QUALITY OF CARE FOR INTIMATE PARTNER VIOLENCE

Dr Kate Joyner
Division of Nursing
Stellenbosch University
IPV – COMPLEX PHENOMENON

• Layers of emotional, spiritual & financial abuse intertwined with varying degrees of physical and sexual violence
• Massive public health problem (WHO, 2005)
• South Africa: more women killed by current or ex-intimate male partner than in any other country (Abrahams et al., 2009)
“For any other disease process as costly in financial and human measures we would demand answers, find cures, and disseminate evidence about interventions. What is it about IPV?”

Moral argument: Health providers should address the problematic impact of IPV on family systems.
JOHNSON’S TYPOLOGY OF IPV

1. Intimate terrorism/coercive control: use of violence by one partner to control other
2. Violent resistance: resister’s response to partner’s effort to gain control
3. Mutual violent control: use of violence by each partner to control the other
4. Situational couple violence: either couple can be violent due to escalating conflict, but not to exert control
11 CASE STUDIES

1st Interview
N = 168

Follow-up Interview
N = 124

Medical Records
N = 114

Methods
RESULTS

• N = 11; 10 = cohabiting with abusive partner
• Mean age = 41 years
• Average number of children = 3
• 9/11 experienced coercive control
• 1 = violent resistance
• 1 = mutual violent control
RESULTS

- Recognition of IPV without action
- Biomedical care overlooks IPV
- Recognition of mental health problems
- Quality of counseling
- Continuity & co-ordination of care
- Poor record keeping (medico-legal deficit of care)
LIMITATIONS

• Hidden nature of IPV & lack of standardized care guidelines: impossible to conduct a quality of care audit
• Findings based on small number of case studies
• Not possible to generalize
• Yet findings reasonably applicable to similar primary care settings
IMPLICATIONS & RECOMMENDATIONS

• Provider training: comprehensive approach to IPV

• IPV-related knowledge and skills: compulsory component of all nursing, medical and allied health workers’ curricula

• Providers need to be more empathic and patient-centred
IMPLICATIONS & RECOMMENDATIONS

• IPV generalist: holistic, on-going care and co-ordination of services

• Improve documentation of IPV: build an evidence-base of abuse

• Active case finding: part of structured medical record in specific settings
CONCLUSIONS

• Recognition, management, and appropriate documentation of IPV: training priority

• Appoint IPV champions within primary health care to ensure comprehensive care for survivors of IPV


