know how to recognise and manage a victim of IPV.

Studies in the USA have assessed the adequacy of health science and humanity curricula. Connor et al (2012) have used a modified version of the PREMIS (Readiness to Manage Intimate Partner Violence Survey) tool for their assessment of learners which measures the knowledge, attitudes, beliefs, and self-reported behaviours amongst students by way of a four part (Background, Intimate Partner Violence Knowledge, Opinions, and Practice Issues), 67-item survey that requires approximately fifteen minutes to complete (13). Any IPV education that students receive could be effective in increasing confidence and perceived preparedness to address IPV with patients (14).

University students are considered an elite sector of society and one could assume that attending a tertiary institution would consequently render them less likely to be perpetrators or victims of IPV (15). Some of these students are studying toward degrees which would see them dealing with the victims of IPV. There is a paucity of data relating to South African university students to understand how many are victims of IPV, particularly in the fields of medicine and social work where they may, in future, be treating patients with IPV related conditions.

The study aims to ascertain the prevalence of intimate partner violence within a South African tertiary institution population which has a diverse demographic profile. It also aims to assess whether personal experience of IPV in final year students changes perceived or actual IPV knowledge.

The outcomes of the study may be used to improve the current curricula of professional degrees which may better equip future healthcare providers with the information and tools needed to provide an IPV victim with excellent quality of care. It may also help universities to develop appropriate support structures for health care providers who themselves have been victims of intimate partner violence.

5.2 Objectives

1) To ascertain the personal exposure of university students to intimate partner violence

2) To determine the readiness of graduating students to deal with intimate partner violence

3) To compare the personal violence and readiness of students to deal with patients who have been victims of violence while noting any gender differences or differences between students studying social work and those studying medicine.

5.3 Study Group

1) First – fourth year social work students

First – sixth year medical school students

2) Final year medical and social work students

Estimated sample size: approximately 1500 students

5.4 Study setting

WITs University Medical School and Main Campus (Social Work Department)

5.5 Method

1) After permission is obtained from the lecturer, concerned students will be shown a brief presentation detailing the study. The presentation will include the information about the study as well as the consent process and how to answer the questions on the answer sheet provided. Students can decide whether they wish to participate or opt out. Consent to participate in the study will be assumed if they answer the questionnaire.

2) Students will be made aware of psychological counselling services that are available to them, should they experience discomfort from the survey process:

A dedicated, confidential counselling service is available to medical students through Mrs Kuschke at the Faculty of Health Sciences.

Social work students have access to the counsellors Maria Wanyane and Twinette Bradley at the CCDU at WITs Main Campus.

Other useful counselling resources including POWA and Lifeline is provided.

3) Two anonymous questionnaires will be handed out to learners at the end of one of their exam sessions. Both will be in a multiple choice format.

i) The first questionnaire (all students) – to assess prevalence is a combination of 2 CDC recommended screening tools: the Computer based IPV Questionnaire and the Women Abuse Screening tool (2). Three questions are about relationships and were derived from the Women Abuse Screening Tool. The rest of the questions are from the computer-based IPV questionnaire. Two questions involving handguns from the original IPV questionnaire were not included in this questionnaire as it had no relevance to a student population. Two original questions were added in: 1) If you were sexually abused were you able to negotiate safe sex?

Rationale: With high rates of sexually transmitted infections and HIV are students able to protect themselves? Does a tertiary education confer some kind of protection or reduction in risk taking behaviours?

2) If you were to be a victim of intimate partner violence do you know where to get help?

Rationale: Are students aware of university service available to help them if they become victims of IPV?

ii) The second questionnaire (final year medical and social work students)

PREMIS tool (physician readiness to manage intimate partner violence) – modified to our context.

The questionnaires will be anonymous as no names or student numbers will be reflected anywhere on the questionnaire response sheet. A standard MCQ sheet will be used and all students provided with a pencil. Completed questionnaires will be placed in a sealed envelope by the student which they will then place in a sealed box placed in the front of the exam venue. The students will be told that they can omit any questions they do not want to answer for any reason.

5.6 Ethics/Permissions

Approval for the study will be obtained from the Human Research Ethics Committee (HREC). Permission has been obtained from the Dean of Students of the Health Science Faculty as well as from the Head of the Department of Social work.

5.7 Data collection and analysis

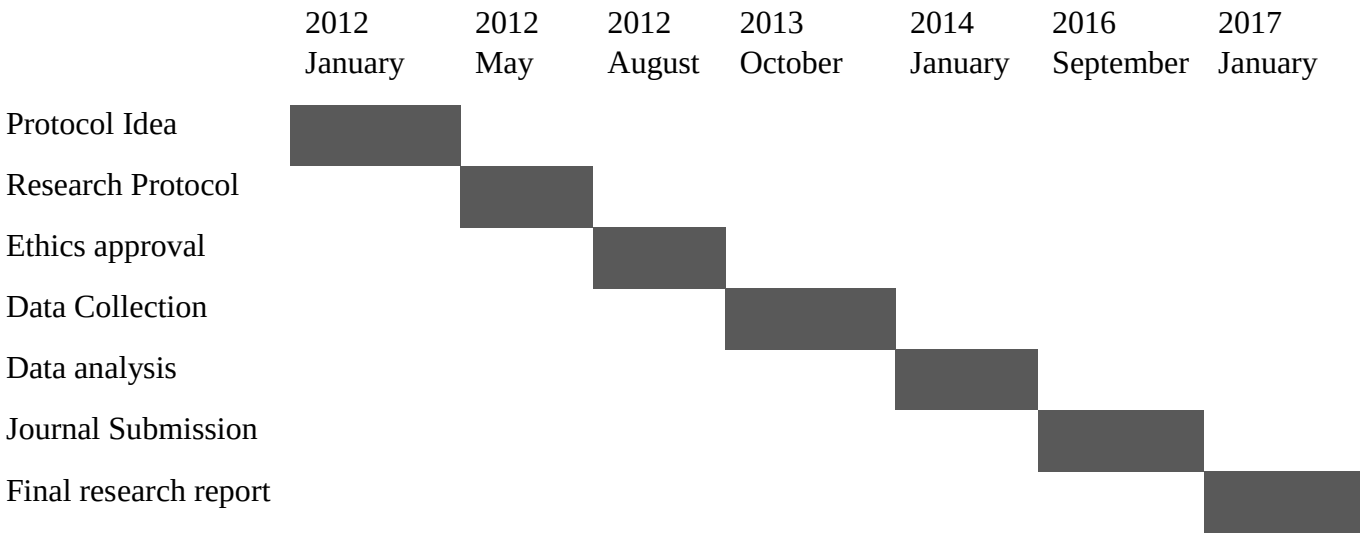
Data will be recorded on an EXCEL spreadsheet. Descriptive statistics including mean (SD) for numerical data and percentages for categorical data. Any differences e.g. between genders would be compared using a Chi-squared test or unpaired t-test as appropriate.

5.8 Variables (see questionnaires in appendix attached):

- Demographics (Age range, Total number of males versus females, Ethnicity profile, HIV status)
- Extent of intimate partner violence
- If participants are victims – what access do they have to getting help
- Specific focus on gender based violence
- Health care providers knowledge and ability to deal with victims of IPV

  (including exposure to completion of the sexual assault kit)

5.9 Timeline



5.10 Study costs

For stationary and photocopies (to be covered by the Department of Urology)

5.11 References

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Appendix 1

Powerpoint presentation for students (Information/Consent):

Intimate Partner Violence at a Tertiary Institution

Definitions (1)

- Interpersonal violence: violence between individuals, subdivided into family and intimate partner violence and community violence

(1) Schoeman MI, Roos I.(2009) Contemporary Criminological issues: Chapter 2 - Interpersonal Violence. Pretoria. UNISA

Definitions (2)

- Intimate partner violence (IPV): actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner. An intimate partner can be a current or former spouse or non-marital partner, such as a boyfriend, girlfriend, or dating partner. Intimate partners can be of the same or opposite sex.

(2) Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention

South Africa

- One of the highest rates of IPV in the world.
- 19% lifetime prevalence of victimisation among female respondents
- Physical violence among South African men found that 27,5% reported perpetration in their current or most recent partnership.
- One women is raped every 36 seconds.
- Over half of female homicide victims are killed by their intimate partners.
- A national study on female homicide indicated that a woman is killed by her intimate partner every six hours.

(3) Gass JD, Stein DJ, Williams DR, Seedat S. Intimate partner violence, health behaviours and chronic physical illness among South African Women. SAMJ. 2010; 100(9): 582-585
(4)Ursula Lau: Intimate partner fact sheet. June 2009. UNISA http://www.mrc.ac.za/crime/intimatepartner.pdf. Accessed on 04/06/2012.

Study Aims

- 1) To ascertain the student's personal exposure to intimate partner violence
- 2) To determine the readiness of graduating students to deal with intimate partner violence

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Study Group

- Wits University:

1) First – fourth year social work students

   First – sixth year medical school students

2) Final year medical and social work students

Consent

- By listening to this presentation and understanding what the study entails
- Option to opt out
- Option to leave out any questions that make you feel uncomfortable

---

Your role as study participant

- MCQ Questionnaire
- Medical students: 1-5 year

& Social worker students: 1-3 year

- 25 questions (<5 mins)
- Final year medical and social work students
- Additional 80 questions (25 min in total)

Instructions

1) Fill out MCQ card with pencil provided
2) At no point enter your name or student number (confidentiality)
3) Don't write on the card/envelope (confidentiality)
4) Circle correct answers only
5) Leave out questions uncomfortable with
6) Once complete place completed questionnaire in envelope provided
7) Drop envelope in box provided

Counselling Services

(Handout with phone numbers to each student)

1) Wits Medical school

Office of student support: (011) 7172703

2) CCDU [WITs Main campus]: (011)7179140

Twinette Bradley/Maria Wanyane

(011)7179137

3) POWA: (011)6424345/6

4) Lifeline JHB: (011)7281347

Counsellors at Wits aware of the days this survey taking place and will be available

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Appendix 2

Questionnaire 1 on Intimate Partner Violence (IPV) (all students)

Please indicate the correct answer by shading in the appropriate answer on the MCQ answer sheet provided.

Demographics:

1) What degree are you currently studying towards?

(a) Medicine

(b) Social Work

2) What is your current Year of study?

(a) 1

(b) 2

(c) 3 (in medicine GEMP1)

(d) 4 (in medicine GEMP2)

(e) 5 (in medicine GEMP3)

(f) 6 (in medicine GEMP4)

3) Age group:

(a) 17- 19

(b) 20-24

(c) 25-29

(d) 30 – 34

(e) 34- 39

(f) 40- 44

(g) 45-50

(h)>50

4) Gender:

(a) Male

(b) Female

5) Sexual orientation:

(a) Lesbian

(b) Gay

(c) Bisexual

(d) Transgender

(e) Still deciding

(f) Straight

6) Relationship status:

(a) Single

(b) Relationship

(c) Engaged

(d) Married

(e) Divorced

(f) Widowed

7) Have you ever been sexually active?:

(a) Yes

(b) No

8) If you are sexually active do you have protected sex?:

(a) Always

(b) Sometimes

(c) Never

(d) Not applicable

9) With which Race group do you identify yourself?:

(a) White

(b) Black

(c) Coloured

(d) Indian

(e) Chinese

(f)Other

10) HIV status:

(a) Positive

(b) Negative

(c) Not yet tested

(d) Confidential

Is this where the questions from the validated questionnaire start? You must identify them as such.

Questions 11-13 are derived from the WAST Screening Tool

Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandscreening.pdf (accessed 16 May 2012)

11) In general how would you describe your current relationship:

(a) A lot of tension

(b) Some tension

(c) No tension

(d) Not applicable

12) Do you and your current partner work out arguments with

(a) Great difficulty

(b) Some difficulty

(c) No difficulty

(d) Not applicable

13) Do arguments ever result in you feeling bad about yourself

(a) Often

(b) Sometimes

(c) Never

(e) Not applicable

Questions 14 – 23 were derived from the computer based IPV Questionnaire

Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandscreening.pdf (accessed 16 May 2012)

Questions 14-18 are related to emotional abuse

14) Have you ever had a partner or spouse who gets very jealous or tries to control your life?

(a) Yes

(b) No

15) Have you ever had partner or spouse try to keep you away from family or friends?

(a) Often

(b) Sometimes

(c) Never

16) Does someone close to you sometimes say insulting things or threaten you?

(a) Yes

(b) No

17) Is there someone you are afraid to disagree with because they might hurt you or other family members?

(a) Yes

(b) No

18) Has someone close to you abused you emotionally?

(a) Yes

(b) No

19) Has someone close to you pushed, kicked, or otherwise physically hurt you?

(a) Yes

(b) No

20) Have you ever physically hurt someone close to you?

(a) Yes

(b) No

21) Are you worried that you might hurt someone physically close to you?

(a) Yes

(b) No

22) In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide because you are a victim of any form of IPV?

(a) Often

(b) Sometimes

(c) Never

23) Have you ever been made to have sex (oral, anal, vaginal) when you didn't want to?

(a) Yes

(b) No

24) If the answer to 23) was “yes”, were you able to negotiate safe sex?

(a) Yes

(b) No

(c) Not applicable

25) If you were to be a victim of intimate partner violence do you know where to get help?

(a) Yes

(b) No

Appendix 3

Modified PREMIS Questionnaire 2 (for final year students only)

BACKGROUND

26) How much training about intimate partner violence (IPV) issues have you had in medical school?

a) None

b) Watched a video

c) Attended a lecture/talk

d) Attended a skills-based training or workshop

e) Plenary session (SCORPIO)

27) Estimated total number of hours of IPV training in medical school:

a) None

b) 1-4 hours

c) 5-10 hours

d) More than 10 hours

For questions 28-38:

Please select from (a) to (e)

(a) Not prepared

(b) Slightly prepared

(c) Moderately prepared

(d) Fairly well prepared

(e) Quite well prepared

Which from (a) to (e) best describes how prepared you feel to perform the following:

28) Ask appropriate questions about IPV

29) Appropriately respond to disclosures of abuse

30) Identify IPV indicators based on patient history and physical examination

31) Asses an IPV victims readiness to change

32) Help an IPV victim asses his/her danger of lethality

33) Conduct a safety assessment for the victim's children

34) Help an IPV victim create a safety plan

35) Document an IPV history and physical examination findings in a patients chart

36) Make appropriate referrals for IPV

37) Complete the sexual assault kit

38) Complete the J88 form

For questions 42-54:

Select from (a) – (e)

(a) Nothing

(b) Very little

(c) A moderate amount

(d) Quite a bit

(e) Very much

How much do you feel you know about:

Your legal reporting requirements for (Questions 39-41):

- 39) IPV
- 40) Child abuse
- 41) elder abuse

42) Signs or symptoms of IPV

43) How to document IPV in a patients chart

44) Referral sources for IPV victims

45) Perpetrators of IPV

46) Relationship between IPV and pregnancy

47) Recognising the childhood effects of witnessing IPV

48) What questions to ask to identify IPV?

49) Why a victim might not disclose IPV

50) Your role in detecting IPV

51) What to say and not to say in IPV situations with a patient

52) Determining danger for a patient experiencing IPV

53) Developing a safety plan with an IPV victim

54) The stages an IPV victim experiences in understanding and changing her/his situation

IPV KNOWLEDGE

55) What is the strongest single risk factor for becoming a victim of intimate partner violence?

(a) Age (<30 yrs)

(b) Partner abuses alcohol/drugs

(c) Gender-female

(d) Family history of abuse

(e) Don't know

56) Which of the following is generally true about batterers?

(a) They have trouble controlling their anger

(b) They use violence as a means of controlling their partners

(c) They are violent because they drink or use drugs

(d) They pick fights with anyone

57) Which of the following are the signs that a patient may have been abused by his/her partner?

(Bubble all that apply)

(a) Chronic unexplained pain

(b) Anxiety

(c) Substance abuse

(d) Frequent injuries

(e) Depression

58) Which of the following are reasons an IPV victim may not be able to leave a violent relationship?

(Bubble all that apply)

(a) Fear of retribution

(b) Financial dependence on the perpetrator

(c) Religious beliefs

(d) Children's needs

(e) Love for one's partner

(f) Isolation

59) Which of the following are the most appropriate ways to ask a patient about IPV?

(Bubble all that apply)

(a) " Are you a victim of intimate partner violence?"

(b) "Has your partner ever hurt or threatened you?"

(c) "Have you ever been afraid of your partner?"

(d) "Has your partner ever hit or hurt you?

60) Which of the following is/are generally true? (bubble all that apply)

(a) There are common, non-injury presentations of abuse patients

(b) There are behavioural patterns in couples that may indicate IPV

(c) Specific areas of the body are most targeted in IPV cases

(d) There is common injury patterns associated with IPV

(e) Injuries in different stages of recovery may indicate abuse

Please match the following descriptions of the behaviours and feelings of patients with a history of IPV with the appropriate stage of change:

(a) Precontemplation

(b) Contemplation

(c) Preparation

(d)Action

(e) Maintenance

(f) Termination

61) Begins making plans for leaving the abusive partner

62) Denies there's a problem

63) Begins thinking the abuse is not their own fault

64) Continues changing behaviours

65) Obtains order(s) for protection

For questions 66-75:

(a) True

(b) False

(c) Don't know

For the following questions select (a), (b) or (c) as above:

66) Alcohol consumption is the greatest single predictor of the likelihood of IPV

67) There are good reasons for not leaving an abusive relationship

68) Reasons for concern about IPV should not be included in a patients chart if s/he does not disclose the violence.

69) When asking patients about IPV, health care providers should use the words "abused" or "battered"

70) Being supportive of a patients choice to remain in a violent relationship would condone the abuse

71) Healthcare providers should not pressure patients to acknowledge that they are living in an abusive relationship

72) Victims of IPV are at greater risk of injury when they leave the relationship

73) Strangulation injuries are rare in cases of IPV

74) Allowing partners or friends to be present during a patient's history and physical exam ensures safety for an IPV victim

75) Even if a child is not in immediate danger, health care providers in all provinces are mandated to report an instance of a child witnessing IPV to Child protection Services

OPINIONS

For questions 76 - 105

(a)Strongly disagree

(b)Disagree

(c)Impartial

(d)Agree

(e)Strongly agree

For each of the following opinions select from the above options (a)-(e):

76) If an IPV victim does not acknowledge the abuse, there is very little that I can do to help

77) I would ask all new patients about abuse in their relationships

78) I can make appropriate referrals to services within the community for IPV victims

79) I am capable of identifying IPV without asking my patient about it

80) I do not have sufficient training to assist individuals in addressing situations of IPV

81) Patients who abuse alcohol or other drugs are likely to have a history of IPV

82) Victims of abuse have the right to make their own decisions about whether hospital staff should intervene.

83) I feel comfortable discussing IPV with my patients

I don't have the necessary skills to discuss abuse with an IPV victim who is (Questions 84-86)

- 84) Female
- 85) Male
- 86) from a different cultural/ethnic background

87) If victims of abuse remain in the relationship after repeated episodes of violence, they must accept responsibility for that violence.

88) I am able to gather the necessary information to identify IPV as the underlying cause of patient illnesses (e.g. depression, migraines)

89) If a patient refuses to discuss the abuse, staff can only treat the patient's injuries

90) Victims of abuse could leave the relationship if they wanted to

91) Victims of abuse often have valid reasons for remaining in the abusive relationship

92) Screening for IPV is likely to offend those who are screened

93) I am able to gather the necessary information to identify IPV as the underlying cause of patient injuries (e.g. bruises, fractures)

94) Women who choose to step out of traditional roles are a major cause of IPV

95) I can match therapeutic interventions to a patient's readiness to change

96) I understand why IPV victims do not always comply with staff recommendations

97) I can recognise victims of IPV by the way they behave

98) IPV can happen in same sex-relationships

99) I would be able treat a perpetrator objectively

100) I would involve law enforcement if a victim's perpetrator is accompanying the patient to hospital

101) It may be culturally acceptable for a man to beat his partner

102) A strong predictor of becoming a perpetrator of IPV is previous abuse or witness of abuse

103) Men who are violent towards their partners tend to adopt rigid stereotyped views on how women and men should behave

104) Male perpetrators of IPV have feelings of powerlessness at not being able to meet social expectations of manhood.

105) IPV contains an emotional component (feeling a "loss of control"), as well as an instrumental purpose ("having control" over another.)

References

1) Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta, Ga: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2007. https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf (accessed 16 May 2012).

Appendix 4 – SAMJ submission

SAMJ RESEARCH

Intimate partner violence at a tertiary institution

K Spencer,[1] MB BCh; **M Haffejee**,[1] MB BCh, FCS (Urol); **G Candy**,[2] MSc, PhD; **E Kaseke**,[3] BA, PhD

[1] *Department of Urology, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*
[2] *Department of Surgery, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*
[3] *Department of Social Work, Faculty of Humanities, University of the Witwatersrand, Johannesburg, South Africa*

Corresponding author: *K Spencer (doctorkspencer@gmail.com)*

Background. Intimate partner violence (IPV) is actual or threatened physical, sexual, psychological, emotional or stalking abuse by an intimate partner. Despite the high prevalence of IPV in South Africa (SA), there is a paucity of data on university students training in fields where they are likely to have to manage the after-effects of such events in their personal capacity in the future.
Objectives. To ascertain the prevalence of IPV in an SA tertiary institution population with a diverse demographic profile.
Methods. Students from the faculty of health sciences and the faculty of humanities, social work department, completed an anonymous questionnaire. Students were made aware of psychological counselling available to them.
Results. Responses were obtained from 1 354 of 1 593 students (85.0%) (67.8% female, 45.9% black, 32.7% white, 16.6% Indian, 4.8% coloured). Of the respondents, 53.0% indicated that they were in a relationship. The prevalence of any type of IPV (sexual, physical or emotional abuse) among all respondents was 42.6%. Emotional abuse was reported by 54.9% of respondents, physical abuse by 20.0% and sexual abuse by 8.9%. Thirty-five females (6.5% of respondents who had suffered IPV) indicated that they had been emotionally, physically and sexually abused. Fourteen percent identified themselves as perpetrators of abuse, but only three perpetrators of sexual abuse reported having also been victims of sexual abuse. Most respondents (58.7%) knew where to get help.
Conclusion. The extent of IPV among the medical and social work students sampled was found to be unacceptably high, both as victims and as perpetrators. As a result of their exposure to IPV, these individuals may have difficulty in managing patients who have been subjected to abuse.

S Afr Med J 2016;106(11):1129-1133. DOI:10.7196/SAMJ.2016.v106i11.12013

Victims of intimate partner violence (IPV) may experience numerous physical, sexual, psychological, behavioural and even fatal consequences (Table 1).[1] These include an increased number of visits to emergency departments, and an increased risk of gastrointestinal, cardiovascular, gynaecological and psychiatric disorders, including depression, substance abuse and post-traumatic stress disorder.[1] Women who refuse to have sex without a condom have an increased likelihood of becoming IPV victims, and if forced to do so face the additional risk of sexually transmitted infections, including HIV, and unplanned pregnancies.[1] The effects of IPV may not be immediately apparent, and may only manifest with targeted questioning or after an examination. It is precisely because of the complexity of these implications that it is important for the clinician to know how to screen for and manage these individuals.

The World Report on Violence and Health[1] defines IPV as 'actual or threatened physical, sexual, psychological, emotional, or stalking abuse by an intimate partner'. An intimate partner can be a current or former spouse or a non-marital partner, such as a boyfriend, girlfriend or dating partner, and can be someone of the same or the opposite sex. The South African (SA) Domestic Violence Act 116 of 1998[2] expands on this definition and speaks of a 'complainant' as any person who is or has been in a domestic relationship and has been or allegedly has been subjected to an act of domestic violence. The term domestic relationship is all-encompassing and includes customary marriages, various types of relationships and even flatmates. The definition of domestic violence is further expanded to include economic abuse, intimidation, harassment, stalking, damage to property, entry into the complainant's residence without consent, and controlling behaviour.[2]

Looking at the global prevalence rates, a review of more than 50 population-based studies from 35 nations found that 10 - 52% of females reported that they had been physically abused, and 10 - 30% had experienced sexual violence from an intimate partner at some point in their lives.[3] The reported IPV prevalence of 20 - 71% in sub-Saharan Africa has been thought to be an underestimate due to under-reporting and poor standardisation of methods.[3]

A national study from SA found a 19% lifetime prevalence of victimisation among female participants and a 27.5% prevalence of men perpetrating violence in their current or most recent relationship.[4] More than 50% of female homicide victims were killed by their intimate partners.[4] Furthermore, an SA study on female homicide indicated that every 6 hours a woman was killed by her intimate partner.[5]

University students are considered an elite sector of society, and it could be assumed that attending a tertiary institution would render individuals less likely to be perpetrators or victims of IPV.[6] Some of these students study towards careers in which they will need to deal with the victims of IPV. There is a paucity of data relating to SA students who are victims of IPV, particularly in the fields of medicine and social work. The objective of this study was to ascertain the prevalence of and gender differences in IPV in a group of students studying to be healthcare workers in an SA tertiary institution.

Methods

Approval to conduct the study was obtained from the University of the Witwatersrand Human Research Ethics Committee (ref. no. M120670).

Study participants

A sample of male and female students from the medical school and department of social work at a university in Gauteng Province, SA, were asked to complete a quantitative anonymous questionnaire. The sample consisted of all 1st- to 6th-year medical students and all 1st- to 4th-year social work students. These two faculties comprised

Table 1. Effects of intimate partner violence[1]

Physical
Abdominal/thoracic injuries
Bruises and welts
Chronic pain syndromes
Disability
Fibromyalgia
Fractures
Gastrointestinal disorders
Irritable bowel syndrome
Lacerations and abrasions
Ocular damage
Reduced physical functioning
Sexual and reproductive
Gynaecological disorders
Infertility
Pelvic inflammatory disease
Pregnancy complications/miscarriage
Sexual dysfunction
Sexually transmitted infections (HIV)
Unsafe abortion
Unwanted pregnancy
Psychological and behavioural
Alcohol and drug abuse
Depression and anxiety
Eating and sleep disorders
Feelings of shame and guilt
Phobias and panic disorder
Physical inactivity
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders
Smoking
Suicidal behaviour and self-harm
Unsafe sexual behaviour
Fatal health consequences
AIDS-related mortality
Maternal mortality
Homicide or suicide

1 593 students, and the decision was made to use the entire group as a sample. Connor *et al.*[7] found that students who received education about IPV while at medical school reported having greater confidence and perceived preparedness to deal with IPV victims. We therefore selected this population because they would be exposed to IPV and would be likely to screen for it.

Data collection process

The consent process consisted of a brief presentation by the first author (KS) detailing the study prior to handing out the questionnaire. The information sheets, consent forms and questionnaires were handed out after lectures or exam sessions. Participation in the study was voluntary, and students were told they could leave questions unanswered if necessary. An electronic marking sheet was used, and the questionnaires were anonymous with no name or student number reflected anywhere on the response sheet. Completed questionnaires were then placed into a sealed box. After the survey, each student was given a form with the contact details of a dedicated psychological counselling service available to them if they experienced discomfort as a result of the survey process.

Data collection tool

Two recommended screening tools from the US Centers for Disease Control and Prevention (CDC) were combined to create 25 multiple-choice questions, which were adapted to the SA context. These tools were the computer-based IPV Questionnaire and the Women Abuse Screening Tool (WAST). The WAST had a Cronbach's alpha of 0.75 estimated for the reliability of the tool and a correlation with the construct validity of the Abuse Risk Inventory of 0.69.[8]

The data collection tool comprised four domains, of which this article covers only two – demographics and the prevalence of the different types of abuse.

The first six questions requested demographic information from the participants, including the degree for which they were enrolled (medicine or social work), year of study, age group, gender, racial group and relationship status.

Questions 14, 15 and 16 were about relationships and were derived from the Women Abuse Screening Tool (Table 2).[8] Questions 11 - 13 and 17 - 22 were derived from the questions on the computer-based IPV questionnaire listed in Table 3.[8] Two questions involving handguns from the original IPV questionnaire were not included in this questionnaire. Questions 24 and 25 were original questions (Table 4).

Statistical analysis

The results of each sheet were tallied electronically per question. Data were recorded on an Excel 2013 spreadsheet (Microsoft, USA), and Statistica version 12 (Statsoft, USA) was used for all statistical procedures. Descriptive statistics were reported as totals and percentages for categorical data. Comparative statistics were done using a χ^2 test or Fisher's exact test as appropriate, with a p-value of <0.05 being considered statistically significant.

For the purposes of definition, participants were deemed to have been victims of physical abuse if they answered in the affirmative to the questions referring to being pushed, kicked, or otherwise physically hurt, victims of sexual abuse if they had been made to have sex (oral, anal, vaginal) when they did not want to, and victims of emotional abuse if they answered in the affirmative to the question directly asking the respondent whether he/she had been emotionally abused. The definition of emotional abuse was further expanded to include whether a partner gets very jealous or tries to control the respondent's life, tries to keep them away from family or friends, says insulting things or threatens them, is disagreeable, or may try to hurt them or other family members.

Results

Responses were obtained from 1 354 of the 1 593 students (85.0%). The responses collected were similar for each year of study. Most respondents were aged 20 - 24 years (61.9%) and were female (67.8%); 45.9% were black, 32.7% white, 16.6% Indian and 4.8% coloured (Table 5).

Fifty-three percent of the respondents were in a relationship, engaged or married. Of the 718 respondents who reported that they were in a relationship, 123 (17.1%) indicated that they had a jealous partner. Of the remaining 636 respondents who indicated they were not currently in a relationship, a very similar proportion (n=127; 19.9%) indicated that they had had a jealous partner in the past. The following responses pertain to respondents in a relationship (n=718): 40 (5.6%) often and 250 (34.8%) sometimes felt that their

Table 2. Components of the WAST[8]

Question	Response			
In general, how would you describe your current relationship?	A lot of tension	Some tension	No tension	Not applicable
How do you and your current partner work out arguments?	Great difficulty	Some difficulty	No difficulty	Not applicable
Do arguments ever result in you feeling bad about yourself?	Often	Sometimes	Never	Not applicable

Table 3. Components of the computer-based IPV Questionnaire[8]

Question	Response		
Have you ever had a partner or spouse who gets very jealous or tries to control your life?	Yes	No	
Does someone close to you sometimes say insulting things or threaten you?	Yes	No	
Is there someone you are afraid to disagree with because they might hurt you or other family members?	Yes	No	
Has someone close to you pushed, kicked, or otherwise physically hurt you?	Yes	No	
Has someone close to you abused you emotionally?	Yes	No	
Have you ever been made to have sex (oral, anal, vaginal) when you didn't want to?	Yes	No	
Have you ever physically hurt someone close to you?	Yes	No	
Are you worried that you might hurt someone physically close to you?	Yes	No	
Have you ever had a partner or spouse try to keep you away from family or friends?	Often	Sometimes	Never
In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide as a result of being an IPV victim?	Often	Sometimes	Never

Table 4. Additional original questions

Question	Response	
If you were sexually abused, were you able to negotiate safe sex?	Yes	No
If you were to be a victim of IPV, do you know where to get help?	Yes	No

partner tried to keep them away from family and friends, while 250 (34.8%) reported that their partner was sometimes insulting or threatening towards them and 123 (17.1%) were afraid to disagree with their partner because they might hurt them or other family members. Two hundred and three respondents (28.3%) felt that there was some tension in their current relationship, 310 (43.2%) experienced some difficulty when settling arguments with their partners, 555 (77.3%) sometimes felt lowered self-esteem after settling an argument, and 124 (17.3%) were afraid not to agree with their partner.

The prevalence of any type of IPV (sexual, physical or emotional abuse) among all the respondents was 42.6% (577/1 354). Emotional abuse was the most common type of abuse (35.0% of respondents). With the expanded definition of emotional abuse (as above) the prevalence increased to 54.9%. Physical abuse (20.0%) and sexual abuse (8.9%) were reported less often. Thirty-five females (6.5% of respondents who had suffered IPV) indicated that they had been emotionally, physically and sexually abused. Most of these females (28/35, 80.0%) indicated they were not currently in a relationship.

Table 5. Demographic information on the respondents

Demographic variables	%
Age (years)	
17 - 19	25.1
20 - 24	61.9
≥25	13.0
Gender	
Female	67.8
Male	32.2
Ethnic group	
Black	46.0
White	32.7
Indian	16.6
Coloured	4.8
Study year	
1	23.8
2	17.1
3	20.2
4	16.1
5	13.3
6	9.5
Relationship status	
Single	47.0
Relationship/engaged/married	53.0

With sexual abuse, although no trend according to age was apparent among male students, the percentage of females reporting sexual abuse increased by 6.1% between the 17 - 19-year-old (9.8%) and >24-year-old (15.9%) age groups. Older females (>24 years) appeared more vulnerable to emotional (43.4%) and sexual abuse (15.9%) (Fig. 1).

Responses of females relating to questions pertaining to whether the partner was isolating or insulting, to whether there was tension in the relationship, and to settling of arguments and disagreeing with a partner did not appear to indicate a major problem, with less than half of the respondents reporting that these were issues. However, overall 59.5% of female respondents in a relationship aged <25 years indicated they had a jealous partner. Furthermore, overall 68.0% had arguments resulting in the individual 'feeling bad' often (14.4%) or sometimes (55.2%). This response was also more common in the two younger age groups. Of all the victims of sexual abuse, 45.0% were at least able to negotiate protected sex. Overall, 58.7% of the respondents knew where they could get help and counselling as victims of abuse.

The perpetrators (14.0% of total respondents) of IPV tended to be males in the white and Asian ethnic groups, females among coloured respondents, and without an apparent gender difference (p=0.55) among black respondents. There were no age-related differences (males p=0.87 and females p=0.69) among the perpetrators, although younger males were more often perpetrators in the 17 - 19-year age group. Only three perpetrators of sexual abuse indicated that they themselves had been sexually abused.

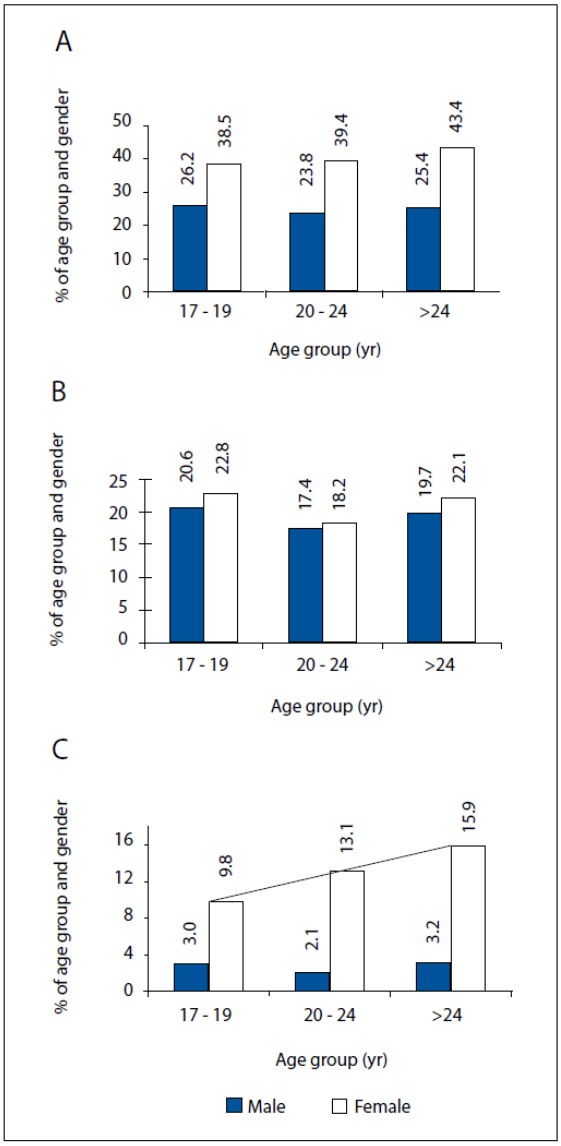

Fig. 1. Types of abuse by age group and gender. (A) Emotional; (B) Physical; (C) Sexual.

Discussion

Future healthcare workers tend to provide superior management to victims of IPV when they seek assistance for themselves first. Christofides and Silo[9] found that practitioners who reported their own, a friend's or a family member's experience with IPV had an increased 'quality of care score'. This could be the result of their ability to identify and empathise with victims. Kim and Motsei[6] stated that healthcare workers who were victims of IPV tended to have the same cultural values as the victims they treated and counselled, underlining the 'gender-bound constructs' within which they operated, which extended from their personal to their professional capacities. Sugg and Inui,[10] however, reported that doctors were 'emotionally inactivated' and therefore not able to manage patients with similar experiences, and might experience personal distress.

This study determined the prevalence of IPV in an SA tertiary institution population, representative of the ethnic makeup of the national population. The study is unusual as it obtained responses from medical and social work students in all years of study and from respondents of both genders. These students, whose future professions include counselling of victims of abuse, would be expected to be aware of this problem.

The total prevalence of IPV at the institution in question was 42.6%, comparable to a study from China that found a prevalence of 37.1%.[11] The university with the highest reported prevalence of IPV victims was in Nigeria, with a figure of 58.8% for female students.[12] Studies at other universities found varying prevalences (in descending order) from 28.7% (Tennessee), 22% (Wisconsin) and 10% (Vanderbilt) in the USA, to 7% (Ontario, Canada).[13-16] A study at numerous institutions in the UK found an overall prevalence of 14.2%.[17]

In line with previous studies, the present study found a higher prevalence of female (particularly in the older age groups) than male IPV victims. A report from the Office of Justice in the USA[18] stated that female students in full-time education were at a higher risk of sexual violence than the general female population. Several risk factors were noted: 'living on campus, being unmarried, getting drunk frequently, and experiencing prior sexual victimization'.[19]

In an SA study by Gass *et al.*[4] it was found that the single most common risk factor for IPV victims of both genders was witnessing parental violence. Specific risk factors pertaining to male victims included 'low income and lack of closeness to a primary female caregiver', whereas risk factors for female victims included 'low educational attainment, childhood physical abuse, and adult-onset alcohol abuse/dependence and intermittent explosive disorder'.[4] IPV has been strongly linked to intergenerational cycling of violence and risk exposure across the life course.[4]

An interesting observation in our study was the low use of condoms. Peltzer[19] had similar findings, and reported that 29.2% of SA students never, 35.4% always, 19.8% regularly and 8.5% irregularly

used condoms over a 3-month period. This is concerning given the high national HIV incidence and that this was a well-educated group of individuals who should be aware of the risks of unprotected sexual intercourse.

An interesting and unexpected finding was the high rate of female perpetrators, particularly among black and coloured students. The National Intimate Partner and Sexual Violence Survey by the CDC expanded the definition of IPV to include rape while under the influence of illicit drugs, undesirable touching, expressive aggression, conceiving by coercion, refusing to use a condom, and stalking.[20] With the new definition they found an equal rate of perpetration between the genders. Female aggressors are also at increased risk of becoming a victim later on.[21] Gass *et al.*[4] reported that risk factors in male perpetrators were likely to include cohabitation, low income and early- and adult-onset mood disorders, whereas risk factors in female perpetrators included low educational attainment and early-onset alcohol abuse/dependence.

Medical schools need to have appropriate support mechanisms in place for victims and potential victims of IPV, and students should be given a list of local resources. According to Ambuel *et al.*,[14] students need to be allowed to process their feelings and experiences within their academic spaces. There should be a safe environment that fosters open, respectful sharing of experiences and ideas, appropriate supervision, and encouragement of responsible self-care including access to psychotherapy and support groups. To this end, our institution has dedicated psychology and counselling services available. Broader institutional and policy changes should also be implemented in academic programmes to enable early detection and management.[14]

Study limitations

Concepts such as physical, sexual or emotional abuse could have been better defined, as the questions assumed that students had prior knowledge or understood the scope of abuse as defined by current legislation. This may have affected their ability to answer the questions. Certain components of emotional abuse as defined by the SA Domestic Violence Act were not specifically included, such as economic abuse, intimidation, harassment, stalking, damage to property, and entry into the complainant's residence without consent. The participants may also have had different perceptions of what defines sexual abuse, and the fact that a person did not agree with the statement does not mean it did not happen. If the data collection tools had covered these various other forms of IPV, labelled domestic violence under the Domestic Violence Act, the prevalence rate might have differed.

Conclusion

The extent of emotional, physical and sexual abuse among university medical and social science students sampled was unacceptably high, both as victims and as perpetrators. As a consequence of their own experiences of abuse, these individuals may have difficulty in managing patients who have been subjected to abuse. To determine possible regional differences in this unacceptable practice, it is recommended that similar surveys be undertaken at other centres of higher learning.

Acknowledgements. The authors acknowledge Amitha Betchan and Magali de la Kethulle de Ryhove for their administrative assistance, and Deidre Pretorius for her advice.

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Accepted 19 September 2016.