Intimate partner violence among undergraduate student nurses at a tertiary institution in the Western Cape

By

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Declaration

I declare that **Intimate partner violence among undergraduate student nurses at a tertiary institution in the Western Cape** is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

ASHLEY GURSHIN KORDOM November 2012

Signed: ……

Key words

Intimate partner violence

Undergraduate student nurse

Abuse

Survivor

Prevalence

Tertiary institution

Western Cape

Abstract

Intimate partner violence among undergraduate student nurses at a tertiary institution in the Western Cape

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M Cur mini-thesis. School of Nursing. University of the Western Cape

Intimate partner violence (IPV), a form of gender-based violence (GBV), has become one of the emerging serious public health issues. It affects all racial, ethnic, socioeconomic and religious groups. Internationally, IPV has also become an increasingly common phenomenon among students at tertiary institutions. In South Africa, there is a paucity of literature that investigates this phenomenon especially among undergraduate student nurses who are supposed to render care to survivors of IPV. The aim of this study was to determine the prevalence of IPV and factors associated with IPV among undergraduate student nurses at a tertiary institution in the Western Cape.

A quantitative, descriptive study was conducted. An adapted version of the WHO's instrument designed to measure partner violence was used to collect the data. This questionnaire was administered to the eligible respondents after lecture time. The total population consisted of 984 undergraduate student nurses. The printed class lists of the 1st-, 2nd-, 3rd- and 4th-year undergraduate student nurses were used as the sample frame. Stratified random sampling method was used to obtain a sample of 243 respondents to ensure that the sample size was representative of the population. The completed questionnaires were analysed quantitatively by using the Statistical Package for Social Sciences (SPSS) version 20. The results are presented in the form

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of tables, pie chart and graphs. Spearman's correlations were used to calculate the strength of the relationship between the dependent variables. Multivariate analysis was done using the Mann-Whitney U test and the Kruskal-Wallis test to determine the associations between the different variables.

The results from the study showed that 42% of undergraduate student nurses experienced IPV during their lifetime. The socio-demographic factors associated with IPV were age (p=0.009*), study year level (p=0.001*) and marital status (p=0.021*). The study also found that family history factors like the respondent's mother's educational status (p=0.005*), financial support during need (p=0.031*) and witnessing of abuse as a child (p=0.008*) were factors related to IPV. In this study, certain substance use factors such as dagga (p=0.004) and cigarette smoking (p=0.000*), alcohol use in their lifetime (p=0.000*), time elapsed since joining university (p=0.000*) and having male or female friends who drink (p=0.000*) were significantly associated with IPV. The study highlighted the need to raise awareness on IPV among undergraduate student nurses.

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List of abbreviations

IPV : intimate partner violence

GBV : gender-based violence

MRC : Medical Research Council

NDoH : National Department of Health

PTSD : Post-traumatic stress disorder

SA : South Africa

SADAG: South African Depression and Anxiety Group

SANC : South African Nursing Council

SoN : School of Nursing

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SPSS : Statistical Package for Social Sciences

STI's : Sexual transmitted infections

USA : United States of America

UWC : University of the Western Cape

WC : Western Cape

WHO : World Health Organisation

DEDICATION

I dedicate this work to all undergraduate student nurses who are survivors of intimate partner violence.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 Introduction

This chapter focuses on the orientation of the study. The background and rationale are discussed, followed by the problem statement, research aim and objectives. Thereafter, the relevant operational definitions are outlined and the chapter concludes with a summary and the layout of this mini-thesis.

1.2 Background

Gender-based violence (GBV) has become a serious public health issue (Ellsberg & Heise, 2005). Research studies initiated by the World Health Organisation (WHO) indicate that globally, between 40% and 70% of femicides were committed by an intimate male partner (Krug, Dahlberg, Zwi & Lozano, 2002:89). The WHO initiated 10 countries' case studies that investigated GBV, found that in most countries, the prevalence estimates ranged from 30% to 60%. The findings indicate that 15% to 71% of women experience some form of violence at some point in their lives (Garcia-Moreno, Jansen, Ellsberg, Heise & Watts, 2005:41).

Intimate partner violence (IPV), one form of GBV, has become one of the emerging serious public health issues because the survivors of IPV often sustain injuries due to the attacks from the perpetrators (Garcia-Moreno *et al*., 2005). The WHO defines IPV as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug *et al*., 2002:89). The perpetrators of IPV vary from boyfriends, to girlfriends,

cohabiting partners and husbands, wives, current and former spouses.

While factors such as poverty, unemployment, substance abuse among others have been identified as being responsible for the increase of IPV (Jewkes, 2002), studies indicate that IPV is also common among health care professionals (Kim & Motsei, 2002, Gerber & Tan, 2009). IPV affects all racial, ethnic, socioeconomic, and religious groups and has also become a common phenomenon among students at tertiary institutions. The findings from previous research studies confirmed that IPV is a serious problem and that it is a common occurrence among tertiary institution-age people (Gebreyohannes, 2007; Arnold, Getaye, Goshu, Berhane & Williams, 2008; Lysova & Douglas, 2008; Fass, Benson & Leggett, 2008). In the United States of America (USA), it is estimated that one in five students experience some form of violence or abuse during an intimate relationship (Wasserman, 2003:17). In Canada, a study was conducted among 522 students in the schools of medicine, nursing and rehabilitation to examine students' prior knowledge of and attitudes and personal exposure to IPV. The results from the study showed that 9% of medical students, 5.5% of nursing students and 11% of rehabilitation students were survivors of IPV (Gerber & Tan, 2009:3).

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According to the South African Police Services (SAPS, 2011), reports during 2010 and 2011 indicated that murder decreased by 5.3% and sexual offences by 3.1%. Despite this decrease in murder and sexual related crimes, overall statistics showed that these two criminal activities are most prevalent in South Africa (SA). The trend of these types of violence has been identified to increase against IPV (Seedat, van Niekerk, Jewkes, Suffla & Ratele, 2009). In SA, IPV accounted for 62% of the total incidence of interpersonal violence and ranked behind HIV/AIDS

as the leading cause of death among South Africans (Norman, Bradshaw, Schneider, Jewkes, Mathews, Abrahams, Matzopoulos & De Vos, 2007). According to a national study conducted by the Medical Research Council (MRC), a woman is killed every six hours by her intimate partner (Mathews, Abrahams, Martin, Vetten, van der Merwe & Jewkes, 2004:1). These disturbing statistics highlight the extent of IPV in SA.

1.3 Rationale for the study

IPV is a universal problem and has become a serious public health issue, which has so far been underreported and which is not adequately diagnosed by nurses and other health care professionals (Julie, Daniels & Adonis, 2005). Concurring with these authors, Gerber and Tan (2009) recommend that training on the management of IPV by health care professionals and health science students has become imperative.

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In SA, most of the studies conducted on IPV are either on measuring the prevalence of IPV among survivors attending health facilities, or large population-based studies that entail a few questions on IPV (Jewkes, Levin & Penn-Kekana, 2002; Joyner & Mash, 2011). However, there is a paucity of literature on the magnitude of the problem and factors associated with IPV among undergraduate student nurses at tertiary institutions, who are supposed to render care for the survivors of such violence (Gerber & Tan, 2009). Currently, no South African study could be located but only studies conducted abroad (Gebreyohannes, 2007; Arnold *et al.*, 2008; Lysova & Douglas, 2008). Consequently, there is a need to conduct this baseline study amongst undergraduate student nurses in the Western Cape, South Africa.

1.4 Problem statement

Public health personnel are often the first contact point – if not the only – for survivors of IPV. Hence, it is important for health care professionals to be able to identify and manage IPV survivors effectively. However, a study conducted with undergraduate students at the School of Nursing (SoN) at a tertiary institution in the Western Cape, found that IPV is underreported and not adequately diagnosed by nurses and other health care professionals (Julie *et al*., 2005). The student nurses' personal experiences of IPV impact negatively on their ability to render effective nursing care to survivors of IPV. In order to take remedial steps it is necessary to get an overview of the magnitude of the problem by measuring the prevalence of IPV and to determine the factors associated with IPV among the undergraduate student nurse population.

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1.5 Aim

The aim of the study was to determine the prevalence and factors associated with IPV among the undergraduate nursing student population at a tertiary institution in the Western Cape, South Africa.

1.6 Objectives

The objectives of the study were:

I. to determine the prevalence of IPV (psychological, physical, sexual and financial abuse) among undergraduate student nurses at a tertiary institution in the Western Cape; and

II. to identify the socio-demographic factors, family history and substance use factors associated with IPV among undergraduate student nurses at the research institution.

1.7 Operational definitions

The following definitions are referred to in this mini-thesis:

Violence

According to the WHO, violence is defined as –

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (Krug *et al*., 2002:5).

Intimate partner violence (IPV)

IPV is defined as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug *et al.,* 2002:89). In the current study, IPV was broadly addressed in relation to psychological, physical, sexual and financial abuse perpetrated by spouses or intimate partners. "Intimate partners" refer to any of the following: husbands and wives, boyfriends and girlfriends, dating partners, current and former spouses.

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Prevalence

For the purpose of this study, prevalence was defined as "the proportion of survivors who have experienced abuse in a given study population during their lifetime" (Ellsberg & Heise, 2005:85).

Abuse

In this study, abuse was defined as a single or repeated act of psychological, physical, financial or sexual violence perpetrated by a partner during an intimate relationship.

Psychological abuse

According to the Domestic Violence Act (116 of 1998:4), psychological abuse is also known as "emotional abuse". It involves trauma to the survivor caused by acts, threats of acts, or coercive tactics, through use of humiliation, controlling what the survivor can and cannot do, withholding information, deliberately doing something to make the survivor feel diminished or embarrassed or isolating the survivor from friends and family (Domestic Violence Act 116 of 1998:4).

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Physical abuse

Physical abuse refers to "any act or threatened act of physical violence towards a person" (Domestic Violence Act 116 of 1998:6). In this study, physical abuse included any sort of violent acts such as slapping, hitting, pushing, shoving, choking, burning, and threatening with a weapon that will result in physical harm.

Sexual abuse

Sexual abuse includes rape, unwanted sexual advances or sexual harassment, sexual abuse of children and of disabled people, forced marriage, denial of sexual and reproductive rights (including forced abortion), violent acts against the sexual integrity of men and women, including female genital mutilation and obligatory virginity testing, forced prostitution and trafficking of people for purposes of sexual exploitation (Krug *et al*., 2002:149-150).

Financial abuse

Financial abuse or "economic abuse" is one of the most common controlling behaviours in an intimate partner relationship. It refers to the unreasonable denial of financial resources to which the survivor is entitled under law or which the survivor requires out of necessity. This includes "household necessities for the survivor and mortgage bond repayments or payment of rent in respect of the shared residence" (Domestic Violence Act nr. 116 of, 1998:4).

Undergraduate student nurse

An "undergraduate student nurse" refers to a person who is studying towards a four year integrated diploma or degree programme, leading to registration as a nurse (general, psychiatry, community) and midwife according to the South African Nursing Council Regulation R425 of 22 February 1985, as amended.

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1.8 Outline of the chapters in the study

The thesis consists of the following chapters:

- **CHAPTER 1: INTRODUCTION**

This chapter is an introduction of the study. The background and rationale were discussed here, followed by the problem statement, research aim and objectives. Thereafter, the relevant operational definitions were defined and the chapter concludes with a summary and the study layout of this mini-thesis.

- **CHAPTER 2: LITERATURE REVIEW**

In this chapter, the reviewed literature is explored, which includes the global perspective of violence, the definition of IPV, factors that contribute to IPV and prevalence of IPV among students of tertiary institutions. The concluding part of this literature review focuses on the consequences of IPV relative to health, and the role of health care providers are summarised.

- **CHAPTER 3: RESEARCH METHODOLOGY**

This chapter outlines the research methodology of the study. The research methodology is discussed in terms of the research setting, research design, population, sampling, data collection, data analysis and ethical considerations. The research design utilised allowed the researcher to achieve the aim and objectives of the current study.

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- **CHAPTER 4: RESEARCH FINDINGS**

In this chapter, the research findings of the study are presented. The findings of the study are presented according to the items in the questionnaire.

- **CHAPTER 5: DISCUSSION**

In this chapter, the interpretation of data is presented, along with an in-depth discussion of each of the objectives of the study.

- **CHAPTER 6: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

In Chapter 6, a summary of the study is provided and conclusions are made based on the findings of the study. Limitations to the study are also outlined. In addition, recommendations based on the main findings of the study are made.

1.9 Conclusion

In Chapter one, an overview of the current research study was given. It consisted of the background, rationale for the study, problem statement, aim, objectives, operational definitions and outline of the chapters in the study.

In the next chapter, Chapter 2, an in-depth analysis of the relevant literature, as well as a review of recent research on IPV and research findings are presented.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter will highlight available literature on intimate partner violence (IPV). The reviews will focus on various aspects such as the global perspective of violence, the definition of IPV, factors that contribute to IPV and prevalence of IPV among students at tertiary institutions. The concluding part of this literature review will focus on the consequences of IPV relative to health, and the role of health care providers is summarised.

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2.2 Global perspective of violence

There is no universally agreed definition on IPV among the proponents and experts of gender issues (Jansen, 2007). As a result of the none-specific definition for IPV, it is important to look at violence from a broader perspective. The WHO defines violence as –

> the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation *(*Krug *et al*., 2002:5).

According to the WHO's Report on Violence and Health (Krug *et al*., 2002:6), violence is divided into three categories. These are the *self-directed violence,* which includes suicidal behaviours, self-abuse and self-mutilation. The second type of violence is referred to as *interpersonal violence,* which is prevalent between family members, intimate partners or co-

habitants. This type of violence fits into this study and will be further explained. *Collective violence* is described as violence between different groups in order to achieve political, social or economic objectives (Krug *et al*., 2002:6).

2.3 Definition of intimate partner violence (IPV)

Intimate Partner Violence (IPV) is classified as a branch of interpersonal violence and is defined as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm carried out by the perpetrator between two partners in a relationship" (Krug *et al*., 2002:89). While this definition of IPV is gender-neutral, Krug *et al*. (2002:89) acknowledge, that "the overwhelming burden of partner violence is borne by women at the hands of men". As a result, IPV can further be described as any act of aggression between genders. Research has shown that this form of violence mostly occurs during the periods of dating, cohabitation and/or married relationship (Joyner & Mash, 2010). The patterns of abuse may include physical abuse, psychological abuse, sexual abuse or any controlling behaviour such as preventing a person from seeing his or her family and friends (Krug *et al*., 2002).

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According to the Domestic Violence Act (nr.116 of 1998), IPV are classified as a form of domestic violence. *Domestic violence* occurs within the domestic sphere, which can be perpetrated by any member of the family such as father towards children, whereas IPV occurs between heterosexual partners or partners from the same sex within a romantic relationship.

2.4 Risk factors of intimate partner violence (IPV)

"There is no single factor that explains why violence is more prevalent in some communities than in others" (Krug *et al*., 2002:12). Therefore, researchers in health and social sciences use the ecological model to explain the inter-relatedness of factors that contribute to violence within an intimate relationship (Heise, Ellsberg & Gottemoellet, 1999; Krug *et al*., 2002; Ellsberg & Heise, 2005; Gebreyohannes, 2007; Arnold *et al*., 2008).

The ecological model was developed by Heise (1998) in order to understand and explain the interrelatedness of personal, situational and socio-cultural factors that combine to cause IPV (Ellsberg & Heise, 2005). The ecological model is divided into four levels, namely individual, relationship, community and societal level. Each of these levels can further be viewed as concentric circles as presented in the schematic below in Figure 2.1 (Heise,1998; Heise *et al*., 1999; Krug *et al*., 2002; Gebreyohannes, 2007; Arnold *et al*., 2008).

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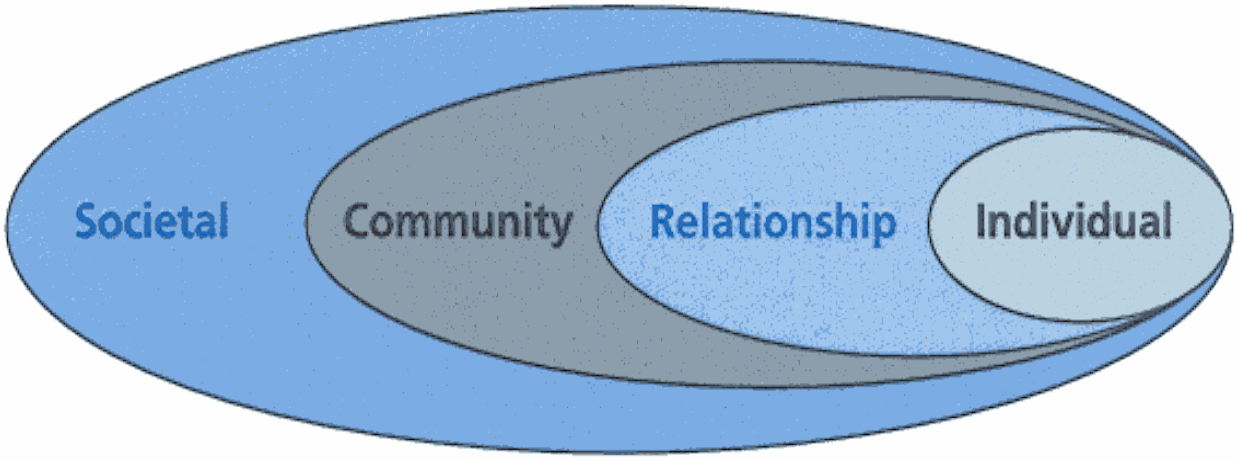

Figure 2.1: The ecological model adopted from Krug *et al*. (2002:12)

2.4.1 Individual factors

The individual is the first level of the ecological model. At this level, a number of factors such as gender, i.e. males with abusive parents are often perpetrators of IPV irrespective of the pattern or degree of abuse. The constant exposure of the child to abuse in the house is a strong factor (Krug *et al*., 2002). Nevertheless, research studies constantly point to the three main causes of violence at this level. This includes the witnessing of violence as a child, being abused as a child, and finally the use of alcohol by an intimate partner (Krug *et al*., 2002; Gebreyohannes, 2007; Iliyasu, Abubakar, Aliyu, Galadanci & Salihu, 2011).

Children who witness abuse or who are survivors of violence in the family are more likely than children who never witnessed abuse to display aggressive attitudes, which therefore serve as a strong indicator of future violence against intimate partners (Abrahams & Jewkes, 2005; Jewkes, Sikweyiya, Morrell & Dunkle, 2009; Gass, Stein, Williams & Seedat, 2011). This concept (*witnessing abuse as a child*) was confirmed by South African researchers who found that men who abuse women were approximately four times as likely to have been abused by their parents during childhood (Gupta, Silverman, Hemenway, Acevedo-Garcia, Stein & Williams, 2008). This is one of many findings that support the idea that violence among intimate partners is a learned behaviour; therefore, leaning towards the idea of social learning theory (Jewkes, 2002). The social learning theorists are of the opinion that exposure to violence influences humans violent or aggressive behaviour by modelling, reinforcement and practice (Bandura in Leaver, 2007). It can thus be concluded that children learn to be aggressive from the family context (Jewkes, 2002).

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SA, specifically the Western Cape, is characterised for its high alcohol abuse (Parry, 2008). Among the student population at the University of the Western Cape, 64% of students reported regular use of alcohol (Rich, 2004). Research has also showed that there is a strong link between the use of alcohol and the occurrence of IPV (Sharps, Campbell, Campbell, Gary & Webster, 2003). It is usually the male who is more prone to engage in physical abuse towards his female counterpart due to intoxication (Abrahams, Jewkes, Laubsher & Hoffman, 2006), than the other way round. The level of alcohol intake often leads to aggressive behaviour and impaired judgment on the side of the perpetrators, according to Weich (in Baumann, 2007).

2.4.2 Relationship factors

The second level of the ecological model is known as the relationship level. At this level, the factors identified as predictors of violence during an intimate relationship include marital conflict, male control of wealth and decision-making in the family (Heise *et al*., 1999; Krug *et al*., 2002). Marital conflict is one of the main causes of IPV at the relationship level. This conflict may occur as a result of dominating and controlling behaviours displayed by the male partner (Jewkes, 2002). This assertion was confirmed by feminist theorists who believe that IPV is rooted in gender and power which represent the male's active attempts to maintain dominance and control over the female (Anderson, 1997). An example of control and dominance can be linked to the patriarchal framework in some societies. Patriarchy is defined as "a form of social organisation in which the husband is recognised as the head of the house while the wife and children fulfil the role of the subordinates" (Russell in Selokela, 2005:3). By implication, this role of the husband makes him a supreme with unquestionable authority, and any challenge to patriarchal norms will result in violence. In societies where a large number of patriarchal

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relationships are normative it can be expected that IPV will be even higher in such societies (Jewkes, 2002).

2.4.3 Community factors

The community is the third level of the ecological model. At this level, the most consistent markers are poverty and unemployment (Jewkes, 2002; Krug *et al*., 2002). Social inequity and unemployment contribute towards poverty. Research has shown that income inequality, low economic development and high levels of gender inequality are strong predictors of rates of violence across countries (Jewkes, Abrahams, Mathews, Seedat, van Niekerk, Suffla & Ratele, 2009). SA is one of sixty-three countries with the worst income inequality and the highest level of unemployment (Jewkes *et al*., 2009). The implication of societal inequality with respect to access to wealth and opportunities often results in feelings of low self-esteem, which are channelled into anger, frustration, and eventually violence. Financial dependence is viewed as one of the characteristic of masculinity; therefore, any challenge to "being male" will result in violence. In addition, when the male partner can no longer control or financially support his female partner, conflict occurs, and eventually results in violence (Jewkes *et al.,* 2002). The basis for this violence is to relieve anger and frustration.

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2.4.4 Societal factors

The fourth level of the ecological model is known as the societal level. At this level, the factors identified as predictors of violence during an intimate relationship are societal recognition of male over female, the acceptance of violence as a way to resolve conflicts, the notion of masculinity linked to dominance and rigid gender roles (Krug *et al*., 2002). Among these factors,

the acceptance of violence as a way to resolve conflicts is most prevalent. A research study conducted in Cape Town has confirmed this notion and results from this study showed that 73.3% of men interviewed believed that it was acceptable to hit a woman (Abrahams, Jewkes, & Laubsher, 1999). Violence against females is a generally adopted way to resolve conflict situations and enforce authority. The way these men explained violence among intimate partners could mainly be ascribed to the display of superiority in the relationship which often comes with male abuse of females (Jewkes *et al.,* 2002).

2.5 Prevalence of intimate partner violence (IPV)

According to studies on the prevalence of violence, students at tertiary institutions were found to experience high levels of IPV, especially during a dating relationship (Straus, 2004; Lysova & Douglas, 2008). It is estimated that *"*1 in 5 students" experience some form of violence or abuse during a dating relationship (Wasserman, 2003:17). A comprehensive study (Straus, 2004) conducted on dating violence prevalence in sixteen countries among thirty-one tertiary institutions showed that physical violence perpetrated by a dating partner in the year before the study was conducted ranged from 17% to 45%. In Chile, approximately 15% of women and 26.6% of men reported some form of physical victimisation in the twelve months before the study (Lehrer, Lehrer & Zhao, 2009). Similarly, a study in Ethiopia showed that 26.4% of female student respondents experienced physical violence (Gebreyohannes, 2007). In another study in Russia, among three hundred and thirty-eight (338) undergraduate health science students at three universities, Lysova and Douglas (2008) found that 25.5% of students had experienced physical abuse and 3.6% of them had experienced injury as a result of this violence. In the

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Western Cape province of SA, 40% of men interviewed reported that they have physically abused their female partners in the last decade (Abrahams *et al*., 1999).

Sexual abuse is one of the most common forms of IPV perpetrated by a male partner against the female counterpart (Jewkes & Abrahams, 2002). This type of sexual abuse occurs in different dimensions, such as –

> rape, unwanted sexual advances or sexual harassment, forced marriage, forced prostitution and trafficking of people for purposes of sexual exploitation, denial of sexual and reproductive rights (including forced abortion), violent acts against the sexual integrity of men and women, including female genital mutilation and obligatory virginity testing (Krug *et al*.,2002:149-150).

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The results from a study conducted on historically black tertiary institutions in the US (Krebs, Barrick, Lindquist, Crosby, Boyd & Bogan, 2011), showed that approximately 14% of students experienced an attempted sexual assault since joining a tertiary institution. In a study conducted among college students in Chile (Lehrer, Lehrer, Lehrer & Oyarzún, 2007), 31% of the female students reported that they had experienced some form of sexual abuse since age fourteen and 17% reported that they had been sexually abused in the last twelve months before the study was conducted. Among female students at tertiary institutions, sexual abuse rates were even higher, with 46.2% in Greece (Chan, Straus, Brownridge, Tiwari & Leung, 2008). A study conducted in India among five hundred and fifty-two (552) medical students at a college in Punjab (Sobti & Biswas, 2008), found that 32.1% of medical students experienced sexual abuse. In Nigeria, 22.2% of female students reported being sexually abused with unwelcome sexual touches as the

most common type of sexual violence (Iliyasu *et al*., 2011). In Ethiopia, an institutionally based cross sectional survey among 1 330 female students attending colleges in Awassa (Arnold *et al*., 2008), found that sexual violence was reported by 54.9% females during their lifetime and 35.3% during the 2006 academic year. Furthermore, in SA, using the SAPS (2011) documented cases, rape is one of the most common types of sexual abuse leading to the cataloguing SA as the "rape capital" of the world (Jewkes & Abrahams, 2002). According to Jewkes and Abrahams (2002), the rate of rape perpetration is underreported because only a small proportion of rapes are reported to the police. In the Eastern Cape and in KwaZulu-Natal, results from a study conducted on rape perpetration by young males show that 8.4% of men reported to have raped a female partner during an intimate relationship (Jewkes, Dunkle, Koss, Levin, Nduna, Jama & Sikweyiya, 2006). Although the prevalence of sexual abuse in SA is already consistently and disturbingly high, this may only be the tip of the iceberg, due to the underreporting of such violence (Jewkes & Abrahams, 2002). The reason for the underreporting of such violence is based on the personal views about sexual abuse as rape is seen as a private matter and therefore survivors of such violence are not eager to report such abuse (Jewkes & Abrahams, 2002).

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Apart from the physical and sexual abuse experienced by survivors, psychological abuse has been shown to have a severe effect especially on the mental state of the survivors. According to the Domestic Violence Act (116 of 1998:4), psychological abuse is also known as "emotional abuse". It involves trauma to the survivor caused by acts, threats of acts, or coercive tactics, through use of humiliation, controlling what the survivor can and cannot do, withholding information, deliberately doing something to make the survivor feel diminished or embarrassed or isolating the survivor from friends and family (Domestic Violence Act 116 of 1998:4).

Psychological abuse often occurs when there has been a prior threat or actual physical or sexual violence. A study conducted in Nigeria (Iliyasu *et al*., 2011) found that psychological abuse among university students is the most common type of IPV, with 50.8% of perpetrators being male students. On the other hand, in a similar study conducted in Chile (Lehrer *et al*., 2009), it was found that 79.9% of male students experienced psychological abuse in comparison with the 67.3% of female students that reported psychological abuse. Similarly, a study in the USA (Fass *et al*, 2008) reported 86.5% of males and 83% of female university students as recipients of psychological abuse. In SA, among 1 395 pregnant women attending antenatal clinics at four hospitals, 67.5% of women were survivors of psychological abuse (Dunkle *et al*., 2003).

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Another form of IPV is financial abuse. Financial abuse implies denying the survivor sufficient financial resources to fulfil his or her basic need (Fawole, 2008). It thus refers to the unreasonable denial of financial resources to which the survivor is entitled under law or which the survivor requires out of necessity. This includes "household necessities for the survivor and mortgage bond repayments or payment of rent in respect of the shared residence" (Domestic Violence Act 116 of 1998:4). This type of abuse is a tactic that an abuser uses to gain power and dominance over his or her partner (Postmus, Plummer, McMahon, Murshid & Kim, 2011). In a national study conducted in Malawi (Pelser, Gondwe, Mayamba, Mhango, Phiri & Burton, 2005), 28% of females were financially abused by their male intimate partners. In SA, the MRC conducted an epidemiological community-based prevalence study in three of the nine provinces, namely the Eastern Cape, Mpumalanga and the Northern Province (Jewkes, Penn-Kekana, Levin, Ratsaka & Schrieber, 2002). The result from the study showed that 51% of women in the Eastern Cape, 50% of women in Mpumalanga and 40% of women in the Northern Province were

financially abused by their male intimate partners. Among pregnant women in this country, financial abuse accounted for 13.7% (Dunkle *et al*., 2003).

2.6 Gender symmetry

In recent times, research (Lehrer *et al*., 2009; Fass *et al*., 2008), seems to show that IPV is bi-directional with males and females being equally and likely perpetrators of IPV. This is often referred to as "gender symmetry" (Straus & Ramirez, 2007:285, Straus, 2009:247). Although the term "gender symmetry" is used to describe the equal perpetration of IPV by both males and females, Straus (2009) acknowledges that males are still more likely to perpetrate abuse with the aim of controlling and dominating their female partners, while their female partners mostly act in self-defence or revenge as the reason behind their violence.

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2.7 Health consequences of intimate partner violence (IPV)

IPV has negative effects on the health of the survivor and in the long term leads to serious health problems. These health problems are divided into two groups, namely fatal outcomes and non-fatal outcomes (Krug *et al*., 2002; Campbell, 2002; Ellsberg & Heise, 2005, Garcia-Moreno *et al*., 2005). The fatal consequences include death often due to HIV/AIDS, "femicide" (killing of a woman), suicide and "maternal mortality" (death of a pregnant woman), whereas the non-fatal outcomes include negative effects on the physical health, mental health and reproductive health, which could lead to chronic conditions (Campbell, 2002). The fatal and non-fatal outcomes are discussed below:

2.7.1 Fatal outcomes

According to UNAIDS (2011:6), "34 million people are living with HIV/AIDS worldwide" with the majority of those infected with HIV/AIDS "between the ages 15 to 24 years". In SA, the same trend of HIV/AIDS infections among youths gives rise to the high death rate among this group. According to the 2010 South African National HIV Survey (Department of health, 2011:47), 21.8% of women between the ages of 15 and 49 that attended antenatal clinics were living with HIV/AIDS. In addition to the high prevalence of HIV/AIDS, IPV is also a growing public health concern (Joyner & Mash, 2011). A recent research study (Dunkle *et al*., 2003) suggested that there is a strong association between IPV and HIV/AIDS. IPV is often seen as the result of HIV infection (Dunkle *et al*., 2003). IPV makes women specifically vulnerable to HIV/AIDS in three ways. Firstly, there is a probability of direct transmission through sexual violence. Secondly, the trauma associated with violent experiences can impact later negatively on the behaviour of the individual. Thirdly, violence or the threat of violence may limit women's ability to negotiate safer sex practices within on-going relationships (Dunkle *et al*., 2003).

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Suicide is one of the tactics that the victim of IPV uses to get out of an abusive relationship. According to the WHO (2012:1), around "one million people die worldwide as a result of suicide each year". Suicide is among the leading causes of the death of human beings worldwide and one of the three leading causes of the death for young people under the age of 25 (WHO, 2012). Furthermore, the predictions are that by the year 2020, this figure is likely to increase to nearly 1.53 million per year. In SA, research has showed that on average, suicide account for 9.5% of non-natural deaths in young people and for 11% in adults (Schlebusch, 2005). According to the South African Depression and Anxiety Group (SADAG, 2012), the group with the highest risk of

suicide is those between the ages of 15 and 29, and 9.5% of all teenage deaths are due to suicide. One of the reasons attributed to the high rate of suicide appears to be related to the increased levels of IPV (Krug *et al.*, 2002).

The worst effect of IPV is intimate femicide, which refers to the killing of a female person by an intimate partner (Mathews *et al*., 2004; Widyono, 2009). These intimate partners range from boyfriends, co-habiting partners and to husbands, current and former spouses (Abrahams, Jewkes, Martin, Mathews & Lombard, 2009). In Chile, femicide statistics showed that approximately every week, one female is killed by an intimate partner (Donoso, 2007). The femicide rate in this country is lower than the rate of femicide in SA. According to a study by the MRC during 1999 (Abrahams *et al.*, 2009), it was estimated that 1 349 females in South Africa had been murdered by their intimate partners. This was the highest recorded rate of femicide across the globe where such research has been conducted (Abrahams *et al.*, 2009). This study highlights the true extent of IPV in this country which implies that "every six hours a woman is killed by her intimate partner" (Mathews *et al*., 2004:1).

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2.7.2 Non-fatal outcomes

The non-fatal outcomes may be less severe but they often bring with them long-lasting physical health, mental health and reproductive health problems. The majority of survivors of IPV who have been physically abused sustain injuries such as fractures, bruises, cuts, burns and in its more severe form, temporary or permanent disability such as hearing or vision loss (Campbell, 2002; McAllister & Roberts-Lewis, 2010). According to the statistics provided by the WHO's multi-country study in ten countries, 19% to 55% of women sustained injuries as a result of IPV

(Garcia-Moreno *et al*., 2005). In SA, 45.9% of survivors of IPV reported sustaining injuries as a result of the violence (Jewkes *et al*., 2002). These injuries are the most prevalent causes for which survivors of IPV seek medical treatment. In Canada, researchers conducted a study among 282 injured women at an orthopaedic fracture clinic. The results from the study showed that 2.5% of the women indicated that their reason for visiting the orthopaedic fracture clinic was due to IPV (Bhandari, Sprague, Dosanjh, Petrisor, Resendes, Madden & Schemitsch, 2011).

In addition to physical health problems, the survivors of IPV may also experience adverse mental health conditions. The survivors of IPV can suffer severe mental health problems for years after the IPV has ended. When the survivors of IPV attend health care facilities they do not necessarily present with a medical history of IPV but would rather complain of a range of somatic health problems, i.e. headaches, chronic bodily pain, etc. (Joyner & Mash, 2011). When a thorough medical examination is performed it is often found that these complaints are due to IPV that is linked to mental health problems. These mental health problems range from post-traumatic stress disorder (PTSD), to depression, anxiety, panic attacks, sleeping and eating disturbances and low self-esteem (Campbell, 2002). PTSD is one of the most frequent mental health consequences of IPV, with a mean prevalence of 64% in abused women. In the Western Cape, Joyner and Mash (2011) found that approximately 40% of female survivors suffered from PTSD as a result of IPV. Characteristic features of PTSD include re-experiencing the traumatic event, emotional numbness or avoidance, and increased arousal (Seedat & Stein in Baumann, 2007).

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Adverse physical and mental health conditions are not the only effects of IPV. A survivor of IPV may experience reproductive health problems. The most common reproductive health problems include sexual transmitted infections (STIs), vaginal bleeding, decreased sexual desire, genital irritation, pain during sexual intercourse, chronic pelvic pain, unwanted pregnancies, low birth weight, premature labour and urinary tract infections (Campbell, 2002, Krug *et al*., 2002). Campbell *et al.,* (2002) assert that a sexually abused woman has a 50% to 70% chance of gynaecological problems.

2.8 The role of nurses in responding to intimate partner violence (IPV)

IPV has become a serious public health issue and the survivors of such violence often report to health care facilities on a regular basis. A study conducted at health care facilities in the US has showed that 34.8% of survivors of IPV attended an emergency department and 31.4% attended an academic health care facility with 13.7% of survivors presenting with severe physical or sexual abuse as a result of the violence (Kramer, Lorenzon & Mueller, 2004). Based on these findings, it is evident that nurses are in a unique position to identify, prevent, assist and manage survivors of IPV by providing them with the necessary support and referring survivors to the nearest support services (Du Plat-Jones, 2006; Barber, 2008). Unfortunately, research has shown that IPV is underreported and inadequately diagnosed by nurses and other health professionals (Julie *et al*., 2005). The reasons for not reporting and inadequately diagnosing IPV are mainly influenced by the personal and informational barriers in SA (Kim & Motsei, 2002; Joyner, 2009).

The personal barriers for not screening survivors of IPV include nurses' personal experience of

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such violence. In a study conducted among 38 primary health care nurses in the Northern Province of SA, it was found that nurses experience high levels of IPV, which influence the type of health care that they render (Kim & Motsei, 2002). Joyner (2009) identified nurses' personal experience of IPV as the fundamental barrier to providing care and for not asking survivors about IPV. Furthermore, Kim and Motsei (2002) also found that nurses' negative attitudes towards the survivor, frustration and perceptions are key indicators for not screening survivors for IPV. These negative attitudes may influence whether a survivor of IPV will be encouraged or discouraged towards disclosing abuse.

Apart from the personal barriers, informational barriers are also a reason for not screening, identifying, managing and referring survivors of IPV to the appropriate resources. The informational barrier is mainly based on the education of nurses that would ensure the effective health care response towards survivors of IPV. Kruetzkamp (2011) conducted a quantitative study among 89 nurses working in an emergency department, transitional care unit and labour and delivery unit to determine the nurses' knowledge in screening women for IPV. The results from the study showed that 75% of the nurses felt that they needed education and in-service training on the screening of IPV survivors. Similarly, in SA, the response of nurses indicated that they would find it valuable if IPV were incorporated into the training curriculum of nursing (Kim & Motsei, 2002). In SA, the main reasons for not reporting and diagnosing IPV include –

- under-staffed health facilities;
- limited time to conduct a comprehensive physical examination;
- inadequate skills to deal with the survivors of IPV;
- personal history of abuse that the person experience;

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- fear of legal reprisal;
- limited institutional resources; and
- inadequate or unclear policies at health facilities (Kim & Motsei, 2002, Joyner, 2009).

Despite all the factors that prevent nurses from screening survivors for IPV, one of the WHO's recommendations in the World Report (Krug *et al*., 2002) is that of strengthening the capacity and funding of health care, particularly in terms of nurses, in order to provide high-quality care to survivors of all types of violence. Based on this recommendation, the South African National Department of Health (NDoH) also started to train all health care professionals on the accurate identification and management of survivors of IPV and conducted numerous awareness campaigns that focus on the prevention of IPV. In the Western Cape, the School of Nursing (SoN) at the University of the Western Cape responded by introducing GBV training in the undergraduate programme in 2003 via a module entitled "Gender-Based Violence as a Public Health Issue". The undergraduate student nurses in their fourth year are trained to identify, manage and refer the survivors of IPV to the appropriate resources. Training of nurses is not the only important in the identification of survivors of IPV but protocols and policies should also be in place to direct older nurses who would still require certain guidelines on the management of survivors of IPV. Recently, Martin and Jacobs (2003) started to implement a comprehensive health approach to manage the survivors of IPV. This comprehensive health care approach includes:

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- the screening for IPV;
- offering of comprehensive physical and psychological care for those survivors who disclose abuse;

- a safety assessment and safety plan if the survivor's life is in danger;
- the documentation of previous and present incidents of abuse which include any physical injuries;
- the provision of information about the survivors' rights; and
- referral to the appropriate resources (Martin & Jacobs, 2003).

2.9 Conclusion

The review of literature highlights the extent of IPV among the student population at tertiary institutions and among the general population within the South African context. The lack of studies on the prevalence and the factors associated with IPV among undergraduate student nurses within the South African context is a serious gap in research to date.

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Research in this area may contribute to improved patient care by providing support to undergraduate student nurses who could identify survivors of IPV, earlier intervention, and referral to the most nearest, appropriate resources, which would enhance the proper management of such survivors.

In the next chapter, the attention is focused on a discussion of the research methodology used during this study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology. The research methodology is discussed in terms of the research setting, research design, population, sampling, data collection, data analysis and ethical considerations. The research design utilised allowed the researcher to achieve the aim and objectives of the current study.

3.2 Research setting

The current study was conducted at one of the four tertiary institutions, located in the Western Cape. Since 2005, the School of Nursing (SoN) and another institution was identified as the only two enrolling institutions for undergraduate student nurse training (Daniels, 2010:46). As a result of the transformation and reorganisation of training for undergraduate student nurses, the SoN increased their number of intake for undergraduate student nurses (Le Roux, 2007:2-3). To date, the SoN is one of the leading departments in the Faculty of Community and Health Science being the largest department with the most undergraduate student nurses in SA. The student nurses come from different backgrounds, representing the diverse society in SA.

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3.3 Research design

The research design is "the overall plan for addressing a research question including specifications for enhancing the study's integrity" (Polit & Beck, 2008:765). In the current study, a quantitative, descriptive survey was used to answer the research objectives. Burns and Grove

(2007:241-242) regard a quantitative, descriptive research design as most suitable when describing what exists in real-life situations. Brief descriptions of these methodological concepts are given below.

3.3.1 Quantitative research

Quantitative research refers to the "formal, objective, systematic process in which numerical data are used to obtain information about the world" (Burns & Grove, 2007:17-18). Furthermore, Polit and Beck (2008:763) define *quantitative research* as "the investigation of a phenomenon that lends themselves to precise measurement and quantification, often involving a rigorous and controlled design".

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3.3.2 Descriptive research

Descriptive research refers to "the accurate interpretation of the characteristics of persons, situations, groups or the frequency with which certain phenomena occur" (Polit & Beck, 2008:752). A *descriptive research design* was considered most appropriate for the current study because the aim of the study was to determine the prevalence and factors associated with IPV among the undergraduate nursing student population at a tertiary institution in the Western Cape, South Africa.

3.3.3 Survey

According to Burns and Grove (2007:556), *survey design* is a "design used to describe a phenomenon by collecting data using questionnaires or personal interviews" In this study, the WHO's questionnaire designed to measure partner violence (Garcia-Moreno *et al*., 2005) was

used to collect the data from the respondents. This questionnaire is further described later under section 3.8.

3.4 Research population

In research, the term *population* can be defined as "the entire aggregation of cases in which the researcher is interested" (Polit & Beck, 2008:237). In the current study, the population comprised all the undergraduate student nurses registered for the 2012 academic year at a tertiary institution in the Western Cape. The total number of registered undergraduate student nurses at this tertiary institution was 984 for the 2012 academic year.

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3.5 Sample frame and sample size

A *sample frame* is defined as "the comprehensive list of the sampling elements in the target population" (Brink, van der Walt & van Rensburg, 2006:124). The researcher obtained the class lists of undergraduate student nurses from the respective coordinators of each year level. On these lists the surnames of the undergraduate student nurses were arranged in alphabetical order. The lists of undergraduate student nurses according to the different year levels were used as the sample frames.

A *sample size* is defined as "the number of subjects, events, behaviours, or situations that are examined in a study" (Burns & Grove, 2007:554). In order to calculate the sample size required according to the different year levels, the total population of undergraduate student nurses was calculated. After consultation with a statistician, the sample size was calculated, and the required sample size was 243. The formula used to calculate the sample size was as follows:

To select the sample, the Cocharn (1977) formula was used, which assumed that:

- the distribution of undergraduate students from the nursing department was normal;
- the confidence level was 95%, the level of significance was 5% and the margin error (d)=0.10=10%; and
- the proportion (p) of people ultimate in the previous studies, p=71% and q=29%, which represented the proportion of people did not ultimate according to the previous studies.

Sample size (n) can be computed as:

$$n = \frac{N * n_0}{N + n_0} \text{ where } n_0 = \frac{z^2_{\alpha/2} * p * q}{d^2}$$

where N=984, the total number of undergraduate students from the nursing department, and p=71%, q=29%.

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$$n_0 = \frac{z^2_{\alpha/2} * p * q}{d^2} = \frac{(1.96)^2 * (0.71) * (0.29)}{(0.05)^2} = 316.3942 \cong 316$$

$$n = \frac{N * n_0}{N + n_0} = \frac{948 * 243}{948 + 243} \cong 243$$

Table 3.1: Sample frame according to the different year levels

Year level of undergraduate student nurses	Number of undergraduate student nurses	Sample size required according to year level	Percentage (%)
1st year	397	99	24%
2nd year	236	57	24%
3rd year	188	47	24%
4th year	163	40	24%
Total population	**984**	**243**	**25%**

3.6 Sampling and sample choice

The term *sample* refers to "a subset of a population selected to participate in a study" (Polit & Beck, 2008:765). In this study, a form of probability sampling, namely *stratified random sampling*, was used to select the sample. Stratified random sampling "is a process whereby the population is divided into subgroups or strata according to the variables of importance so that each element of the population belongs to one stratum" (Brink *et al.,* 2006:130). At first, the population under study was divided according to the four study year levels, which were used as the stratum. Secondly, the systematic sampling process was followed, which involved the selection of members from a sampling frame at regular intervals (Polit & Beck, 2008:347). The researcher followed the process of the systematic sampling method as suggested by Brink *et al.* (2006:129–130), which involved the following steps:

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I. Obtain a list of the total population

In this study, the printed class lists of the undergraduate student nurses were obtained from the respective course coordinators. On the class lists were all the names of the registered undergraduate student nurses for the academic year, 2012.

II. Determine the sample size

The sample size for this study was calculated with the assistance of a statistician. The required sample size for the study was 243.

III. Determine the sampling interval.

The sampling interval was determined by dividing the size of the population with the size of the

sample. In this case, 984 (size of the population) ÷ 243 (size of the sample) = 4.04 (sampling interval), which means that every fourth (4^{th}) element on the class lists of the different year levels was sampled.

IV. Choose a random starting point

The starting point of the systematic selection was done by selecting every first student on the class list.

V. Select the other elements based on the sampling interval

After the first respondent was selected, every fourth respondent was included in the sample. This process was repeated until the desired number of respondents was selected.

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3.6.1 Sample inclusion criteria

The researcher was particularly interested in describing the prevalence of IPV and to determine the factors associated with IPV among undergraduate student nurses. However, due to the sensitivity of the research topic and some ethical concerns the sampling inclusion criteria was that:

- respondents had to be over the age of 18 years;
- respondents had to be willing to participate in the study;
- respondent had to be a registered undergraduate student nurse at the specific tertiary education institution for the 2012 academic year and
- respondents had to be involved in a dating relationship

3.7 Data collection procedure

Firstly, before the data collection period, permission was obtained from the Head of SoN to conduct the study. After approval from the Head of SoN, the researcher contacted the coordinators of the various year levels and informed them about the study, and followed this up by an appointment with the individual class lecturers. During the appointment, the lecturers informed the researcher specifically when to come to class to collect the data.

On the day of data collection, all suitable respondents were asked to remain behind in the classroom. All other undergraduate student nurses were asked to leave the classroom including those that had been part of the pilot study. After all the other undergraduate student nurses had left the classroom, an information session was held. During the information session, the researcher explained in detail the purpose of the study, ethical considerations and possible risks from participating in the study. After the information session, the questionnaires were handed out to the selected respondents. No formal written consent forms were obtained from the respondents but once the respondents had voluntarily decided to complete the questionnaire this served as the voluntary consent.

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After the respondents had completed the questionnaires, the latter were placed in a sealed container provided by the researcher, thereby ensuring and upholding complete confidentiality and anonymity. The researcher continued with the data collection over a period of three months. After all the questionnaires had been completed, the researcher started to code the questionnaires by assigning a numerical code to each of the questionnaires.

3.8 Data collection instrument

The WHO's instrument designed to measure partner violence (Garcia-Moreno *et al*., 2005) was used as the data collection instrument. This was an anonymous questionnaire. The questionnaire was in English, which is the medium of instruction at tertiary institutions in SA. The questionnaire had fifty-seven questions, which were further sub-divided into four sections.

Section one of the questionnaire focused on the demographic information of the respondent. This section consisted of thirteen questions, which requested information on the respondent's age, gender, home language, year level of studies, ethnic origin, marital status, number of children and place of residence. In addition, in this section, information regarding the respondent's partner (boyfriend or girlfriend, husband or wife) such as educational status, monthly income, and employment status was also requested.

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Section two of the questionnaire referred to the family history. This section entailed questions on the educational and marital status of the respondent's parents as well as the family support structure. Another question incorporated in this section was the witnessing of violence between parents. A total number of nine questions were included in this section.

Section three of the questionnaire focused on the respondent's substance use history. The questions focused on cigarette or dagga smoking habits and alcohol use by the respondent. This section consisted of seven questions.

Section four of the questionnaire covered intimate partner violence (IPV). In this section, the

frequency and prevalence of each type of abuse (psychological abuse, physical abuse, sexual abuse and financial abuse) were assessed. A total of twenty-eight questions were included in this section. The questionnaire could be completed within less than thirty minutes.

3.9 Pilot study

"A pilot study is a small-scale version or trial run designed to test the methods to be used in a larger, more rigorous study" (Polit & Beck, 2008:213). The researcher conducted the pilot study during March 2012 on forty undergraduate student nurses.

The forty respondents were recruited in a similar manner as those of the main study. Ten undergraduate student nurses from each year level (i.e. 10 student nurses in their 1st year, 10 student nurses in their 2nd year, 10 student nurses in their 3rd year and 10 student nurses in their 4th year) were randomly selected to participate in the pilot study.

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The forty undergraduate student nurses had to comply with the same selection criteria as the respondents who were selected to participate in the main study. The respondents who took part in the pilot study were excluded from the main study.

The reasons for conducting a pilot study were:

- to identify and address possible problems with the questionnaire such as confusing statements or language difficulties;
- to enhance the validity and reliability of the questionnaire and to clarify or avoid any misconceptions; and

- to determine the time it would take for the respondents to complete the questionnaire.

The pilot study was successful because the respondents had no problems with completing the questionnaire. The questions were clear and minor revisions were done where necessary. The Cronbach's alpha co-efficient of the research instrument during the pilot study was 0.927. Based on the success of the pilot study, the researcher decided to continue with the research methodology exactly as planned.

3.10 The scientific rigor of the study

Validity and reliability are the two concepts used in quantitative research to assess the quality of the research instrument that is used in the study (Polit & Beck, 2008:196). These two important concepts are discussed below:

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3.10.1 Validity

Validity refers to "the ability of an instrument to measure the variable that it is intended to measure" (Brink *et al.*, 2006:209). On the other hand, Burns and Grove (2007:559) define the validity of an instrument as "the extent to which the instrument actually reflects the abstract construct being examined". In this study, the degree of face and content validity of the instrument for the intended purpose and the context where the study was conducted were determined.

3.10.1.1 Face validity

Face validity refers to "the extent to which an instrument looks as though it is measuring what it

purports to measure" (Polit & Beck, 2008:753). In this study, face validity was ensured by carefully selecting the items to be included in the questionnaire. It was also established by consulting the experts on IPV, nurse lecturers and the study supervisors to provide feedback.

3.10.1.2 Content validity

Content validity is defined as "the degree to which an instrument covers the scope and range of information that it sought" (Brink *et al*., 2006:200). At first, the researcher conducted a detailed literature review that addressed the concept of IPV, followed by a presentation of the questionnaire for review to the statistician, the research ethics committee and the study supervisors to give input because of their experience in practice and quantitative research. This helped with refining the questions for better meaning, clarity and conceptualisation.

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3.10.2 Reliability

The reliability of an instrument refers to the accuracy and consistency with which an instrument measures the target attributes (Polit & Beck, 2008). "Reliability exists in degrees and is usually expressed as a form of correlation coefficient with 1.00 indicating perfect reliability and .00 indicating no reliability" (Burns & Grove, 2007:365). "A reliability coefficient of 0.80 is considered the lowest acceptable value for a well-developed instrument and for a newly developed instrument, a reliability of 0.70 is considered acceptable" (Burns & Grove, 2007:365). In this study, the researcher used the Cronbach's alpha co-efficient in consultation with a statistician to test reliability. The Cronbach's alpha co-efficient of the research instrument was 0.950, which indicated that this instrument had a high internal consistency.

3.11 Data analysis

The data was analysed quantitatively, which entailed "categorising, ordering, manipulating and summarising the data and describing them in meaningful terms" (Brink *et al*., 2006:170). The data analysis was done with the assistance of a statistician. Data was entered into a Microsoft Excel spread sheet and thereafter imported into the Statistical Package for Social Sciences (SPSS) version 20. The data was then summarised and descriptive statistics were expressed in frequencies and percentages. The results are presented in the form of tables, pie chart and graphs. Spearman's correlations were used to calculate the strength of the relationship between the dependent variables. Multivariate analysis was done by using the Mann-Whitney U test and the Kruskal-Wallis test to determine the associations between the different variables.

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3.12 Ethical considerations

The World Health Organisation (WHO) has set out the ethical and safety recommendations on research that involves IPV among any given population (Ellsberg & Heise, 2005). The study was therefore conducted strictly according to these ethical and safety recommendations. The researcher adhered to certain principles as discussed below.

3.12.1 Permission

The research proposal was firstly approved by the Senate Research Committee of the University of the Western Cape and the Faculty Higher Degrees. After the approval of the research project, a letter was sent to the Head of SoN, requesting permission to conduct the study. Permission to conduct the study was granted by the Head of SoN.

3.12.2 Informed consent from respondents

No formal written consent was obtained from the respondents but information sessions were conducted. During the information sessions, in a detailed presentation, the purpose of the study, the way respondents were selected and possible risks from participating in the study were discussed. After the information session, the undergraduate student nurses were given the opportunity to decide for themselves whether they wanted to participate or not. Once the students had voluntarily decided to participate and had completed the questionnaire this served as voluntary consent.

3.12.3 Protecting the privacy and confidentiality of the respondents

The research questionnaire took the form of an anonymous, self-administered survey. After the selection of the respondents, an information session was held with the eligible respondents. The reason for only having an information session was due to the sensitivity of the research topic. After the information session, the eligible respondents received the questionnaire. The respondents were not expected to write any personal details on the questionnaire in order to prevent the researcher from linking respondents to the data entered on the survey, thereby upholding the ethical principles of confidentiality and anonymity.

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3.12.4 Minimising respondent distress

The researcher informed the respondents about the possible risk of participating in the study. Before the respondents completed the questionnaire, the contact details of the Campus Health Centre were provided on the information sheet. Respondents who have might have felt distressed

after completion of questionnaire, could have contacted the Campus Health Centre to arrange a counselling and debriefing session.

3.12.5 Ensuring the safety of the respondents

The study was conducted on the university campus, which was considered as a safe place because none of the respondents' immediate family or intimate partners was present during the completion of the questionnaire.

3.12.6 Respect for human dignity

Respondents were informed about their rights to participate or not to participate in the study. The respondents were also informed about their right to withdraw from the study at any time if they wished.

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3.13 Conclusion

In this chapter, the research methodology was discussed in terms of the research setting, research design, population, sampling, data collection, data analysis and ethical considerations. The research design utilised allowed the researcher to achieve the aim and objectives of the study. The pilot study described, was used to enhance the validity and reliability of the instrument. In the next chapter, the research findings of the study are presented.

CHAPTER 4

RESEARCH FINDINGS

4.1 Introduction

The research design of the study was quantitative by nature. The population under study was composed of 984 registered undergraduate student nurses at a tertiary institution in the Western Cape. During the data collection period, questionnaires were handed out to 243 (25%) respondents randomly selected among participants for each of the first (1st), second (2nd), third (3rd) and fourth (4th) year of study. In this manner, 99 questionnaires were handed out to first-year students, 57 to second-year students, 47 to third-year students and 40 to fourth-year students. Therefore, a total of 243 questionnaires were handed out, completed and returned by respondents, which equalled a response rate of 100%.

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To test the reliability of the research questionnaire, the Cronbach's alpha reliability coefficient was used. Table 4.1 shows the reliability estimates for the main components of the questionnaire.

As Table 4.1 shows, the different components of the questionnaire indicated that the questionnaire was highly reliable as these components showed a high reliability coefficient, indicating an internal consistency among the different individual questions.

Table 4.1 Cronbach's reliability coefficient

Subscale	Number of items	Cronbach's alpha
4.1 Psychological abuse	6	.887
4.2 Physical abuse	8	.921
4.3 Sexual abuse	5	.907
4.4 Financial abuse	9	.938

To present the findings of the study, the descriptive results are firstly illustrated followed by the bivariate analysis using Spearman's correlation to test the relationship between the dependent variables. In conclusion, multivariate analysis is used to examine the difference in the mean rank of the dependent variables. The study findings are presented according to the items in the questionnaire.

4.2 Socio-demographic results

In this section, the frequencies and percentages of the socio-demographic variables are presented. This section consisted of thirteen questions which requested information on the respondent's age, gender, home language, year level of studies, ethnic origin, marital status, number of children and place of residence. In addition, in this section the information on the respondent's partner such as educational status, monthly income, and employment status was also requested. Two hundred and forty-three respondents answered this section.

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4.2.1 Age, gender and year level of study

Table 4.2 indicates the age, gender and level of education of the respondents in the study. The results from the survey showed that the majority of respondents, namely 151 (62.7%), were in age group 18 to 24 years, followed by 62 (25.7%) in the age group 25 to 34 years, 22 (9.1%) in the age group 35 to 44, and only 6 (2.5%) were in the age group 45 to 54 years.

Furthermore, Table 4.2 indicates that respondents consisted of 180 (74.1%) females and 63 (25.9%) males.

The sample consisted of 99 (42%) first-year students, 55 (22.6%) second-year students, 46 (18.9%) third-year students and 40 (16.5%) fourth-year students as indicated in Table 4.2.

Table 4.2: Age, gender and year level of study

Variables	Categories	Frequencies	Percentages
Age	18–24	151	62.7
	25–34	62	25.7
	35–44	22	9.1
	45–54	6	2.5
Gender	Male	63	25.9
	Female	180	74.1
Year level of study	1st year	99	42.0
	2nd year	55	22.6
	3rd year	46	18.9
	4th year	40	16.5

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4.2.2 Ethnic origin, religious affiliation, marital status and number of children

Table 4.3 indicates that the sample consisted largely of black respondents, namely 169 (69.5%), followed by 57 (23.5%) coloured respondents and 16 (6.0%) white respondents. Only 2 (1%) of the respondents indicated that they were from other ethnic groups.

In this study, the largest number, 219 (90.1%) of respondents reported being of the Christian faith, while only 12 (4.9%) of the respondents were Muslim-affiliated. Two (0.8%) of the respondents in the study were Buddhist or from the Hindu religious affiliation. Only 6 (2.5%) of the respondents indicated that they believed in ancestral spirits while only 4 (1.7%) of respondents answered that they had no religion (Table 4.3).

The results shown in Table 4.3 reveal that the majority of the respondents (188 or 77.4%) were single, 39 (16.1%) were married and a further 9 (3.7%) indicated that they were co-habiting with their partners. Only 3 (1.2%) of the respondents indicated that they were separated and 4 (1.6%) reported that they were divorced.

Table 4.3 further illustrates that 152 (62.8%) of the respondents did not have any children and 90 (37.2%) reported that they had at least one child and more.

Table 4.3: Ethnic origin, religious affiliation, marital status and number of children

Variables	Categories	Frequencies	Percentages
Ethnic origin	Black	169	69.5
	Coloured	57	23.5
	White	16	6.0
	Other	2	1.0
Religious affiliation	Christian	219	90.1
	Muslim	12	4.9
	Hindu	1	.4
	Buddhist	1	.4
	Ancestral spirits	6	2.5
	None	4	1.7
Marital status	Single	188	77.4
	Married	39	16.1
	Co-habiting	9	3.7
	Separated	3	1.2
	Divorced	4	1.6
Number of children	None	152	62.8
	One	59	24.4
	Two	21	8.7
	More than two	10	4.1

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4.2.3 Place of residence and siblings

As shown in Table 4.4, 128 (53.1%) of the respondents were living at home, 76 (31.5%) were living in the university residence and only 37 (15.4%) were living private.

One hundred and five (43.8%) of the respondents were living with their family and only 70 (29.2%) were living alone and a further 39 (16.3%) cohabited with their partners. Twenty-six (10.7%) of the respondents indicated that they lived with other people as shown in Table 4.4.

Table 4.4: Place of residence and siblings

Variables	Categories	Frequencies	Percentages
Place of residence	University	76	31.5
	Home	128	53.1
	Private	37	15.4
Siblings living with	Alone	70	29.2
	Family	105	43.8
	Partner	39	16.3
	Other	26	10.7

4.2.4 Educational and employment status of partner and monthly income

From Table 4.5 it is clear that 122 (52.8%) of the respondents' partners had attended a tertiary institution, 72 (31.2%) have attended a secondary school and only 19 (8.2%) had primary school education. Eighteen (7.8%) of the respondent's partners had no formal education.

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Ninety -eight (42.1%) of the respondents' partners were employed at the time that the study was conducted and 80 (34.3%) were still students, while 46 (19.7%) were unemployed. Nine (3.9%) of the respondents indicated that their partners did something else, other than been employed, unemployed or being a student as shown in Table 4.5

The monthly income status of respondents was determined with a range from a minimum of R2 000 to a maximum of R6 000 and more. In the current study, 95 (41.3%) of the respondents had a low monthly income of less than R2 000 in comparison with the 53 (23.1%) respondents

who had a high monthly income of R6 000 and more. Eighty-two (35.6%) of the respondents had a monthly income of at least R2 000 to R5 999 (Table 4.5).

Table 4.5: Educational, employment status of partner and monthly income

Variables	Categories	Frequencies	Percentages
Educational status of partner	No formal education	18	7.8
	Primary education	19	8.2
	Secondary education	72	31.2
	Tertiary education	122	52.8
Employment status of partner	Unemployed	46	19.7
	Employed	98	42.1
	Student	80	34.3
	Other	9	3.9
Monthly income	Less than R2 000	95	41.3
	R2 000 to R2 999	27	11.7
	R3 000 to R3 999	29	12.6
	R4 000 to R4 999	11	4.8
	R5 000 to R5 999	15	6.5
	More than R6 000	53	23.1

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4.3 Family history results

In the following section, the family history results are presented. This section entailed questions on the educational and marital status of the respondent's parents as well as the family support structure. Another question incorporated in this section was the witnessing of violence between parents. A total of nine questions were examined in this section. A total of two hundred and forty-three respondents answered this section.

4.3.1 Marital and educational status of parents

Table 4.6 shows that 128 (54.5%) of the respondents were from married parents, 40 (17%) were from single parents and 44 (18.7%) were from parents of whom either the mother or father had died. In addition, the results show that 16 (6.8%) of the respondents' parents were divorced and 7 (3%) had parents who were cohabiting at the time the study was conducted.

The educational status of the respondents' mothers and fathers ranged from no formal education to obtaining an educational qualification above Grade 12. As shown in Table 4.6, 65 (27.5 %) of the respondents' fathers and 70 (28.9%) of the respondents' mothers had acquired an educational qualification above Grade 12. One hundred and twelve (46.3%) of the respondents' mothers and 82 (35.2%) of the respondents' fathers had at least some formal education, which ranged from primary to secondary education, in comparison with 33 (13.6%) of the respondents whose mothers and fathers had no formal education. Fifty-six (23.7%) of the respondents did not know the educational status of their fathers and 27 (11.2%) did not know the educational status of their mothers.

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Table 4.6: Marital and educational status of parents

Variables	Categories	Frequencies	Percentages
Marital status of parents	Married	128	54.5
	Divorced	16	6.8
	Living together	7	3.0
	Single	40	17.0
	Widow	29	12.3
	Widower	15	6.4
Education status of Father	No formal education	33	13.6
	Grade 1 to 8	37	15.7
	Grade 9 to 12	45	19.5
	Above Grade 12	65	27.5
	Don't know	56	23.7
Education status of Mother	No formal education	33	13.6
	Grade 1 to 8	46	19.0
	Grade 9 to 12	66	27.3
	Above Grade 12	70	28.9
	Don't know	27	11.2

4.3.2 Family income

As shown in Figure 4.1, 118 (49%) of the respondents in the study reported an average family income, while 71 (30%) reported their family income as low. A further 38 (16%) reported their family income as very good, and only 13 (5%) viewed their family income as better off.

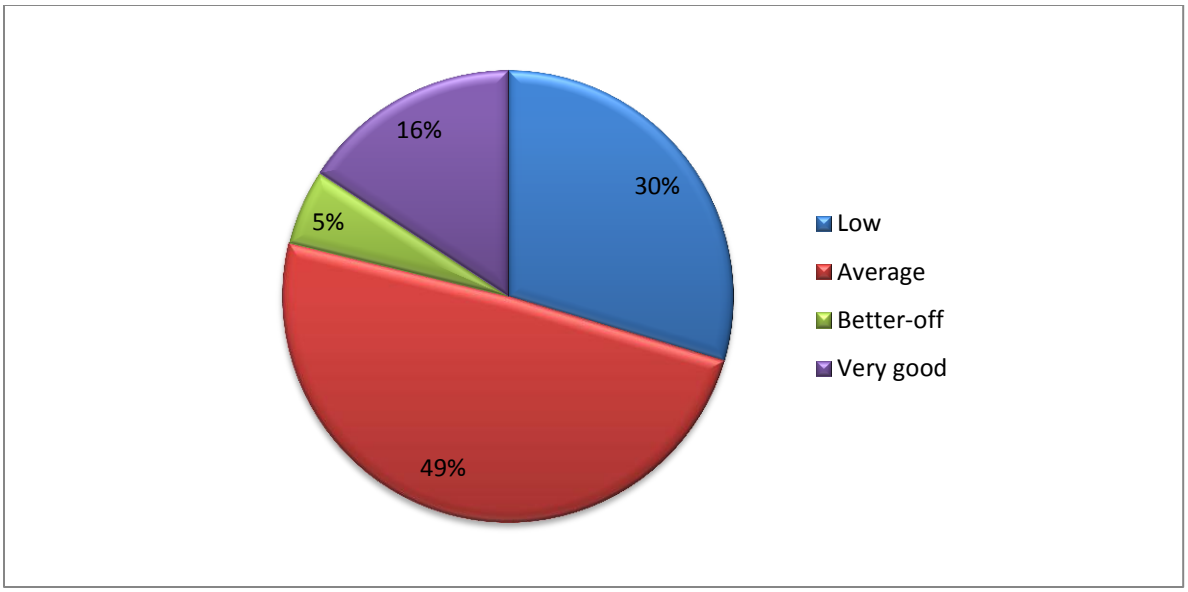

Figure 4.1: Family income

4.3.3 Financial and family support

As shown in Figure 4.2, eighty-six (36%) respondents indicated that they never received adequate financial support according to their needs. Thirty (12%) respondents indicated that they occasionally received adequate financial support. Eighty-four (35%) of respondents reported that they sometimes received financial support and 42 (17%) reported that they often receive adequate financial support.

Figure 4.2, further show that 26 (11%) of the respondents reported that they never received adequate support from their families and 30 (12%) respondents indicated that they occasionally received support from their families. One-hundred-and-one (42%) of the respondents sometimes received support from their families and another 84 (35%) of the respondents indicated that often they received support from their families.

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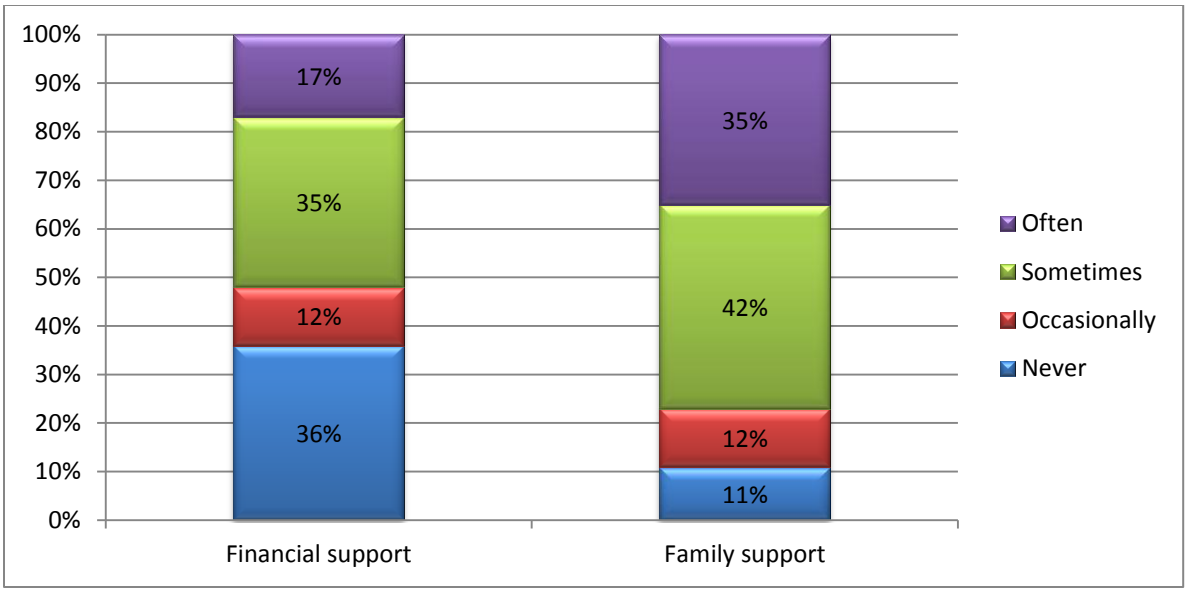

Figure 4.2: Financial and family support

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4.3.4 Family control status

In Figure 4.3, results show that 83 (35%) respondents implied that their family control status was very good in comparison with the 39 (16%) who reported that their family control status was tight. A further 90 (38%) respondents indicated that their family control status was average, and 26 (11%) reported that their family control status was loose or free (Figure 4.3).

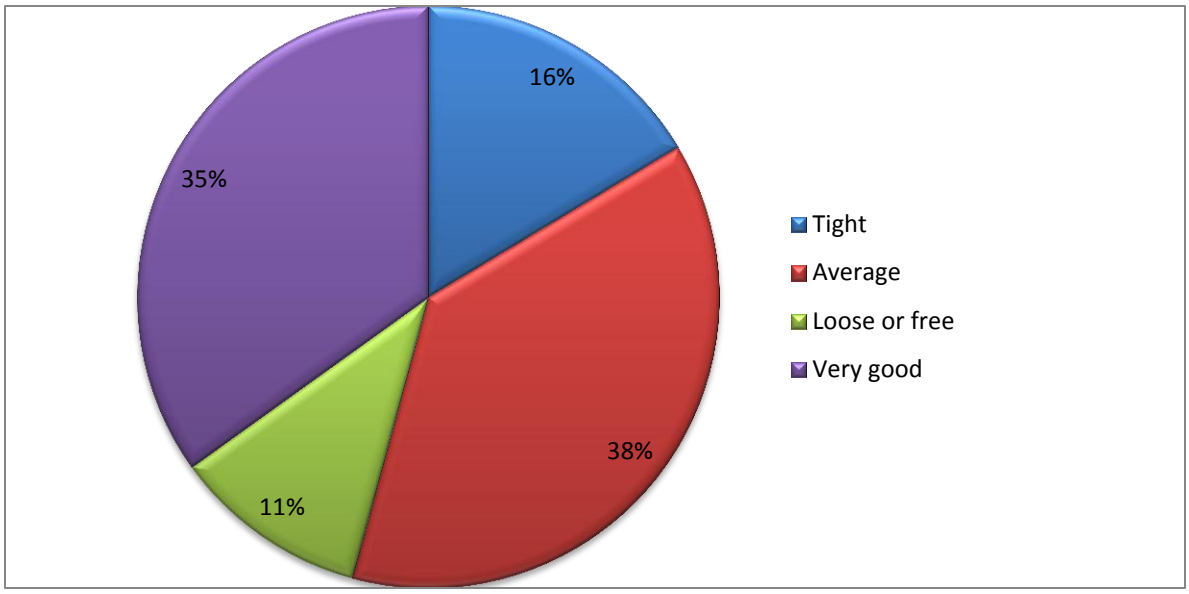

Figure 4.3: Family control status

4.3.5 Visiting family members and witnessing abuse

According to Figure 4.4, the majority of respondents, 220 (92%) reported that their families lived closed enough for them to go visit. Seventy-eight (32%) of the respondents indicated that they visited their families occasionally, 76 (32%) visited their families sometimes and 68 (28%) visited their families often.

The results of the study as shown in Figure 4.4, showed that 123 (51%) of the respondents never witnessed any abuse among their parents in comparison with the 120 (49%) who reported having witnessed inter-parent violence. From the respondents who had witnessed inter-parent violence as a child, 62 (25%) reported that this happened occasionally, 37 (15%) reported that this happened sometimes and 21 (9%) reported that this happened often**.**

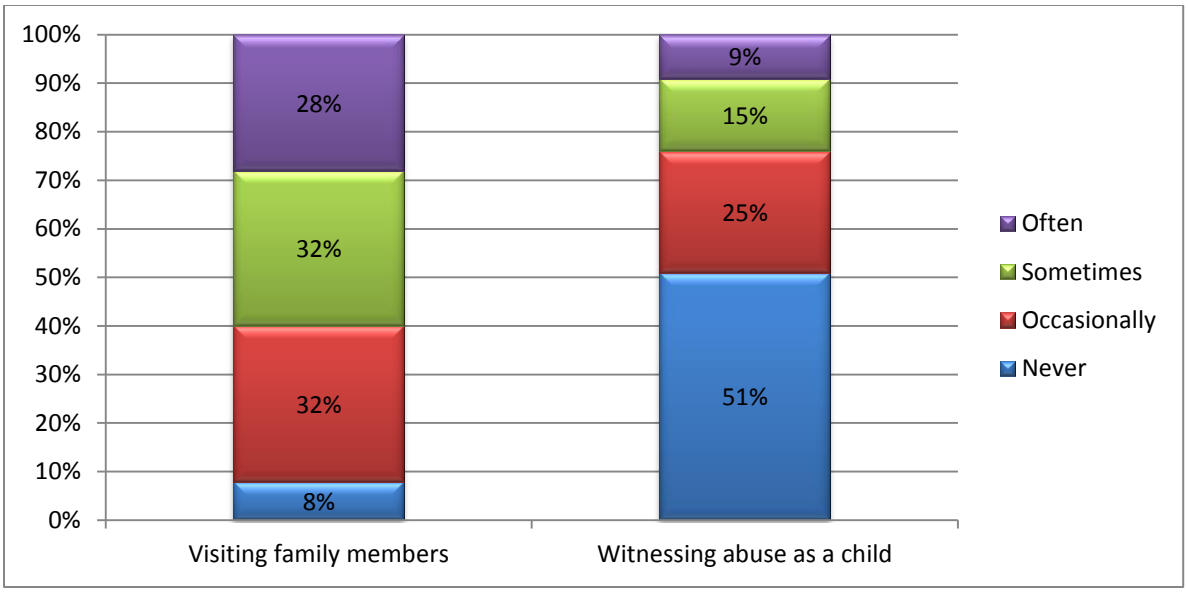

Figure 4.4: Visiting family members and witnessing abuse

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4.4 Substance use results

Section three of the questionnaire focused on the substance use history of the respondents. The questions focused on cigarette and dagga smoking habits and alcohol use of the respondents. This section consisted of seven questions. Two hundred and forty-three respondents answered this section.

4.4.1 Dagga and cigarette smoking

As shown in Figure 4.5, 176 (73%) of the respondents reported that they have never used dagga, while 64 (27%) reported that they have used dagga at least once in their lifetime. Among the respondents who indicated that they were using dagga, 29 (12%) reported to have used it occasionally, 30 (13%) reported that they used it sometimes and only 5 (2%) reported that they used it often.

The majority of respondents, 153 (62%) reported that they have never smoked cigarettes, while 90 (38%) respondents reported that they had been smoking cigarettes for a very long time. In addition, results show that, from the 90 (38%) respondents who were smoking cigarettes, 33 (14%) smoked occasionally, 36 (15%) smoked sometimes, and 21 (9%) often smoked cigarettes (Figure 4.5).

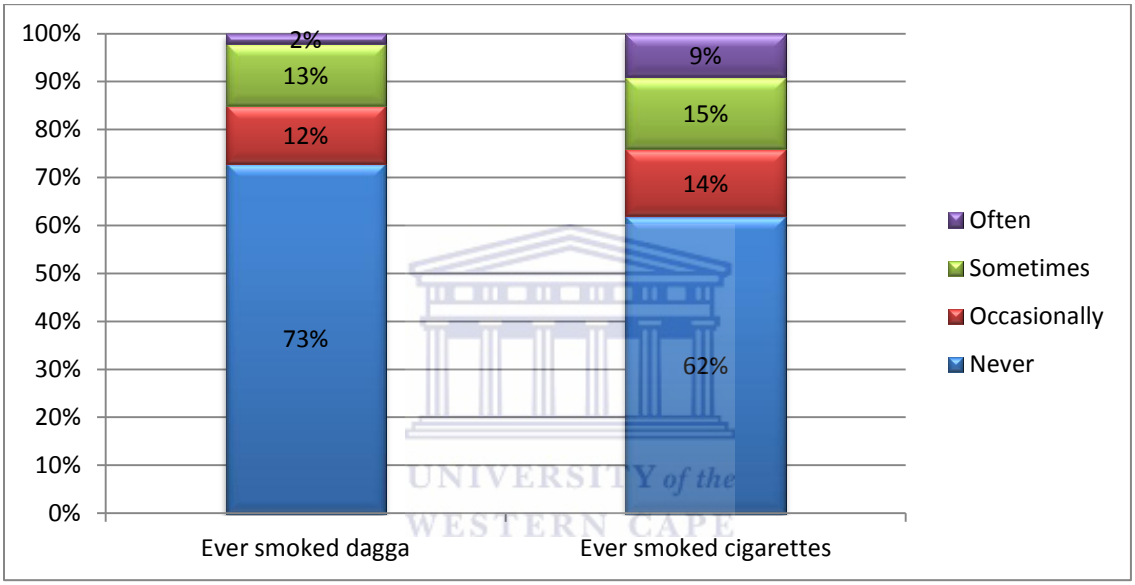

Figure 4.5: Dagga and cigarette smoking

4.4.2 Alcohol use

The results shown in Figure 4.6 revealed that the minority of the respondents in this study (84 or 34%) have never used alcohol in comparison with the majority of respondents 145 (66%) who reported at least one episode of alcohol use. Sixty-nine (29%) respondents reported that they used alcohol occasionally, 62 (26%) reported that they used it sometimes and 25 (11%) reported using it often.

Of the respondents, 103 (42%) indicated that they used alcohol to the point of being drunk in comparison with the 139 (58%) who never became drunk. From the respondents who reported being drunk, 43 (18%) reported that it happened occasionally and sometimes with only 17 (6%) who indicated that this happened often (Figure 4.6).

The study found that 149 (61%) of respondents reported that they have never used alcohol since joining the university and 90 (39%) reported that they have used alcohol since joining the university. Thirty-five (15%) respondents stated that they use alcohol occasionally, 37 (16%) stated that they use alcohol sometimes and 18 (8%) reported that they use alcohol often.

Figure 4.6 shows that 173 (72%) of the respondents have used alcohol in the current academic year while 68 (28%) have not used alcohol in the current academic year. From the 173 (72%) respondents who used alcohol in the current academic year, 51 (22%) reported to have used alcohol occasionally, 73 (30%) reported to have used it sometimes and 49 (20%) reported to have used it often.

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In addition, the results show that 200 (83%) respondents never had friends who drink alcohol in comparison with 41 (17%) who acknowledged that they had friends who drink alcohol. Thirty (12%) respondents in the study reported to have friends who drink occasionally, 9 (4%) sometimes and only 2 (1%) often (Figure 4.6)

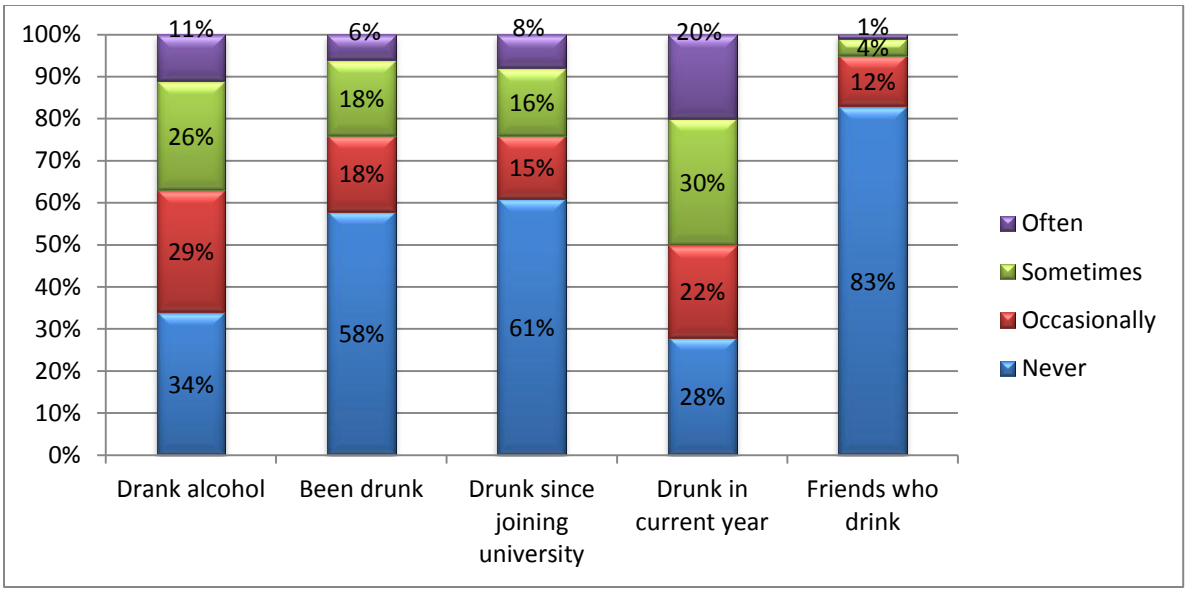

Figure 4.6: Alcohol use

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4.5 Descriptive results on intimate partner violence (IPV)

Section four of the questionnaire dealt with IPV. In order to determine the prevalence of IPV, the respondents were asked if they had experienced any form of psychological, physical, sexual and financial abuse by a boyfriend, girlfriend, husband or wife during the previous twelve months and lifetime. The descriptive results on each of the forms of IPV are presented in the following section. A total number of twenty-eight questions were examined in this section. A total of two hundred and forty-three respondents answered this section. Respondents were asked to use the following response key:

1. Never (0 times)
2. Occasionally (1 to 2 times)
3. Sometimes (3 to 5 times)
4. Often (more than 5 times)

4.5.1 Psychological abuse

In the following section the prevalence of psychological abuse is determined. Psychological abuse involves trauma to the survivor caused by acts, threats of acts, or coercive tactics, through use of humiliation, controlling what the survivor can and cannot do. This section consisted of six questions.

4.5.1.1 Frequency of psychological abuse

From Figure 4.7, it is clear that 118 (49%) and 85 (35%) respondents never experienced any form of psychological abuse during the previous twelve months or during their lifetime respectively. Forty-six (18%) of respondents reported to be psychological abused occasionally and 96 (40%) of respondents admitted to be sometimes psychologically abused during their lifetime. Only 16 (7%) reported that they were often psychologically abused during the lifetime.

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Furthermore as showed in Figure 4.7, thirty-five (14%) of respondents reported that psychological abuse occurred occasionally and, 73 (30%) reported that it happened sometimes in the previous twelve months. Seventeen (7%) of respondents implied that they were often psychologically abused in the previous twelve months (Figure 4.7).

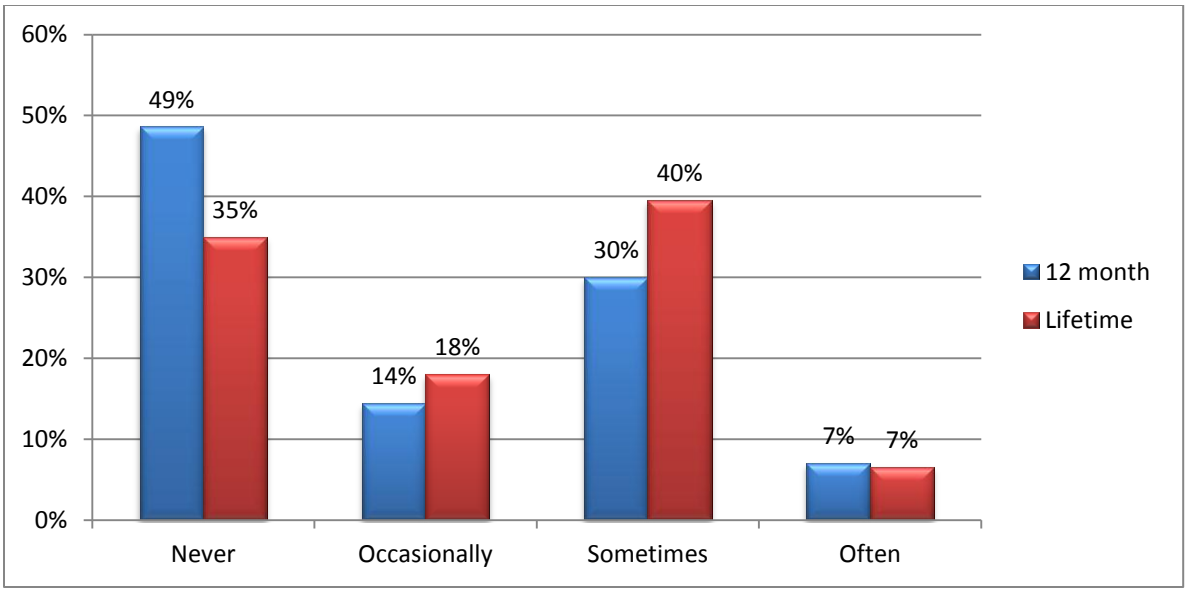

Figure 4.7: Frequency of psychological abuse

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4.5.1.2 Prevalence of psychological abuse

In Figure 4.8, the researcher grouped the frequencies of *occasionally*, *sometimes* and *often*, and compared it with the respondents who never experienced any form of psychological abuse during the previous twelve months or during their lifetime. The reason for grouping these frequencies was to obtain an overall prevalence and to do a comparative analysis with earlier studies done on psychological abuse, which will be discussed later in Chapter 5.

According to the results illustrated in Figure 4.8, 118 (49%) and 85 (35%) of the respondents never experienced any form of psychological abuse during the previous twelve months or before. When calculating these frequencies, it was found that 105 (51%) and 158 (65%) of the respondents reported at least one episode of psychological abuse during the previous twelve months and during their lifetime respectively.

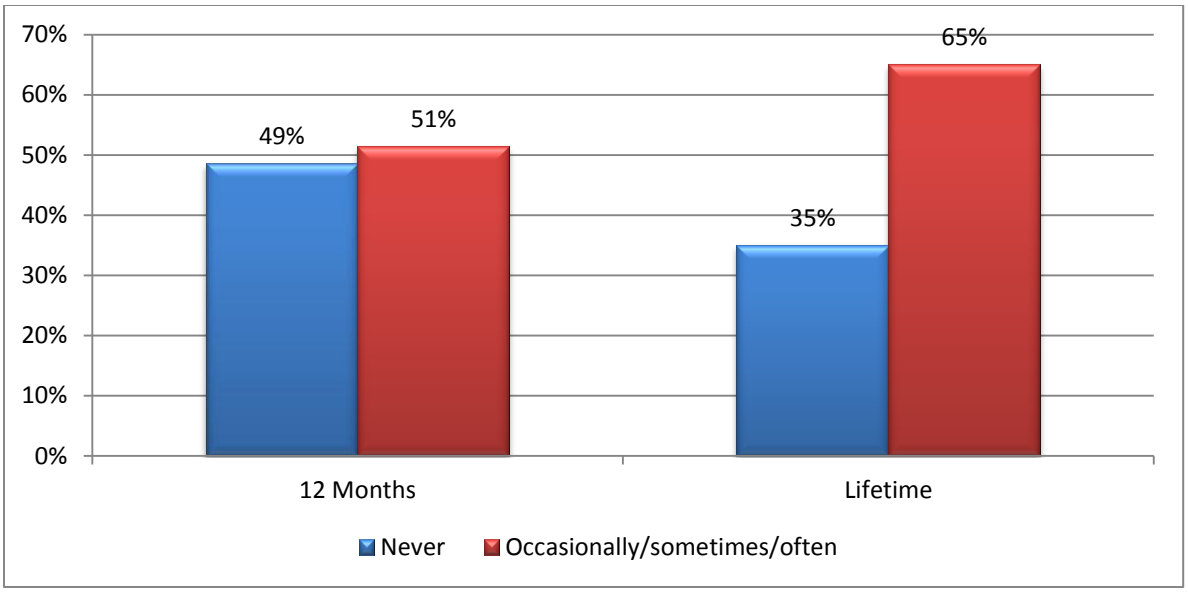

Figure 4.8: Prevalence of psychological abuse

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4.5.1.3 Forms of psychological abuse

According to the findings summarised in Figure 4.9, 141 (58%) of the respondents in the current study had been insulted or made to feel bad about themselves. Sixty-six (27%) of the respondents reported that this had happened to them occasionally, 57 (24%) reported that this happened sometimes and 18 (7%) said it happened often. The figure further illustrates that 97 (40%) of the respondents had been belittled or humiliated in front of other people with 42 (17%) indicating that this had happened to them occasionally, 44 (18%) said it happened sometimes and 11 (5%) said it happened often. A total of 107 (44%) of the respondents also indicated that they were intimidated or scared on purpose. Sixty-three (26%) reported that this had happened to them occasionally, 29 (12%) reported that it happened sometimes and 15 (6%) indicated that it happened often. Of all the respondents, 87 (36%) acknowledged that they were threatened to be hurt, and 46 (19%) reported that this had happened occasionally, 35 (11%) reported that it sometimes with only 15 (6%) who reported that it happened often (Figure 4.9).

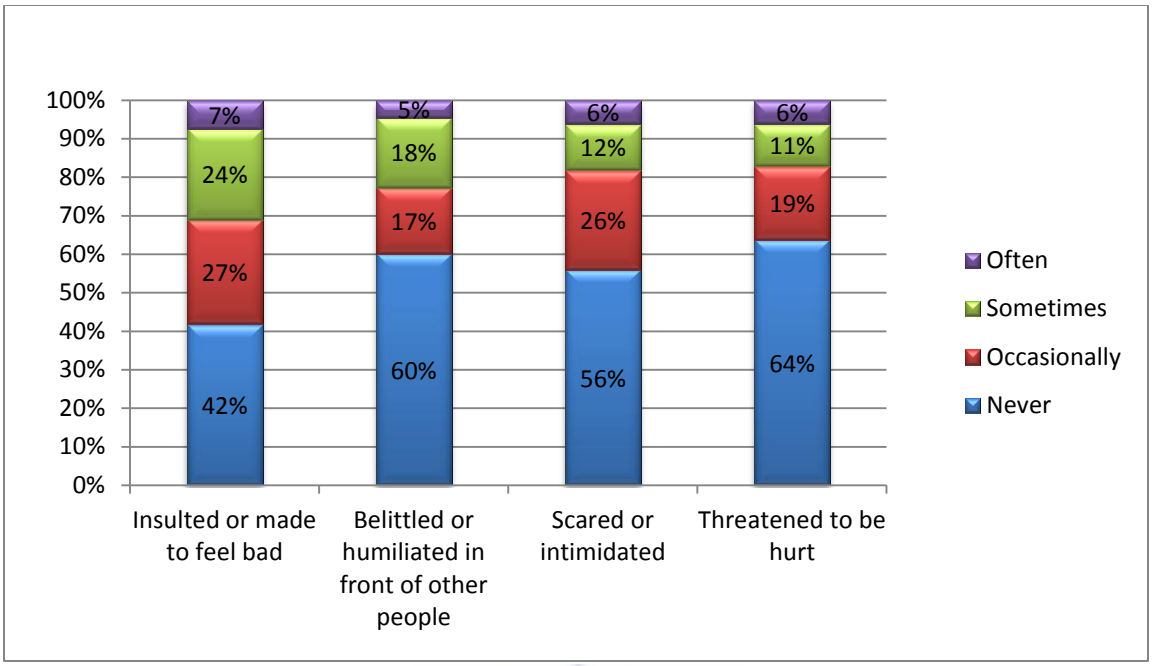

Figure 4.9: Forms of psychological abuse

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4.5.2 Physical abuse

In this section physical abuse included any sort of violent acts such as slapping, hitting, pushing, shoving, choking, burning, and threatening with a weapon that will result in physical harm. Respondents were asked to complete this section which consisted of a total of eight questions.

4.5.2.1 Frequency of physical abuse

Figure 4.10 reveals that 160 (66%) and 132 (55%) of the respondents never experienced any form of physical abuse during the previous twelve months or during their lifetime respectively. Seventeen (7%) and 35 (14%) of the respondents indicated that physical abuse occurred occasionally during the previous twelve months and during their lifetime. The results show that 55 (22%) and 66 (27%) of the respondents reported that such abuse had occurred sometimes during the previous twelve months and during their lifetime respectively. Eleven (5%) and 9

(4%) of the respondents reported that physical abuse occurred often during the previous twelve months and during their lifetime respectively (Figure 4.10).

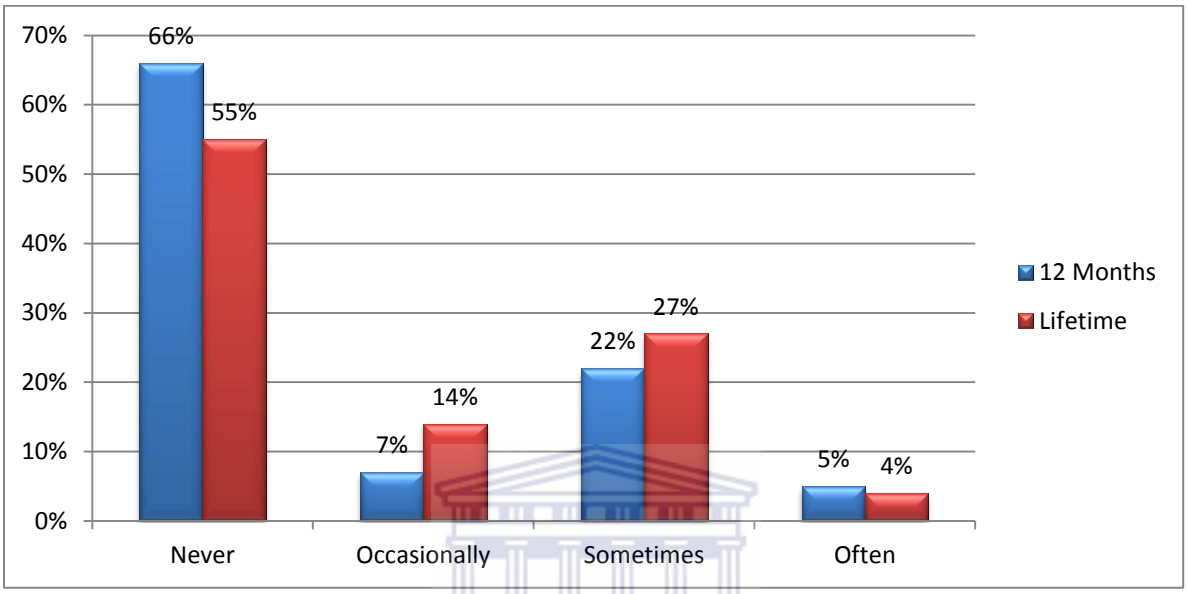

Figure 4.10: Frequency of physical abuse

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4.5.2.2 Prevalence of physical abuse

In order to draw a comparative analysis, the frequencies *occasionally*, *sometimes* and *often* were clustered and compared with the percentage of respondents who had not experienced physical abuse during the previous twelve months and never during their lifetime respectively.

In Figure 4.11, the results show that 160 (66%) and 132 (55%) of the respondents had never been physically abused during the previous twelve months and during their lifetime. Eighty-three (34%) and 111 (45%) of respondents in the study reported at least one episode where they were occasionally, sometimes and often physically abused during the previous twelve months and during their lifetime.

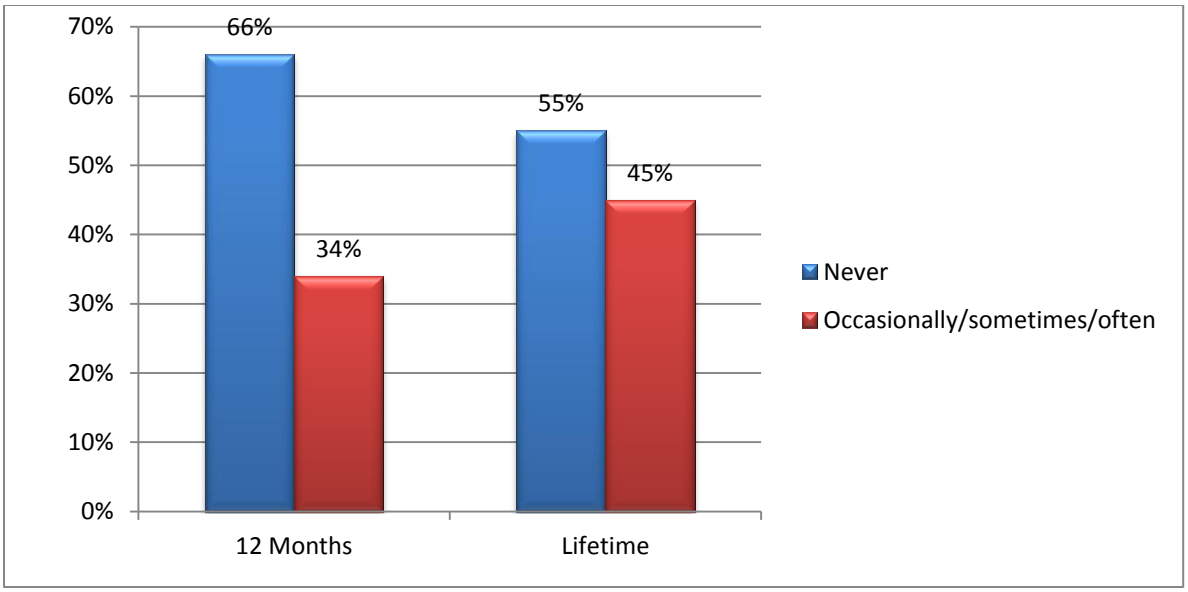

Figure 4.11: Prevalence of physical abuse

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4.5.2.3 Forms of physical abuse

Table 4.7 highlights the different forms of physical abuse which range from being hit with a fist to the more severe physical violence, which could be life threatening, such as being choked or threatened with a weapon. It is evident from Table 4.7 that 95 (39.1%) of the respondents had been slapped or thrown with something that could have hurt them. Fifty-four (22.2%) of the respondents who had experienced such violence reported that this has happened occasionally, 23 (11.5%) reported that it happened sometimes and a further 13 (5.4%) reported that this had happened often before. One hundred and fifty (61.7%) respondents indicated that they had never been pushed, shoved or had their hair pulled. From the 93 (38.3%) respondents that experienced such violence, 49 (20.2%) indicated that it happened occasionally, 33 (13.6%) reported that it happened sometimes and 11 (4.5%) reported that it happened often. Of the 71 (29.2%) respondents who had been hit with a fist, 36 (14.8%) indicated that this has happened occasionally, 19 (7.8%) indicated that it sometimes and 16 (6.6%) indicated that it happened often. The majority 187 (77%) of the respondents reported that they had never been kicked,

dragged or beaten by an intimate partner. Of the remaining 56 (23%) respondents, 29 (11.9%) reported occasionally being kicked, dragged or beaten, 19 (7.8%) sometimes and 8 (3.3%) had often been kicked, dragged or beaten. The majority , 208 (85.6%) of the respondents had never been choked or burnt on purpose with 35 (14.4%) reporting that this had happened to them. From the respondents, 35 (14.4%) who had experienced this, 15 (6.2%) reported that it had happened occasionally, 17 (7%) reported that it had happened sometimes, and 3 (1.2%) reported that it had happened often. In addition, 62 (25.5%) of the respondents had been threatened with a gun, knife or any other weapon. Of the total number of respondents, 31 (12.8%) reported that such behaviour had occurred occasionally, 22 (9.0%) reported that it had occurred sometimes, and 9 (3.7%) reported that this had occurred often.

Table 4.7: Forms of physical abuse

Variables	Categories	Frequencies	Percentages
Slapped or thrown with something that could have hurt	Never	148	60.9
	Occasionally	54	22.2
	Sometimes	28	11.5
	Often	13	5.4
Pushed, shoved or hair pulled	Never	150	61.7
	Occasionally	49	20.2
	Sometimes	33	13.6
	Often	11	4.5
Hit with a fist or something that could have hurt	Never	172	70.8
	Occasionally	36	14.8
	Sometimes	19	7.8
	Often	16	6.6
Kicked, dragged or beaten up	Never	187	77.0
	Occasionally	29	11.9
	Sometimes	19	7.8
	Often	8	3.3
Choked or burnt on purpose	Never	208	85.6
	Occasionally	15	6.2
	Sometimes	17	7.0
	Often	3	1.2
Threatened to use a weapon such as a gun, knife or other weapon	Never	181	74.5
	Occasionally	31	12.8
	Sometimes	22	9.0
	Often	9	3.7

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4.5.3 Sexual abuse

In this section, sexual abuse mean a person has engaged in a sexual activity against his or her will due to being physically forced to, threatened to do so, or intimidated. A total number of five questions were included in this part.

4.5.3.1 Frequency of sexual abuse

As seen in Figure 4.12, 186 (77%) and 168 (69%) of the respondents had not experienced any form of sexual abuse during the previous twelve months or during their lifetime respectively. From the respondents who were sexually abused, 41 (17%) and 62 (26%) reported that such abuse had occurred occasionally during the previous twelve months and during their lifetime. Twelve (5%) and 9 (4%) of the respondents indicated that sexual abuse occurred sometimes during the previous twelve months and during their lifetime, with only 4 (1%) respondents who indicated that sexual abuse occurred often during the previous twelve months and during their lifetime (Figure 4.12).

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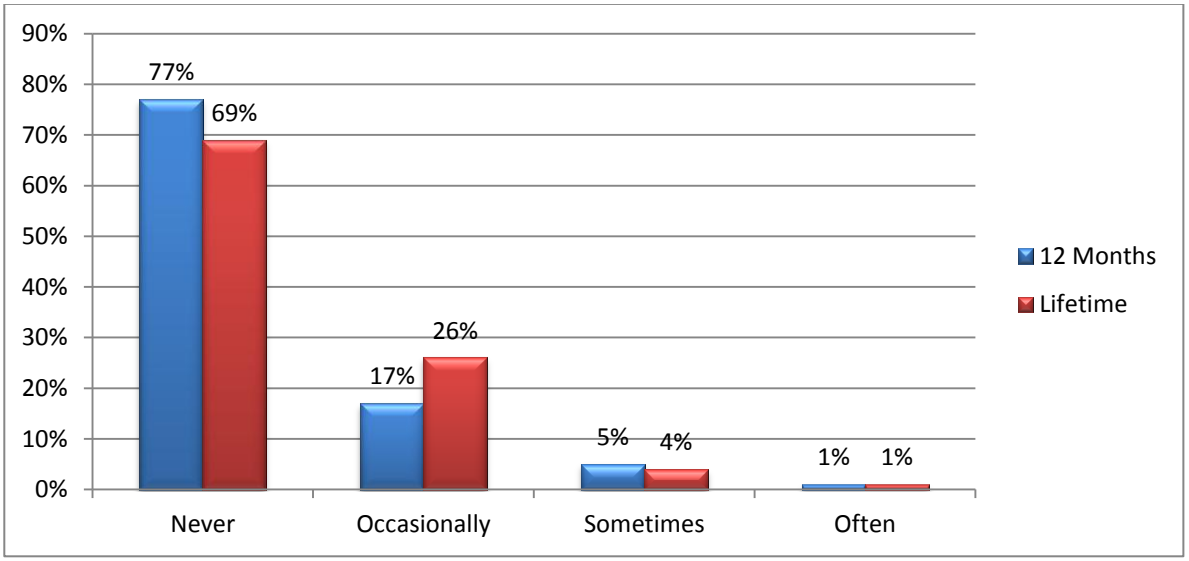

Figure 4.12: Frequency of sexual abuse

4.5.3.2 Prevalence of sexual abuse

In Figure 4.13, the frequencies *occasionally*, *sometimes* and *often* were clustered and compared with the percentage of the respondents who had not been sexually abused during the previous twelve months and during their lifetime. The results from Figure 4.13 show that 186 (77%) and 168 (69%) of the respondents were not sexually abused in the previous twelve months and during their lifetime in comparison with 57 (23%) and 75 (31%) who had experienced at least one episode of sexual abuse during the previous twelve months and during their lifetime respectively.

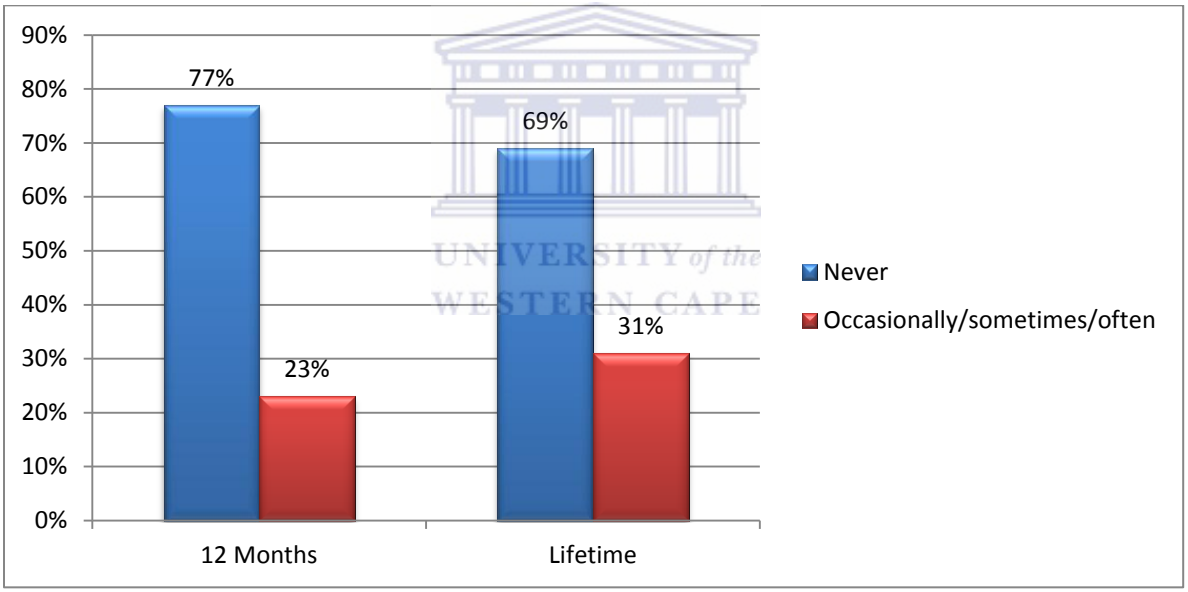

Figure 4.13: Prevalence of sexual abuse

4.5.3.3 Forms of sexual abuse

As evidenced in Figure 4.14, 57 (23%) of the respondents had been physically forced to have sexual intercourse against their will, while 36 (15%) reported that this happened occasionally and as few as 18 (7%) and 3 (1%) reported that this happened sometimes and often. Forty-six (19%) of the respondents were forced to have sexual intercourse and they were afraid of what their

intimate partner might do. Thirty-one (13%) of the respondents indicated that forced sexual intercourse happened occasionally, 13 (5%) reported that it had happened sometimes and 2 (1%) reported that it happened often. Figure 4.14 further illustrates that 46 (19%) respondents who had been forced to have sexual intercourse found this degrading or humiliating. Twenty-nine (12%) respondents reported that such abuse happened occasionally and 15 (6%) respondents reported that it had happened sometimes, with a further 2 (1%) who reported that it happened often.

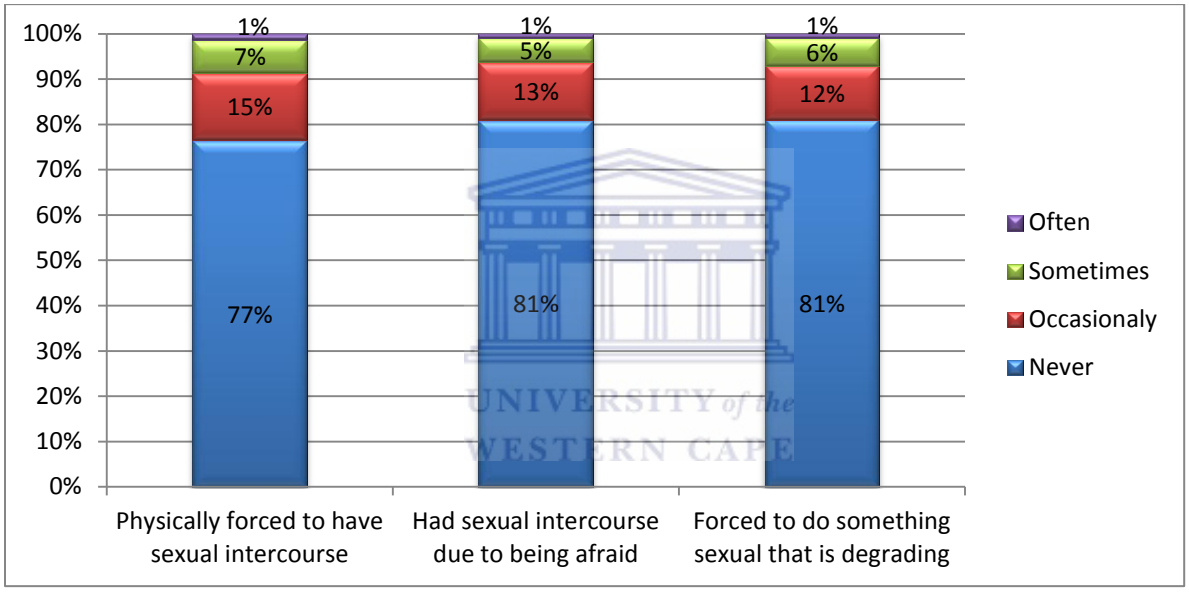

Figure 4.14: Forms of sexual abuse

4.5.4 Financial abuse

In this section, respondents had the opportunity to report on the prevalence of financial abuse. Financial abuse entailed acts of controlling behaviours and the unreasonable denial of financial resources. This section consisted of a total of nine questions.

4.5.4.1 Frequency of financial abuse

The results in Figure 4.15 illustrate that 149 (61%) and 133 (55%) respondents never experienced any form of financial abuse during the previous twelve months and during their lifetime respectively. From the respondents who were financially abused, 61 (25%) and 27 (30%) reported that such abuse had occurred occasionally during the previous twelve months and during their lifetime. Twenty three (10%) and 29 (11%) respondents indicated that financial abuse occurred sometimes during the previous twelve months and during their lifetime, and 10 (4%) respondents reported that financial abuse occurred often during the previous twelve months and during their lifetime.

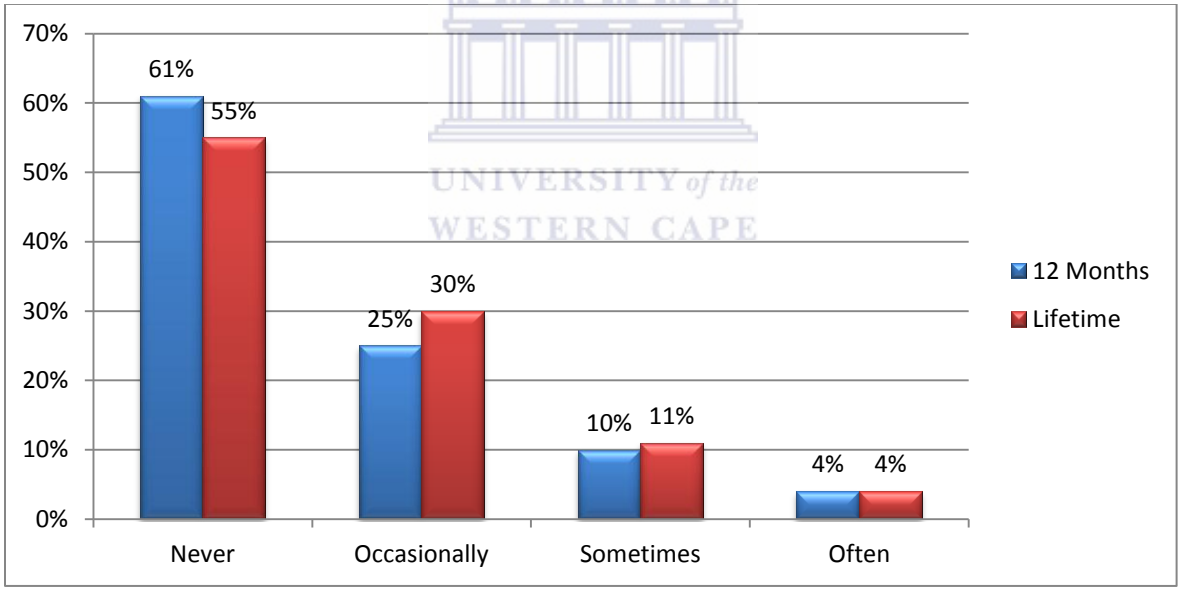

Figure 4.15: Frequency of financial abuse

4.5.4.2 Prevalence of financial abuse

In order to draw a comparative analysis, the frequencies *occasionally*, *sometimes* and *often* were clustered and compared with the percentage of respondents who did not experience financial abuse during the previous twelve months or during their lifetime respectively.

It is reported in Figure 4.16 that 149 (61%) and 133 (55%) of the respondents never experienced any form of financial abuse during the previous twelve months or during their lifetime. Ninety-four (39%) and 110 (45%) respondents reported having experienced at least one episode whereby they were either occasionally, sometimes or often financially abused during the previous twelve months and during their lifetime.

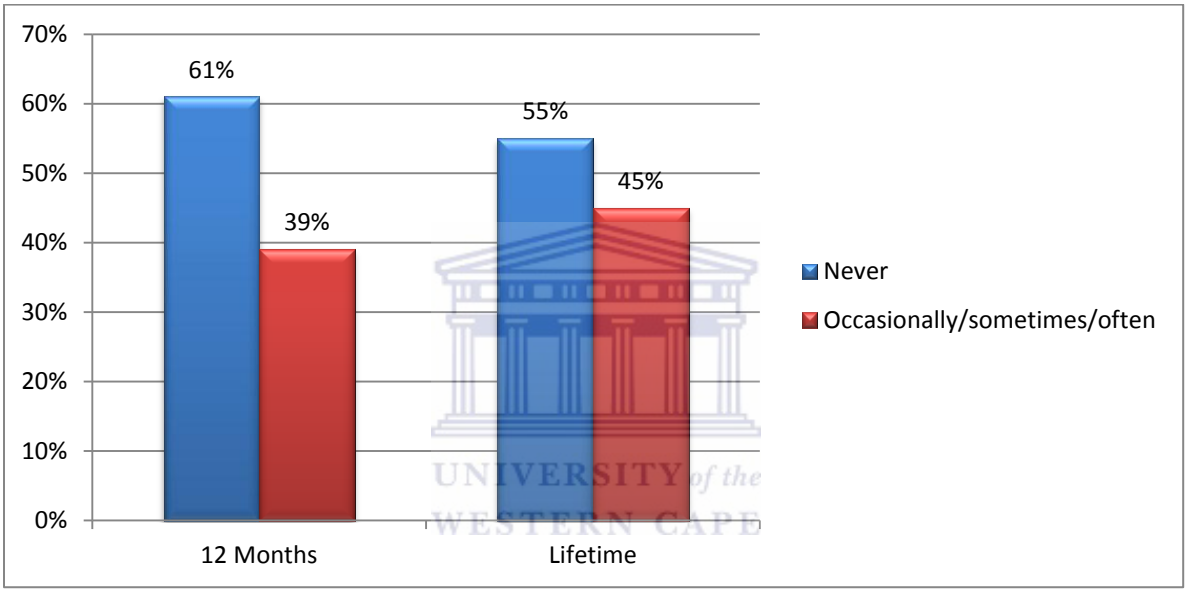

Figure 4.16 Prevalence of financial abuse

4.5.4.3 Forms of financial abuse

In this study as indicated in Figure 4.17, 83 (34%) of the respondents reported that their intimate partners took money from their purse without their consent, while 54 (22%) reported that this had happened occasionally, 19 (8%) reported that this happened sometimes and 10 (4%) reported that this happened often. Figure 4.17 further shows that 78 (32%) respondents had been prevented from knowing about or accessing family income, with 45 (19%) who reported that this happened occasionally, 23 (9%) reported that this happened sometimes and 10 (4%) reported it happened often. A total of 59 (24%) respondents had been prevented from earning an income

and from these respondents, 34 (14%) indicated that this had occurred occasionally, 16 (6%), reported that it happened sometimes and 9 (4%) indicated that it happened often. Sixty-four (26%) respondents reported that they were not paid for work undertaken as promised, with 27 (11%) who reported that this happened occasionally and a further 18 (7%) and 19 (8%) reported that this occurred sometimes and often respectively. In addition, 65 (27%) respondents indicated that they were forced to work without pay. From these respondents, 25 (10%) indicated that this happened occasionally, 21 (9%) reported that it happened sometimes and a further 19 (8%) indicated that this happened often. Twenty-three (13%) respondents were prevented from accessing income-earning resources. Of the total number of respondents, 33 (13%) reported that this happened occasionally, 12 (5%) sometimes and often. In conclusion, 77 (32%) respondents also indicated that they were forced to ask their partners for money, with 45 (19%) who reported that this happened occasionally, 17 (7%) indicated that it happened sometimes and only 15 (6%) reported that it happened often.

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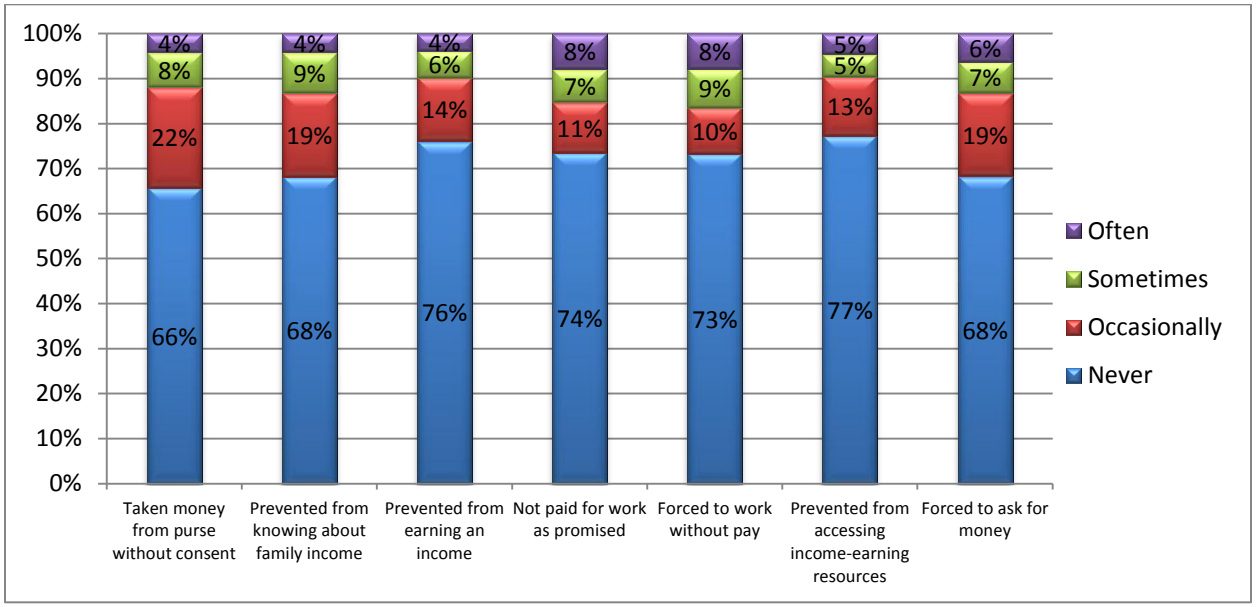

Figure 4.17: Forms of financial abuse

4.6 Overall intimate partner violence (IPV)

In this section the prevalence of the different types of IPV are summarised followed by the mean and standard deviations of the different types of IPV. The concluding part of this section provides the overall prevalence of IPV.

4.6.1 Prevalence of the different types of intimate partner violence (IPV)

As shown in Figure 4.16, 155 (51%) respondents had experienced psychological abuse, 83 (34%) reported at least one episode of physical abuse, 57 (23%) respondents were survivors of sexual abuse and 94 (39%) had experienced financial abuse during the previous twelve months.

In addition, Figure 4.16 further shows that psychological abuse was reported by 158 (65%) respondents, followed by 111 (45%) who reported physical abuse and 75 (31%) who reported sexual abuse during their lifetime. One hundred and ten (45%) respondents indicated that they had been financially abused during their lifetime.

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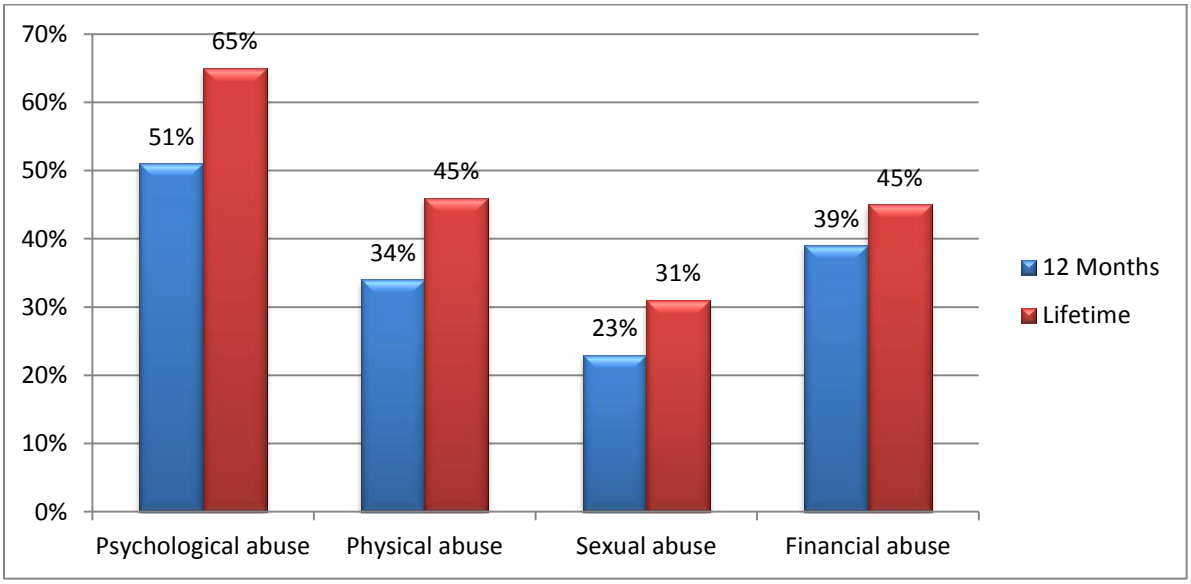

Figure 4.18: Prevalence of the different types of intimate partner violence (IPV)

4.6.2 Mean and standard deviation of intimate partner violence (IPV)

According to Table 4.8, financial abuse (mean=3.3 ≈3, SD=1.5) was the most prevalent form of IPV among the respondents, followed by physical abuse (mean=3, SD=1.3) psychological abuse (mean=2.7 ≈3, SD=1.1) and sexual abuse (mean=1.6 ≈2, SD=0.7), which was reported as the lowest among the respondents.

Table 4.8: Mean and standard deviation of intimate partner violence (IPV)

Total score	Mean	Standard deviation
Psychological abuse	2.7	1.1
Physical abuse	3	1.3
Sexual abuse	1.6	0.7
Financial abuse	3.3	1.5

4.6.3 The overall prevalence of intimate partner violence (IPV)

Figure 4.17 shows the overall prevalence rate of IPV. As illustrated in Figure 4.17, 141 (58%) respondents never experienced IPV during their lifetime while 102 (42%) respondents reported at least one episode of either psychological abuse, physical abuse, sexual abuse or financial abuse.

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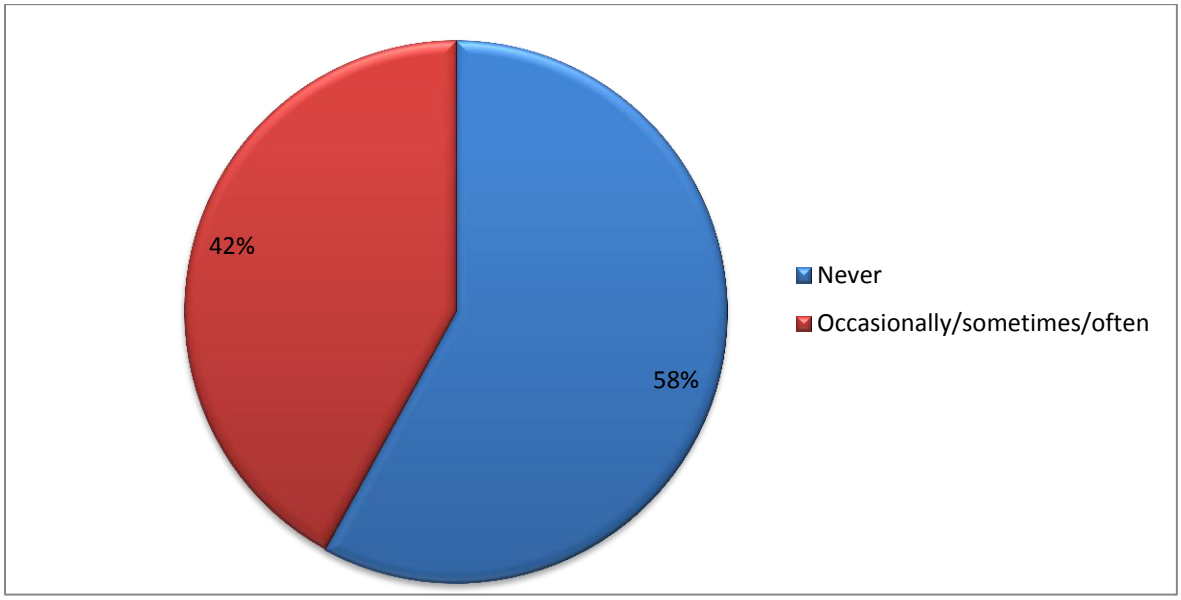

Figure 4.19: Overall prevalence of intimate partner violence (IPV)

4.7 Bivariate analysis

In the following section the bivariate analysis is discussed and an overview is provided of the Spearman's correlation.

4.7.1 Overview

This section investigates the relationship between the variables in the study. Hence, the correlation between the total scores for variables such as psychological abuse, physical abuse, sexual abuse and financial abuse are assessed and the results are presented in Table 4.8. However, as the total score of psychological abuse, physical abuse, sexual abuse and financial abuse are numerical variables, the condition of normality is investigated before Pearson's correlation or Spearman's correlation is selected. It was found that not all variables were normally distributed therefore; the Spearman's correlation was used.

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4.7.2 Spearman's correlation

According to Table 4.9, the Spearman correlation result indicates a moderate positive correlation between psychological abuse and physical abuse (r=0.583 at p=0.0005), a weak positive correlation between psychological abuse and sexual abuse (0.357 at p=0.0005), and a weak positive correlation between psychological abuse and financial abuse (r=0.466 at p=0.0005). The result also indicates a weak positive correlation between physical abuse and sexual abuse (r=0.437 at p=0.0005), and a moderate positive correlation between physical abuse and financial abuse (r=0.527 at p=0.0005). In conclusion, a moderate positive correlation exists between financial abuse and sexual abuse (r=0.481 at p=0.0005).

Table 4.9: Spearman's correlation

			Psychological abuse	Physical abuse	Sexual abuse	Financial abuse
Spearman's rho	Psychological abuse	Correlation coefficient	1.000	583**	.357**	.466**
		Sig (2-tailed)	.	.000	.000	.000
		N	243	243	243	243
	Physical abuse	Correlation coefficient	.583**	1.000	.437**	.523**
		Sig (2-tailed)	.000	.	.000	.000
		N	243	243	243	243
	Sexual abuse	Correlation coefficient	.357**	.437	1.000	.481**
		Sig (2-tailed)	.000	.000	.	.000
		N	243	243	243	243
	Financial abuse	Correlation coefficient	.466**	.523**	.481**	1.000
		Sig (2-tailed)	.000	.000	.000	.
		N	243	243	243	243

****Correlation is significant at the 0.01 level (2-tailed)**

4.8 Multivariate analysis

The following section describes the multivariate analysis by providing an overview of the Mann-Whitney U test and Kruskal-Wallis test.

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4.8.1 Overview

Multivariate analysis is used essentially to examine the difference of the mean rank of dependent variables. The dependent variables are the total score of psychological abuse, physical abuse, sexual abuse, financial abuse and the overall mean score of IPV. The independent variables include the socio-demographic characteristics such as age, gender, year level of study, ethnic origin, religion, marital status, number of children, residence, partner information, and family history information includes the marital status and educational status of parents, perceived income level, witness of parental violence as a child and substance use. Two main tests were used, namely the Mann-Whitney U test (when the independent variable has two categories) and the Kruskal-Wallis test (when the independent variable has more than two categories).

4.8.2 The Mann-Whitney U test

Table 4.10 presents the results from Mann-Whitney U test. This test allowed the researcher to investigate to which extent gender predicts psychological, physical, sexual and financial abuse. The investigation intended to check whether the p-value was less than 0.05 and then had to pick up the highest mean rank between males and females.

The results in Table 4.10 show that gender does not predict psychological abuse, physical abuse and financial abuse because the respective p-values were 0.149; 0.942 and 0.820 and the p-values were greater than 0.05. That means that there was no statistically significance at the level of 5%. However, Table 4.10 shows that sexual abuse had p=0.001, which was less than 0.05. This indicates that gender predicts sexual abuse and it is statistically significant at a level of 5%.

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Table 4.10: Gender and intimate partner violence (IPV)

Variables	Mean rank Psychological abuse	Mean rank Physical abuse	Mean rank Sexual abuse	Mean rank Financial abuse
Gender				
Male	111.16	121.48	101.22	120.39
Female	125.79	122.18	129.27	122.56
Tests				
Mann-Whitney U	4987.000	5637.500	4361.000	5568.500
Z	-1.443	-0.72	-3.256	0.228
p-value	0.149	0.942	0.001	0.820

4.8.3 The Kruskal-Wallis test

The following section presents the results from the Kruskal-Wallis test. This test allowed the researcher to investigate the demographic, family history and substance use factors that predict IPV. The investigation consisted of checking whether the p-value was less than 0.05 and then picking up the highest mean rank between these independent variables.

4.8.3.1 Socio-demographic factors and intimate partner violence (IPV)

The results in Table 4.11 indicate that IPV was significantly associated with age (p=0.009*). The highest mean rank for IPV was among the age group 35 to 44 and the lowest mean rank among the respondents within the age group 18 to 24. Table 4.11 also illustrates that study year level (p=0.001*) was significantly related to IPV. An inspection of the mean rank for the group suggests that for IPV, the highest mean rank was among the 4th-year respondents and the lowest mean rank among the 1st-year respondents. Similarly, the results in Table 4.11 indicate that marital status (p=0.021*) was also significantly associated with IPV. Respondents who had been separated were more likely to have experienced IPV. Conversely, respondents who were single were less likely to have experienced IPV.

Table 4.11 further shows that the number of children (p=0.077), ethnic origin (p=0.843), religion (p=0.611), current place of residence (p=0.610), people residing with the respondent (p=0.289), educational status of partner (p=0.546), employment status of partner (p=0.159) and monthly income (0.744) were not statistically significant because the p-values were more than 5%, therefore not associated with IPV (Table 4.11).

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Table 4.11 Socio-demographic factors and intimate partner violence (IPV)

VARIABLES							TESTS		
							Chi-square	df	p-value
Age									
	18–24	**25–34**	**35–44**	**45–54**					
Mean score IPV	113.54	125.84	159.95	115.95			11.685	3	**0.009***
Study year level									
	1st year	**2nd year**	**3rd year**	**4th year**					
Mean score IPV	112.93	112.47	131.65	147.13			11.364	3	**0.001***
Marital status									
	Single	**Married**	**Cohabiting**	**Separated**	**Divorced**				
Mean score IPV	116.01	133.67	169.44	179.67	139.75		11.532	4	**0.021***
Ethnic origin									
	Black	**Coloured**	**White**						
Mean score IPV	120.83	125.04	115.97				0.342	2	0.843
Religion									
	Christian	**Muslim**							
Mean score IPV	116.46	107.67					0.259	1	0.611
Number of children									
	None	**One**	**Two and >**						
Mean score IPV	114.79	135.32	123.27				5.120	2	0.077
Current place of residence									
	University	**Home**	**Private**						
Mean score IPV	116.93	121.09	129.05				0.988	2	0.610
People residing with respondent									
	Alone	**Family**	**Partner**	**Other**					
Mean score IPV	120.71	114.68	136.68	119.17			3.760	3	0.289
Educational status of partner									
	No formal	**Primary**	**Secondary**	**Tertiary**					
Mean score IPV	103.00	125.61	120.90	113.53			2.128	3	0.546
Employment status of partner									
	Unemployed	**Employed**	**Student**	**Other**					
Mean score IPV	102.70	125.32	116.65	102.67			5.186	3	0.159
Monthly income									
	<R 2000	**R2 000–R2 999**	**R3000–R3 999**	**R4000–R4999**	**R5 000–R5999**	**>R6 000**			
Mean score IPV	112.76	118.39	121.84	98.95	132.03	114.22	2.716	5	0.744

*: significant at level 0.05

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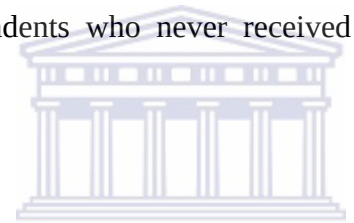
4.8.3.2 Family history factors and intimate partner violence (IPV)

The results in Table 4.12 indicate that IPV was significantly associated with the respondents' mothers' educational status (p=0.005*). The highest mean rank for IPV was among the respondents whose mothers' educational status was unknown and the lowest mean rank among respondents whose mothers had at least obtained some form of secondary education.

Table 4.12 further shows that financial support according to need (p=0.031*) was significantly associated with IPV. The results in this table show that the lowest mean rank of IPV was among respondents who often received financial support according to their need, and the highest mean rank for IPV was among respondents who never received any financial support from their families.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According to the results of the study displayed in Table 4.12, the witnessing of abuse (p=0.008*) during childhood was also a family history factor that was significantly associated with IPV. Respondents who never witnessed abuse as a child had the lowest mean rank score of IPV while respondents who reported to have often witnessed abuse as a child had the highest mean rank total score of IPV.

Marital status of parents (p=0.547), respondent's father's educational status (p=0.380), visiting of family members (p=0.700), family support during need (p=0.523), family income status (p=0.396) and control by the family (p=0.717) was not statistically significant because the p-values were more than 5%, therefore not associated with IPV (Table 4.12).

Table 4.12 Family history factors and intimate partner violence (IPV)

VARIABLES							TESTS		
							Chi-square	df	p-value
Marital status of parents									
	Married	**Divorced**	**Live together**	**Separated**	**Widow**	**Widower**			
Mean score IPV	117.93	136.50	144.71	109.25	113.34	118.73	4.017	5	0.547
Father's educational status									
	No formal	**Gr. 1–8**	**Gr.9–12**	**>Grade 12**	**Don't know**				
Mean score IPV	125.89	103.61	115.43.	117.62	127.46		4.195	4	0.380
Mother's educational status									
	No formal	**Gr. 1–8**	**Gr.9–12**	**>Grade 12**	**Don't know**				
Mean score IPV	129.20	123.21	99.99	125.84	150.50		15.099	4	**0.005***
Visiting family members									
	Never	**Occasionally**	**Sometimes**	**Often**					
Mean score IPV	110.89	125.03	116.03	124.22			1.422	3	0.700
Family support during need									
	Never	**Occasionally**	**Sometimes**	**Often**					
Mean score IPV	129.88	132.73	119.06	116.39			2.247	3	0.523
Financial support according to need									
	Never	**Occasionally**	**Sometimes**	**Often**					
Mean score IPV	136.66	111.07	116.73	107.44			8.863	3	**0.031***
Family income status									
	Better off	**Poor**	**Average**	**Very good**					
Mean score IPV	104.50	113.78	126.58	119.66			2.970	3	0.396
Control by family									
	Tight	**Average**	**Loose/Free**						
Mean score IPV	79.88	75.87	82.56				0.666	2	0.717
Witnessing abuse as a child									
	Never	**Occasionally**	**Sometimes**	**Often**					
Mean score IPV	114.30	117.65	132.92	160.70			11.744	3	**0.008***

***: significant at level 0.05**

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4.8.3.3 Substance use factors and intimate partner violence (IPV)

As indicated in Table 4.13, the results from the study showed no association between being drunk in the current academic year (p=0.188) and IPV.

Furthermore, Table 4.13 also shows that dagga smoking (p=0.004*), cigarette smoking (p=0.000*), alcohol use in their lifetime (p=0.000*), alcohol use since joining the university (p=0.000*) and respondents who had male or female friends who drink (p=0.000*) were the factors significantly associated with IPV.

Among the respondents, those who often smoked dagga or cigarettes, had been drunk in their lifetime, who had often been drunk since joining this university and who had male and female friends who drink recorded the highest mean rank total score for IPV. On the other hand, respondents who never smoked dagga or cigarettes, who had never been drunk in their lifetime, who had never been drunk since joining this university and who did not have male and female friends who drink had the lowest total mean rank score for IPV (Table 4.13).

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Table 4.13 Substance use factors and intimate partner violence (IPV)

VARIABLES					TESTS		
					Chi-square	df	p-value
Dagga smoking							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	111.95	143.07	142.88	156.20	13.246	3	**0.004***
Cigarette smoking							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	109.02	125.05	143.44	156.02	17.897	3	**0.000***
Ever been drunk in your lifetime							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	108.36	112.92	143.26	167.76	22.563	3	**0.000***
Ever been drunk since joining this university							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	108.36	121.92	145.26	167.76	22.563	3	**0.000***
Ever been drunk in the current academic year							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	111.49	122.59	118.67	136.02	4.793	3	0.188
Have male or female friends who drink							
	Never	**Occasionally**	**Sometimes**	**Often**			
Mean score IPV	113.08	146.62	182.50	197.89	25.179	3	**0.000***

***: significant at level 0.05**

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4.9 Conclusion

This chapter highlighted the findings of this research study. At first, the descriptive results were illustrated. This was followed by the bivariate analysis using Spearman's correlation to test the relationship between the dependent variables. In conclusion, the multivariate analysis was used to examine the difference in mean rank of the dependent variables. The findings of the study were presented according the items on the questionnaire.

In the next chapter, the interpretation of data is presented, along with an in-depth discussion of each of the objectives of the study**.**

CHAPTER 5

DISCUSSION

5.1 Introduction

In this chapter, the main findings of the study are discussed and compared with previous studies conducted among students attending tertiary institutions across the globe. In addition, the results are also compared with studies done among the general population and among women attending health care facilities. The reason for doing a comparative analysis in terms of the aforementioned studies is the limited number of previous studies done on IPV among undergraduate student nurses.

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5.2 Discussion

In the following section, the results of the study are discussed according to each of the objectives of the study. The majority of the studies discussed in this section were presented in the literature review (Chapter 2).

5.2.1 Prevalence of IPV among undergraduate student nurses

The first objective of the study was to determine the prevalence of IPV among undergraduate student nurses at a tertiary institution in the Western Cape. In this study, IPV was broadly addressed in terms of psychological, physical, sexual, and financial abuse perpetrated by spouses or intimate partners. In this sense, reference to intimate partners included any of the following: husbands and wives, boyfriends and girlfriends, same-sex partners, current and former spouses.

Psychological abuse is one of the most common forms of IPV, and in previous research (Kramer *et al*., 2004; Iliyasu *et al.,* 2011) has been found to predict physical violence. The results of the current study revealed that 51% and 65% of the undergraduate student nurses experienced at least one episode of psychological abuse during the previous twelve months and during their lifetime respectively, which made them prone to future physical violence. The high number of the undergraduate student nurses who had experienced psychological abuse in the current study matched the findings of a study conducted in Russia among male and female university students (Lysova & Douglas, 2008). The findings from the Russian study revealed that 61.6% of the students taking part in the study reported being survivors of psychological abuse perpetrated by an intimate partner (Lysova & Douglas, 2008). Interestingly, the rate of psychological victimisation in the Russian study was 56.5% among males and 66.7% among females. Conversely, 48.9% of males and 74.2% of females were the perpetrators of psychological abuse within an intimate relationship.

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The prevalence rate of psychological abuse in the current study was higher among undergraduate student nurses in comparison with women attending health care facilities in the USA (Kramer *et al*., 2004). The findings from the USA study showed that 28% of women reported at least one episode of psychological abuse during the lifetime. The lower prevalence rate in the USA study could be due to a variety of reasons, which include the settings, in which this study was conducted, the population understudy which only included women who have attended health care facilities and the ability of the women to recall previous episodes of psychological abuse (Ellsberg & Heise, 2005).

The results of the current study were lower than the findings from a recent South African qualitative study conducted among women attending five health care facilities in the Western Cape (Joyner & Mash, 2012). The results from the study showed that 82.7% of women were survivors of psychological abuse (Joyner & Mash, 2012). The possible reason for the higher prevalence rate in this case, might be due to research methodology which focused on an in-depth enquiry on the experiences of psychological abuse among these women.

In the current study, physical abuse was defined according to the acts which included being slapped, thrown with something that could hurt, shoved, hair pulling, hit with a fist, being kicked, dragged, beaten up, choked or burnt on purpose, threatened to use or actually used a gun, knife or other weapon against the respondent. The results from the current study showed that 34% and 45% of undergraduate student nurses experienced physical abuse during the past twelve months and lifetime respectively. The results of this study are comparable with the findings by the International Dating Violence (IDV) study conducted by Straus (2004) in sixteen countries among thirty-one tertiary institutions. The results from this latter study showed that physical violence perpetrated by a dating partner in the previous year before the study was conducted ranged from 17% to 45% (Straus, 2004). Compared to the IDV study, the results of the current study showed lower rates than those reported for the USA (44.7%), Mexico (42.0%) and India (39.0%) (Straus, 2004). However the results of the current study showed higher rates than those reported for Germany (24.5%), Canada (23.0%) and Australia (21.3%) in the IDV study (Straus, 2004). The possible reasons for the lower results on dating violence in Germany, Canada and Australia might be due to the local context in which these studies were conducted. Lysova and Douglas (2008) acknowledge that well-developed Western countries such as Germany, Greece

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and Switzerland have fairly low intimate femicide rates; thus, lower overall IPV prevalence rates in comparison with developing countries such as South Africa (SA), which has highest femicide rates across the globe. In SA, "every six hours a woman is killed by her intimate partner" (Mathews *et al*., 2004:1). It would thus be expected that SA would also have much higher IPV prevalence rates due to an oppressive patriarchal system and a history of apartheid which can be considered as fertile ground for the perpetration of IPV (Jewkes, 2002).

The results of the current study could also be comparable with a study conducted in Ethiopia (Gebreyohannes, 2007), which showed that 46.3% of female students experienced physical violence during their lifetime and 26.4% during the 2007 academic year. The prevalence rate of physical violence during the respondents' lifetime is identical with that of the current study; however, the twelve month prevalence rate in the current study is higher than that of the study conducted in Ethiopia. The findings of the Ethiopian study are controversial because it would be expected that the rates of physical abuse might be higher. The reason for this higher victimisation of physical violence might be due to the fact that the Ethiopian study focused on GBV which includes violence perpetrated by other individuals including intimate male partners. However, the reason for this lower physical violence victimisation in the 2007 academic year might be possible due to the sample inclusion in the study which focused on females only, but could also be due to underreporting (Gebreyohannes, 2007).

Sexual abuse in the current study among undergraduate student nurses was recorded as 23% in the twelve months before the study was conducted and 31% during the respondents' lifetime. Almost identical findings were reported in a study conducted among college students in Chile

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where 31% of the female students reported that they had experienced some form of sexual abuse since age 14, while 17% reported that they were sexually abused in the twelve months before the study (Lehrer *et al.*, 2007).

The results of the present study are also comparable with a study by Sobti and Biwas (2008) among medical students in India. According to the results of this study, 32.1% of medical students have reported at least one episode of sexual abuse during their lifetime. The rates reported in the current study are lower than the prevalence rate reported by Gebreyohannes (2007) in Ethiopia, but higher than the prevalence rate reported by Lysova and Douglas (2008) for Russia and Krebs *et al*. (2011) for the US.

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In terms of the results from the international World Health Organisation (WHO) study in ten countries, the rate of sexual abuse in the current study is comparable with results from the United Republic of Tanzania, which revealed that 18.3% and 30.7% of survivors experienced sexual abuse during the previous twelve months and during their lifetime respectively (Garcia-Moreno *et al*., 2005). The results of the current study show lower rates than the prevalence rate of sexual abuse reported in Bangladesh, Ethiopia and Peru but higher than the prevalence rate of sexual abuse reported in Brazil, Japan and Namibia (Garcia-Moreno *et al*., 2005).

The current study revealed a high lifetime and twelve month prevalence of sexual abuse among undergraduate student nurses; however, the rate of sexual abuse might be even higher still because survivors of this type of violence are not eager to report the abuse. The reason for the underreporting of such violence is based on the personal views about sexual abuse, which is seen

as a confidential matter. Survivors of sexual abuse are therefore not eager to report such violence to the appropriate authorities (Jewkes & Abrahams, 2002).

According to the literature reviewed, there is a paucity of reliable statistics on the prevalence of financial abuse among students attending tertiary institutions and among the general population. The majority of the studies conducted on IPV only include the forms of sexual abuse, psychological abuse and physical abuse (Fawole, 2008). In order the fill the gap, the current study included questions on financial abuse. Financial abuse in this study was defined as acts which include –

- the taking of money from the respondent's purse without consent;
- being prevented from knowing about or accessing family income and from earning an income;
- not being paid for work undertaken as promised;
- being forced to work without pay;
- being prevented from accessing income-earning resources; and
- being forced to asked a partner for money.

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The prevalence of financial abuse was determined by measuring any act of such abuse during the previous twelve months and during their lifetime respectively.

The results of the current study showed that 39% and 45% of the undergraduate student nurses experienced some form of financial abuse during the previous twelve months and during their lifetime respectively. The results of the current study are higher than those from a national study

conducted in Malawi, which showed that 28% of females were financially abused by their male intimate partners (Pelser *et al*., 2005).

In a study conducted among women attending antenatal health care facilities in Soweto, 13.7% of women reported being survivors of financial abuse during their lifetime (Dunkle *et al*., 2003). The rates of financial abuse among women attending antenatal health care facilities were lower than the rates of the current study. The possible reason for the lower prevalence rate of financial abuse among women attending antenatal health care facilities might be due to the setting in which the study was conducted and possibly due to the inclusion criteria which included pregnant women only.

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The high prevalence of financial abuse among undergraduate student nurses might be due to the fact that these students receive financial assistance in the form of a bursary from the Provincial Administration of the Western Cape. The majority of these students come from poor backgrounds and do not have the necessary financial ability to finance their own studies. This is one of the possible reasons that provide fruitful ground for financial abuse perpetrated by intimate partners among undergraduate student nurses in the Western Cape.

The overall prevalence of IPV in the current study accounted for 42% of abuse among undergraduate student nurses during their lifetime. The findings of the current study are comparably lower than a study conducted in Botswana among women attending a public hospital (Zungu *et al*., 2010). According to the Botswana study, 49.7% of women experienced IPV during their lifetime (Zungu *et al*., 2010). Similarly, in a community-based study conducted in

Malawi, the overall prevalence of IPV accounted for 48% among women during their lifetime (Pelser *et al.,* 2005). The results of IPV in the current study are lower possibly due to the fact that this study is conducted among undergraduate student nurses attending a tertiary institution.

5.2.2 Factors associated with IPV among undergraduate student nurses

The second objective of the study was to identify the factors associated with IPV among undergraduate student nurses at a tertiary institution in the Western Cape. This objective was divided into three sections, namely demographic, family history and substance use factors. Each of these factors is discussed and compared with the findings of other studies that have found similar results to those of the current study.

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5.2.2.1 Socio-demographic factors

The results of the current study showed that IPV were significantly associated with age (p=0.009*). The findings of the current study correspond with earlier research studies that have showed a significant relationship between age and IPV (Jewkes, 2002; Jewkes *et al*., 2002; Krug *et al*., 2002; Ellsberg & Heise, 2005; Arnold *et al*., 2008; Iliyasu *et al*., 2011; Zungu *et al*., 2010). Although the aforementioned studies (Jewkes, 2002; Jewkes *et al*., 2002; Krug *et al*., 2002; Ellsberg & Heise, 2005; Arnold *et al*., 2008; Iliyasu *et al*., 2011; Zungu *et al*., 2010) suggest that survivors of IPV are usually young, the findings in the current study show that undergraduate student nurses within the age group 35 to 44 years experienced much higher levels of IPV than other age groups. The possible reason for the lower abuse rates particularly within the age group 18 to 24 years might be the fact that the majority of the undergraduate student nurses were

relatively young and still living at home with their families although they were in dating relationships (Tables 4.2, 4.3 and 4.4).

In the current study, marital status (p=0.021*) was also significantly associated with IPV. According to the results of the current study, respondents who were separated were more likely to have experienced IPV. Conversely, respondents who were single were less likely to have experienced IPV (Table 4.11). The findings of the present study are consistent with the findings of Zungu *et al*. (2010) who found a strong association between marital status and IPV. According to their findings, the highest occurrence of abuse was among the divorced, cohabiting partners and married participants, and the lowest prevalence among single and widowed participants. Similarly, Jewkes (2002) asserts that IPV is most prevalent in separated and divorced women. The reason for this assertion might be the fact that these women openly admitted to IPV only after they had left the abusive relationship (Krug *et al*., 2002). On the contrary, women who are still are in an abusive relationship might be scared to report IPV out of fear for what their partners might do. Instilling fear is only one of the tactics that the perpetrators might use to prevent women from reporting IPV to the appropriate authorities (Jewkes & Abrahams, 2002).

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The current study found that IPV was significantly associated with year level of study (p=0.001*). The fourth-year undergraduate student nurses had the highest meant rank total score of IPV in comparison with the lowest mean rank total score of IPV recorded among second-year undergraduate student nurses (Table 4.11). Previous research studies suggested that IPV is most prevalent among the least educated survivors (Jewkes, 2002; Jewkes *et al*., 2002; Krug *et al*.,

2002; Ellsberg & Heise, 2005; Arnold *et al*., 2008; Iliyasu *et al*., 2011; Zungu *et al*., 2010). The findings of the current study are inconsistent because, according to the results of the current study, more fourth-year undergraduate student nurses reported being survivors of IPV in comparison with the second- and first-year undergraduate student nurses. The reason for the higher prevalence of IPV among the fourth-year undergraduate student nurses could possibly be the higher educational level of the females. This is further supported by Krug *et al*. (2002) who emphasised that IPV is usually the highest when females start to become more educated leading to their social and thus financial independence. In cases where the female partners are more educated, this could be viewed as an indirect challenge to patriarchal norms, which usually predisposes the female to violence (Garcia-Moreno *et al*, 2005; Krug *et al,* 2002). The basis for this violence could be feelings of low self-esteem, which are channelled into anger and frustration.

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In the current study, the number of children (p=0.771), ethnic origin (p=0.843), religion (p=0.611), current place of residence (p=0.610), people residing with the participant (p=0.157), educational status of partner (p=0.546), employment status of partner (p=0.096), monthly income (0.744) were not statistically significant because the p-values were more than 5%, therefore not associated with IPV (Table 4.11).

According to the results of the current study, gender (0.001*) was associated with sexual abuse. It is evident from the results (Table 4.10) that more females are sexually abused than males, which is in many respects not surprising. In this study, the majority of the undergraduate student nurses were female (Table 4.2), which confirms the assertion that nursing is predominantly a

female profession. The results of this study are consistent with the findings from a study done in Russia among female and male students (Lysova & Douglas, 2008). According to the results of this latter study, female students are more likely to be sexually abused than their male counterparts (Lysova & Douglas, 2008). Sexual abuse in SA is widespread (Jewkes & Abrahams, 2002), therefore it can be expected that such violence would infiltrate tertiary institutions. The reasons for the high rates of sexual abuse in this country can be explained against the backdrop of a highly patriarchal society and the long history of male oppression during the apartheid years (Jewkes, 2002). In the South African society, females are regarded as inferior to males who exercise control over females (Jewkes *et al*., 2002).

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5.2.2.2 Family history factors

According to the results of the current study displayed in Table 4.12, the respondents' mothers' educational status (p=0.005*), financial support during need (p=0.031*) and witnessing of abuse (p=0.008*) during childhood were the family history factors significantly associated with IPV. The results in Table 4.12 show that the highest mean rank for IPV was that among the respondents whose mothers' educational status was unknown, and the lowest mean rank among the respondents whose mothers had at least obtained some form of secondary education. Respondents who never received financial support and who had never witnessed abuse as a child had the lowest mean rank score of IPV in comparison with respondents who often received financial support, who reported often witnessing abuse as a child and who also had the highest mean rank total score of IPV.

The association between IPV and financial support during need can be explained against the low socio-economic status of people in SA. This result of the study is consistent with the findings of Jewkes *et al*. (2002). SA is one of sixty-three countries with the worst income inequality and the highest level of unemployment (Jewkes *et al*., 2009). In the Western Cape, undergraduate student nurses are full-time students and they annually receive a bursary from the NDoH to finance their studies. By implication these undergraduate student nurses are prone to IPV due to their financial dependence from their intimate partner.

The association between IPV and the witnessing of abuse as a child is based on the social learning behaviour of a child and the normative use of violence within the SA context. An explanation put forward is that when women are abused in childhood they learn subordination to males and experiencing violence as part of being women (Jewkes, 2002; Abrahams & Jewkes, 2005). It can thus be concluded that women learn to tolerate aggressive behaviour within the society due to their unequal position and view this assertion as normal.

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Marital status of parents (p=0.547), the respondents' fathers' educational status (p=0.380), visiting of family members (p=0.700), family support during need (p=0.523), family income status (p=0.396) and control by the family (p=0.717) were not statistically significant because the p-values were more than 5% therefore not associated with IPV (Table 4.12).

5.2.2.3 Substance use history

In this study, as shown in Table 4.13, certain substance use factors such as dagga smoking (p=0.004*), cigarette smoking (p=0.000*), alcohol use in their lifetime (p=0.000*), alcohol use

since joining the university (p=0.000*) and having male or female friends who drink (p=0.000*) were significantly associated with IPV. Among the respondents, those who often smoked dagga or cigarettes, and who had often been drunk since joining this university recorded the highest mean rank total score for IPV, while respondents who never smoked dagga or cigarettes and who had never been drunk since joining this university had the lowest total mean rank score for IPV (Table 4.13).

This finding is consistent with studies done in Ethiopia (Gebreyohannes, 2007), Botswana (Zungu *et al*., 2010) and SA (Jewkes, 2002). According to the results of these studies, alcohol consumption was one of the main reasons for the perpetration of IPV by a male partner. Furthermore, it was also found that women who reported overusing alcohol were more likely than women who do not consume any alcohol to be the victim of IPV. Abrahams *et al*. (2006) assert that when both male and female intimate partners are consuming alcohol, it is usually the male who is prone to engage in physical abuse towards the female counterpart. In the US, Sharps *et al*. (2003) examined patterns of alcohol and drug use in the murder of women by their intimate partners. The results from this study showed that 80% of males who committed femicide were problem drinkers in the year before the incident; therefore, a significant relationship between femicide and alcohol use was reported (Sharps *et al*., 2003). The reason for this violence was due to intoxication and impaired judgment of the perpetrators (Weich in Baumann, 2007).

In addition, in the current study, alcohol use, dagga and cigarette smoking by the undergraduate student nurses can be viewed as a result of the IPV. According to Krug *et al*. (2002), dagga, cigarette smoking and alcohol use is part of the negative behavioural consequences of IPV.

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The results from the study, according Table 4.13, showed no statistically significant relationship between IPV and alcohol use in the current academic year (p=0.188) because the p-values were more than 5%.

5.3. Conclusion

In Chapter 5, the main findings of the study were discussed and compared with previous studies conducted among students attending tertiary institutions across the globe. In addition, the results were also compared with studies done among the general population and among women who attended health care facilities. The results of the current study were discussed according to each of the objectives of the study.

The next chapter outlines the conclusion, summary and recommendations of the study.

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CHAPTER 6

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

In Chapter 1, the researcher described the background, rationale and problem statement for the study. The researcher also established the research aim, objectives and operational definitions of the study. In Chapter 2, the reviewed literature was explored, which included the global perspective of violence, the definition of IPV, factors that contribute to IPV and prevalence of IPV among students of tertiary institutions. The concluding part of this literature review focused on the consequences of IPV relative to health and the role of health care providers was summarised. Chapter 3 outlined the research methodology of the study in detail. The research methodology was discussed in terms of the research setting, research design, population, sampling, data collection, data analysis and ethical considerations. The research design utilised allowed the researcher to achieve the aim and objectives of the current study. In Chapter 4, the research findings of the study were presented, followed by a detailed discussion of the study findings showing that the objectives of the study were met in Chapter 5. The current chapter provides a summary and conclusion of the mini-thesis. The fundamental findings are highlighted and recommendations made from the study are provided at the end of the chapter.

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6.2 Summary

The aim of the study was to determine the prevalence and factors associated with IPV among the undergraduate nursing student population at a tertiary institution in the Western Cape. The specific objectives of the study were:

I. to determine the prevalence of IPV (psychological, physical, sexual and financial abuse) among undergraduate student nurses at a tertiary institution in the Western Cape; and

II. to identify the socio-demographic, family history and substance use factors associated with IPV among undergraduate student nurses at the research institution.

A quantitative research design, through the use of a descriptive research approach, was followed to conduct the study. The population of the study included all the undergraduate student nurses registered for the four-year nursing programme at a tertiary institution in the Western Cape, Cape Town. This implies that all undergraduate student nurses from first- to fourth-year level who have registered for the 2012 academic year formed the population of this study. Printed class lists and timetables from the different year levels (1^{st}, 2^{nd}, 3^{rd} and 4^{th}) were obtained from the respective coordinators of each year level. The different study year levels were used as a stratum, followed by systematic random selection of the respondents until the required sample size was reached. The respondents who formed part of the study completed a questionnaire.

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A self-administered questionnaire was used to collect the data. The majority of the questions were Likert-type by nature with close-ended questions. There were a total of 54 questions on the questionnaire. The respondents completed the questionnaire in less than thirty minutes. A pilot study was done before the main study on a total of forty undergraduate student nurses. These respondents were recruited in the similar manner as those for the main study. The reasons for conducting a pilot study was to address possible problems with the questionnaire such as confusing statements or language difficulties, to enhance the validity, reliability and to clarify or

avoid any misconceptions. The respondents who took part in the pilot study were excluded from the main study.

In terms of determining the reliability of the research instrument, a statistician was consulted to measure the Cronbach's alpha co-efficient. The Cronbach's alpha co-efficient of the research instrument was 0.950, which indicated that this instrument had a high internal consistency. The data was analysed quantitatively with the assistance of a statistician. The data was entered into a Microsoft Excel spread sheet and thereafter imported into the Statistical Package for Social Sciences (SPSS) version 20. The data was then summarised and descriptive statistics were expressed in frequencies and percentages. The results were presented in the form of tables, pie chart and graphs. Spearman's correlations were used to calculate the strength of the relationship between the dependent variables. The multivariate analysis was done by using the Mann-Whitney U test and the Kruskal-Wallis test to determine the associations between the different variables.

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According to the results of the study, overall IPV accounted for 42% of violence among the undergraduate student nurses during their lifetime. Psychological abuse was experienced by 51% and 65% of undergraduate student nurses during the previous twelve months and during their lifetime respectively. The prevalence rate during the previous twelve months and during their lifetime for physical abuse was reported as 34% and 45% of undergraduate student nurses respectively. Among the undergraduate student nurses, 23% and 31% reported being sexually abused during the previous twelve months and during their lifetime respectively. Of

undergraduate student nurses, 39% and 45% reported being financially abused during the previous twelve months and during their lifetime respectively.

Furthermore, the study revealed that socio-demographic factors such as age, study year level, and marital status, were significantly associated with IPV. The study also found that family history factors like the respondents' mothers' educational status, financial support during need and witnessing of abuse as a child were factors related to IPV. In this study, certain substance use factors such as dagga and cigarette smoking, alcohol use in their lifetime and since joining university and having male or female friends who drink were significantly associated with IPV.

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6.3 Significance

The findings of the study can be used by policy makers at tertiary institutions to develop a support structure specifically for undergraduate student nurses who experience IPV. This support structure can further prepare undergraduate student nurses emotionally before commencing with their training in the management of survivors of IPV. Furthermore, since no study was available that investigated IPV among undergraduate student nurses, this study contributes to the fragmented body of knowledge by providing the latest statistics on the prevalence of IPV and the factors associated with IPV among undergraduate student nurses at a tertiary institution in the Western Cape.

6.4 Recommendations

According to the findings of the current study, overall IPV accounted for 42% of violence among undergraduate student nurses during their lifetime. Various socio-demographic, family history

and substance use factors were significantly associated with IPV among these undergraduate student nurses. Consequently, the recommendations made are based on the findings of the current study.

The researcher recommends that:

1. awareness be created on the prevalence of IPV among undergraduate student nurses in order to show the real extent of the problem. Awareness can be created in the form of interactive lectures, pamphlets and posters.
2. since nurse lecturers are also health care providers, in-service training should be provided to equip them with the necessary skills and knowledge of IPV. In this manner, these nurse lecturers at the specific tertiary institution will also be able to identify, manage and refer undergraduate student nurses who are victims of IPV during crisis.
3. undergraduate student nurses who are victims of IPV should be referred to the Campus Community Health Centre where support and counselling sessions should be provided by trained members of a multi-disciplinary team.
4. the module Gender-Based Violence (GBV) as a public health issue should be introduced as early as first year to create awareness of IPV, which will also help the undergraduate student nurses who are victims of IPV so that they can begin with a process of self-awareness and personal healing.
5. since it is required of undergraduate student nurses to identify and manage clients of IPV, onsite debriefing sessions at clinical facilities should be conducted for those who are traumatised as a result of the IPV.

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6. interdisciplinary collaboration among the different faculties at the specific tertiary institution is necessary to provide adequate, appropriate and comprehensive care to undergraduate student nurses who are victims of IPV.

6.5 Recommendations for further research

- A quantitative research study is recommended, which should include the entire undergraduate and postgraduate student population at the different tertiary institutions in order to show important similarities among this population in the diverse provinces of SA.
- Since this is the first study among undergraduate student nurses in SA, the researcher strongly recommends that this study be replicated at all tertiary institutions among undergraduate student nurses to draw a comparative analysis on the prevalence of IPV and to reinforce its results.
- A qualitative research study should be conducted in order to gain a deeper understanding on the factors that are significantly associated with IPV among undergraduate student nurses.

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6.6 Limitations of the study

All research studies have limitations. This study, which was conducted among undergraduate student nurses at a tertiary institution in the Western Cape is no exception. The most serious limitations of the study are:

- that the findings of the study cannot be generalised because the study was conducted among undergraduate student nurses at one of the tertiary institution, which prevented generalisation to the larger population;
- the findings on the prevalence of IPV in the study can only be viewed as estimates because survivors of IPV often underreport their true experience of IPV resulting in recall bias;
- the research questionnaire, which consisted of closed ended questions, did not explore in-depth experiences of IPV therefore providing only a superficial overview of the problem; and
- certain factors associated with IPV, i.e. substance use, in the study are difficult to determine because of the inability to conclude which occurred first, the substance use as a result of the IPV or the substance use prior the IPV.

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6.7 Conclusion

This was the final chapter which provided a summary and conclusion of the mini-thesis. The fundamental findings were highlighted and recommendations made from the study were provided at the end of the chapter.

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Appendix A:

Questionnaire

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QUESTIONNAIRE

Title of the research project

Intimate partner violence (IPV) among undergraduate student nurses at a tertiary institution in the Western Cape.

Definition of Intimate Partner Violence

The definition of intimate partner violence (IPV) as provided by the World Health Organization, defines IPV as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship" (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). In this study intimate partners will include husbands, wives, boyfriends, and girlfriends, current and former spouses.

Instructions

The questionnaire is divided into four (4) sections namely demographic information, family history, substance use and IPV. Please try to answer all sections of the questionnaire. Please answer all relevant questions by marking the most appropriate answer with an "X".

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Please note the following response keys:

a) Never - means 0 times

b) Occasionally - means 1 to 2 times

c) Sometimes - means 3 to 5 times

d) Often - means more than 5 times

SECTION 1: DEMOGRAPHIC INFORMATION

Please kindly complete your demographic details before answering the questionnaire.

	Questions		
1.1	What is your date of birth?	…….	
1.2	What is your age group?	**1**=18-24	**2**=25-34
		3=35-44	**4**=45-54
		5=55-64	**6**=65 and above
1.3	What is your gender?	**1**=Male	**2**=Female
1.4	What is your year level of study?	**1**=First (1st) year	**2**=Second (2nd) year
		3=Third (3rd) year	**4**=Fourth (4th) year
1.5	What is your ethnic origin?	**1**=Black	**2**=Colored
		3=White	**4**=Indian
		5=Other (specify)……..	
1.6	What is your religion?	**1**=Christian	**2**=Muslim
		3=Hindu	**4**=Buddhist
		5=Ancestors spirits	**6**= None
		7=Other (specify)……	
1.7	What is your marital status?	**1**=Single	**2**=Married
		3=Co-habiting	**4**=Separated
		5=Divorced	**6**=Widowed
1.8	How many children do you have?	**1**=None	**2**=One
		3=Two	**4**= More than two
1.9	Where do you currently reside?	**1**=University residence	**2**= Home
		3= Private	
1.10	With whom are you currently living?	1=Alone	**2**=With family
		3=With partner	**4**=Other (specify)……
1.11	What is the educational status of your boyfriend, or girlfriend, husband or wife?	**1**=No formal education	**2**=Primary education
		3=Secondary education	**4**=Tertiary education
1.12	What is the employment status of your boyfriend, or girlfriend, husband or wife?	1=Unemployed	**2**=Employed
		3=Student	**4**=Other (specify)……
1.13	What is the monthly income?	**1**= Less than R2 000 monthly	**2**= Between R2 000 and R2 999
		3= Between R3 000 and R3 999	**4**= Between R4 000 and R4 999
		5= Between R5000 and R5 999	**6**= More than R 6 000

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SECTION 2: FAMILY HISTORY

Please kindly complete your family history details before answering the questionnaire.

No	Questions	Values [mark the correct number with a "x" which has the correct answer for you]	
2.1	What is the current marital status of your parents?	**1**=Married	**2**=Divorced
		3=Living together	**4**=Separated
		5=Widow	**6**=Widower
2.2	What is the level of education of your father?	**1**=No formal education	**2**=Grade 1 to 8 completed
		3=Grade 9 to 12 completed	**4**=Above grade 12
		5= I don't know	
2.3	What is the level of education of your mother?	**1**=No formal education	**2**=Grade 1 to 8 completed
		3=Grade 9 to 12 completed	**4**=Above grade 12
		5= I don't know	
2.4	How often do you visit or see your family members whom live close to you?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
2.5	When you need help or have a problem, do you usually count on your family members for support?	**1**=Never	**2**=Occasionally
		3= Sometimes	**4**= Often
2.6	Do you think that you are receiving enough money (e.g. for education materials) according to your demand?	**1**=Never	**2**=Occasionally
		3= Sometimes	**4**=Often
2.7	How do you appreciate the level of income of your family or guardian?	**1**=Better-off	**2**= Poor
		3= Average	**4**= Very good
2.8	How do you perceive the control that your family made on you?	**1**=Tight	**2**=Average
		3=Loose/free	**4=**Very good
2.9	When you were a child, have you seen your mother being beaten by her boyfriend or husband?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often

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SECTION 3: SUBSTANCE USE

Please kindly complete the substance use details before answering the questionnaire.

No	Questions	Values [mark the correct number with a "x" which has the correct answer for you]	
3.1	Have you ever smoked dagga in your life?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
3.2	How often do smoke dagga?	1=Every day	2=Once or twice a week
		3= 1 or 2 times a month	4= More than 2 times per month
3.3	Have you ever smoked tobacco or cigarettes in your life?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
3.4	How often do smoke cigarettes?	1=Every day	2=once or twice a week
		3= 1 or 2 times a month	4= More than 2 times per month
3.5	Have you ever drink alcohol in your life?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
3.6	Have you ever been drunk in your life?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
3.7	Have you been drunk since you joined this university?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often
3.8	Have you been drunk in the current academic year?	**1**=Never	**2**=Occasionally
		3= Sometimes	**4**=Often
3.9	Do you have male or female friends who drink?	**1**=Never	**2**=Occasionally
		3=Sometimes	**4**=Often

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SECTION 4: INTIMATE PARTNER VIOLENCE

In the following section of this questionnaire IPV will be measured by determining the prevalence of psychological abuse, physical abuse, sexual abuse and financial abuse. Please answer all the questions in this section.

4.1 Psychological Abuse

Please note that in this study psychological abuse refers to the trauma to the survivor caused by acts, threats of acts, or coercive tactics and deliberately doing something to make the survivor feel diminished or embarrassed.

Please select the correct answer from column (c) and write the appropriate answer in the column (d)

(a)	(b) Questions	(c)1=Never 2=Occasionally 3=Sometimes 4=Often	(d)
1	Has your boyfriend, or girlfriend, husband or wife ever insulted you or made you feel bad about yourself?	1 2 3 4	
2	Has your boyfriend, or girlfriend, husband or wife ever belittled or humiliated you in front of other people?	1 2 3 4	
3	Has your boyfriend, or girlfriend, husband or wife ever done things to scare or intimidate you on purpose (e.g. by the way he looked at you, by yelling and smashing things)?	1 2 3 4	
4	Has your boyfriend, or girlfriend, husband or wife ever threatened to hurt you or someone you care about?	1 2 3 4	
5	Did any of the above mentioned happened in your life?	1 2 3 4	
6	Did any of the above mentioned occur within the last 12 months?	1 2 3 4	

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4.2 Physical abuse

Please select the correct answer from column (c) and write the appropriate answer in the column (d)

(a)	(b) Questions	(c)1=Never 2=Occasionally 3=Sometimes 4=Often	(d)
1	Has your boyfriend or girlfriend, husband or wife ever slapped you or thrown something at you that could hurt you?	1 2 3 4	
2	Has your boyfriend or girlfriend, husband or wife ever pushed you or shoved you or pulled your hair?	1 2 3 4	
3	Has your boyfriend or girlfriend, husband or wife ever hit you with a fist or with something else that could hurt you?	1 2 3 4	
4	Has your boyfriend or girlfriend, husband or wife ever kicked you, dragged you or beaten you up?	1 2 3 4	
5	Has your boyfriend or girlfriend, husband or wife ever choked or burnt you on purpose?	1 2 3 4	
6	Has your boyfriend or girlfriend, husband or wife ever threatened to use or actually used a gun, knife or other weapon against you?	1 2 3 4	
7	Did any of the above mentioned happened in your life?	1 2 3 4	
8	Did any of the above mentioned occur within the last 12 months?	1 2 3 4	

4.3 Sexual Abuse

Please select the correct answer from column (c) and write the appropriate answer in the column (d)

(a)	(b) Questions	(c)1=Never 2=Occasionally 3=Sometimes 4=Often	(d)
1	Has your boyfriend or girlfriend, husband or wife ever physically forced you to have sexual intercourse when you did not want to?	1 2 3 4	
2	Has your boyfriend or girlfriend, husband or wife ever had sexual intercourse you did not want to because you were afraid of what your partner or any other partner might do?	1 2 3 4	
3	Has your boyfriend or girlfriend, husband or wife ever forced you to do something sexual that you found degrading or humiliating?	1 2 3 4	
4	Did any of the above mentioned happened in your life?	1 2 3 4	
5	Did any of the above mentioned occur within the last 12 months?	1 2 3 4	

4.4 Financial Abuse

Please select the correct answer from column (c) and write the appropriate answer in the column (d)

(a)	(b) Questions	(c)1=Never 2=Occasionally 3=Sometimes 4=Often	(d)
1	Has your boyfriend or girlfriend, husband or wife ever taken money from your purse without your consent?	1 2 3 4	
2	Has your boyfriend or girlfriend, husband or wife prevented you from knowing about or accessing family income?	1 2 3 4	
3	Has your boyfriend or girlfriend, husband or wife prevented you from earning an income?	1 2 3 4	
4	Has your boyfriend or girlfriend, husband or wife ever not paid you for work undertaken as promised?	1 2 3 4	
5	Has your boyfriend or girlfriend, husband or wife ever forced you to work without pay?	1 2 3 4	
6	Has your boyfriend or girlfriend, husband or wife ever prevented you from accessing income-earning resources?	1 2 3 4	
7	Has your boyfriend or girlfriend, husband or wife ever forced to you asked him or her for money?	1 2 3 4	
8	Did any of the above mentioned happened in your life?	1 2 3 4	
9	Did any of the above mentioned occur within the last 12 months?	1 2 3 4	

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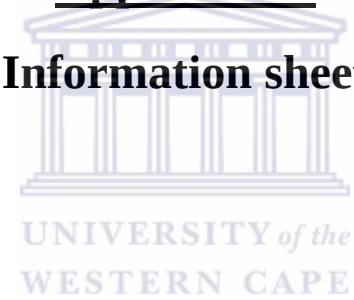
THANK YOU FOR YOUR PARTICIPATION

REMEMBER ALL THE INFORMATION OBTAINED ARE STRICTLY CONFIDENTIAL

Appendix B:

Information sheet



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INFORMATION SHEET

Project Title: Intimate Partner Violence among undergraduate student nurses at a tertiary institution in the Western Cape

What is this study about?

This is a research project being conducted by Mr. Ashley Gurshin Kordom of the University of the Western Cape. We are inviting you to participate in this research project because you are one of the student nurses that can help me determine the prevalence and factors associated with Intimate Partner Violence among undergraduate student nurses at the University of the Western Cape. The purpose of this research project is to develop a support structure in the near future for student nurses.

What will I be asked to do if I agree to participate?

You will be asked to complete a questionnaire. The whole process will not take longer than thirty (30) minutes.

Would my participation in this study be kept confidential?

In accordance with the legal requirements and/or professional standards, it is expected from us to share the findings of this research project with other academics. The research findings of this study will be published in an accredited peer reviewed journal. We will not disclose your personal identity and we will do our best to keep your personal information confidential. To help protect your confidentiality; the survey is anonymous and will not contain information that may personally identify you. Your name

will not be included on the questionnaire. A code will be placed on the survey. Through the use of an identification key, the researcher will not be able to link your questionnaire to your identity. Only the researcher will have access to the identification key.

What are the risks of this research?

There might be some risk such as psychological and or emotional that may result from participating in the research.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator to learn more about the prevalence and factors associated with Intimate Partner Violence among undergraduate student nurses at a tertiary institution in the Western Cape. We hope that, in the near future, a support structure will be developed to respond to the needs of student nurses.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

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Is any assistance available if I am negatively affected by participating in this study?

Should you be negatively affected by participating in the study, please feel free **to contact the Campus Community Health Centre at 021 959 2875** where trained counselors and registered nurses will provide you with counseling sessions.

What if I have questions?

This research is being conducted by Mr. Ashley Gurshin Kordom and is supervised by Mrs. Hester Julie and Dr. Sathasivan Arunachallam from the School of Nursing at the University of the Western Cape.

If you have any questions about the research study itself, please contact Mr. Ashley Gurshin Kordom at: cell: 076 416 7531; address: 10 Manitoba Close, Portland's, Mitchell's Plain, 7785 or email: 2444879@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of the School of Nursing: Prof O. Adejumo
Dean of the Faculty of Community and Health Sciences: Prof H. Klopper
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

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Appendix C:

Ethical clearance letter from the University of the Western Cape

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OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

29 February 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Mr A Kordom (School of Nursing)

Research Project: Intimate partner violence among undergraduate student nurses at a tertiary institution in the Western Cape

Registration no: 12/1/9

UNIVERSITY of the
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Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

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Appendix D:

Letter for consent to the Head of the School of Nursing

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From: Ashley GurshinKordom

School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

The Head of School of Nursing

Faculty of Community and Health Sciences

University of the Western Cape

Bellville

UNIVERSITY of the
WESTERN CAPE

Dear Professor O. Adejumo

Re: Permission to a conduct a research project

Herewith, I wish to request your consent to undertake a research project at this institution as a requirement for the completion of the M.Cur degree course I am undertaking. The title of my study focus on **"Intimate Partner Violence among undergraduate student nurses at a Tertiary Institution in the Western Cape**". The research proposal has been approved by the Senate Research Committee of the University of the Western Cape **(Registration number 12/1/9).**

The student nurses from the age eighteen (18) will be eligible key informants. Data will be collected on a questionnaire that informants will voluntarily complete. Please be assured that anonymity and confidentiality will be safeguarded at all times. The study is expected to provide valuable information on the prevalence and factors associated with Intimate Partner Violence among undergraduate student nurses at a tertiary institution in the Western Cape.

I am anxiously awaiting your favorable response.

Thanking You.

Yours faithfully

……..

A.G. Kordom

Contact Details : Cell :076 416 7531

Email: 2444879@uwc.ac.za

Appendix E:

Letter of approval from the Head of the School of Nursing

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From: Oluyinka Adejumo **Date: Friday- March 2012, 12:57PM**

To: KORDOM, ASHLEY GURSHIN

CC: Julie, Hester

Subject: Re: Consent letter

Dear Ashley Gurshin Kordom

Permission is hereby given to you to collect data from the undergraduate nursing students subject to your abiding with all the requirements of the ethics as stipulated in your proposal and approved by the University Senate Research Committee of UWC.

Best wishes

Prof O Adejumo

UNIVERSITY of the
WESTERN CAPE

Prof Oluyinka Adejumo

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Appendix F:

Letter from the editor

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Jackie Viljoen
Language Editor and Translator
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DECLARATION

I hereby certify that the M dissertation of **Ashley Gurshin Kordom** was properly language edited but without viewing the final version.

Title of dissertation:
Intimate partner violence among undergraduate student nurses at a tertiary institution in the Western Cape

UNIVERSITY of the
WESTERN CAPE

JACKIE VILJOEN
Strand
South Africa
29 November 2012