Assignment 4: Dr Leonard Bikinesi 17002087

Prevalence of intimate partner violence and associated factors amongst women attending antenatal care at Outapi primary health care facility, Namibia: A descriptive survey.

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Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my original work and that I have not previously submitted it, in its entirety or in part, at any university for a degree.

Signature: ..... Date: March 2017

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"Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my original work and that I have not previously submitted it, in its entirety or in part, at any university for a degree. I also declare that ethical approval for the study was obtained from the Health Research Ethics Committee of Stellenbosch University (Reference number: S15/07/140)

Signature: Date: 6 February 2017

Abstract

Background
Intimate partner violence (IPV) violence is an important public health problem with negative long term effects on the mother's health and the unborn baby. In one Namibian study performed in the capital city over one third (36%) of ever-partnered women reported physical or sexual violence from an intimate partner. No study had been conducted to determine the prevalence of IPV amongst pregnant women in a primary care setting in Namibia.

Aim and objectives
This study aimed to determine the prevalence of IPV amongst women attending antenatal care at Outapi primary health care clinic, Namibia. The objectives of the study were to measure the prevalence of IPV amongst pregnant women, to assess the relationship between the different types of IPV and to evaluate the presence of known risk factors for IPV.

Methods
A descriptive survey conducted at Outapi clinic in Namibia. Data was collected using a validated questionnaire from 386 consecutive participants in the antenatal clinic.

Results
The mean age of the participants was 27.5 years (SD 6.8) and 335(86.8%) of the women were unmarried, 215(55.7%) with only primary school education and 237(61.4%) in their third trimester. Overall 41(10.6%) had HIV and 44(11.4%) were teenage pregnancies. The reported lifetime prevalence of IPV was 10.1%, the 12-month prevalence was 27(7.0%) and the prevalence during pregnancy was 23(6.0%). Emotional abuse was the commonest type of abuse in 27(7.0%) although the commonest specific abusive behaviour was refusing to provide money to run the house or look after the children when there was money for other things in 19(4.9%). Increased age was associated with an increase in occurrence of IPV.

Conclusion
Presence of IPV in this setting is comparable to Uganda and Malawi but much less than prevalence in neighbouring countries. Nevertheless, the prevalence is sufficient to warrant the development of guidelines to recognize, assess and assist women affected by IPV.

Introduction

Gender-based violence is widely recognized as an important public health problem, both because of the acute morbidity and mortality associated with assault and because of its longer-term impact on women's health.(1) This is why it is important to determine the actual impact of the problem at all levels of health care. The WHO multi-country study on women`s health and domestic violence concluded that 15 – 71% of women experience sexual and/or physical violence at some point in their lives, which is caused by an intimate partner.(2) Intimate partner violence (IPV) refers to behaviour by an intimate or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.(3) Intimate partner violence occurs in different forms which includes various types such as physical, sexual, emotional and economical.(4)

In Namibia over one third (36%) of ever-partnered women have reported physical or sexual violence from an intimate partner.(2) This violence occurred amongst women of varying ages and also during pregnancy. The impact of IPV on women's physical, emotional and psychological health is great. The WHO multinational study showed that among women who reported violence during pregnancy, between one quarter and one half were severely abused (kicked or punched in the abdomen). More worrying is that in more than 90% of cases, IPV was committed by the partner responsible for the pregnancy.(2) In Namibia IPV has been linked to depression and suicide.(5) Physical consequences associated with IPV mostly reported in Namibia have been bruises and cuts, however more serious injuries such as stab wounds have been reported.(5) IPV during pregnancy is important in all contexts as it increases vulnerability to ill health and even death for both mother and her unborn baby.(6) Violence against women results in physical, mental, sexual, reproductive and other health problems, and significantly increases vulnerability to HIV.(7) A month hardly passes without an article in the local newspapers highlighting this problem and its effects.(8) The former President of Namibia, His Excellency Dr Hifikepunye Pohamba, has expressed concern about violence against women and child abuse in the country.(2)

Despite the problem being widespread in our community little research has been done to determine the actual prevalence and impact. In the WHO multi-country study, conducted in Windhoek, Namibia, the lifetime prevalence of IPV was 36% and physical abuse amongst ever pregnant women was 6.1%. The Ministry of Health and Social Services of Namibia in its Demographic and Health Survey(DHS) of 2013 showed that 6% of women had experienced physical violence during pregnancy.(9) These studies clearly

highlight that IPV is present in Namibia and strengthens the need to have more studies done to evaluate IPV in different communities and to assess its different forms. Furthermore, data from studies conducted by neighbouring countries have shown relatively high levels of IPV amongst women, for example in Botswana a lifetime prevalence of 49.7%, South Africa 38.0% and Zimbabwe 61.3%, which are amongst the highest ever recorded.(10–12) From a health perspective, the importance of research which aims to improve clinical practice in this particular field cannot be overlooked. Research is one of the key ways to develop effective strategies to combat the problem.(2) In 1995, the Beijing Platform for Action urged all governments to invest in research to improve the relevant knowledge base on prevalence, causes, nature, and consequences of violence against women.(2)

The primary care facilities are usually the first port of entry for people presenting with a health problem and antenatal care provides a potentially important window of opportunity for identifying IPV. For many women in low resource settings, this will be their only point of contact with health care providers. Ideally, women will be seen four times during a pregnancy and once postpartum, and the possibility of follow-up therefore offers an ideal setting for addressing issues of abuse.(13) One study also found that domestic violence occurs across all levels of society, regardless of socio-demographic variables.(10) This would support the view that all adult females in primary care practice be routinely screened for domestic violence, although others have recommended more selective case-finding.(14,15) Recognizing IPV is vital for any effective strategy to combat the problem. Attention to recognizing IPV at primary care level should be promoted and included in training of primary care providers.(15) The WHO multi-country study on women`s health and domestic violence against women, included Namibia, but was conducted in Windhoek, the capital city. No study has been performed in other parts of Namibia to measure IPV in pregnant women at a primary care level. This is especially useful considering that IPV in pregnancy is associated with increased risk of low birth weight infants, pre-term delivery, neonatal death and negatively affects breast-feeding postpartum.(16)

Aim and objectives

The study aim was to determine the prevalence of IPV amongst women attending antenatal care at a primary care facility in Outapi district, Namibia. The study had three objectives which were:

1. To measure the prevalence of IPV amongst pregnant women.

2. To assess the relationship between the different types of IPV: physical, sexual, emotional and economical.
3. To evaluate the presence of known risk factors for IPV in this context.

Methods

Study design

This was a descriptive survey amongst pregnant women attending Outapi primary health care clinic.

Setting

The clinic is situated in Outapi district near the major district hospital for Omusati region and serves patients from both the local urban area and more distant rural villages as shown in Figure 1. The nearby local urban area is Outapi town with mostly working class professionals whereas the surrounding rural area consists of mainly village homesteads where the majority are not formally employed. The clinic offers services such as antenatal care, postnatal care, family planning, mental health, child health and social work services. Due to the proximity of the clinic to Angola, some of the patients served are Angolans living along the Namibia-Angolan border.

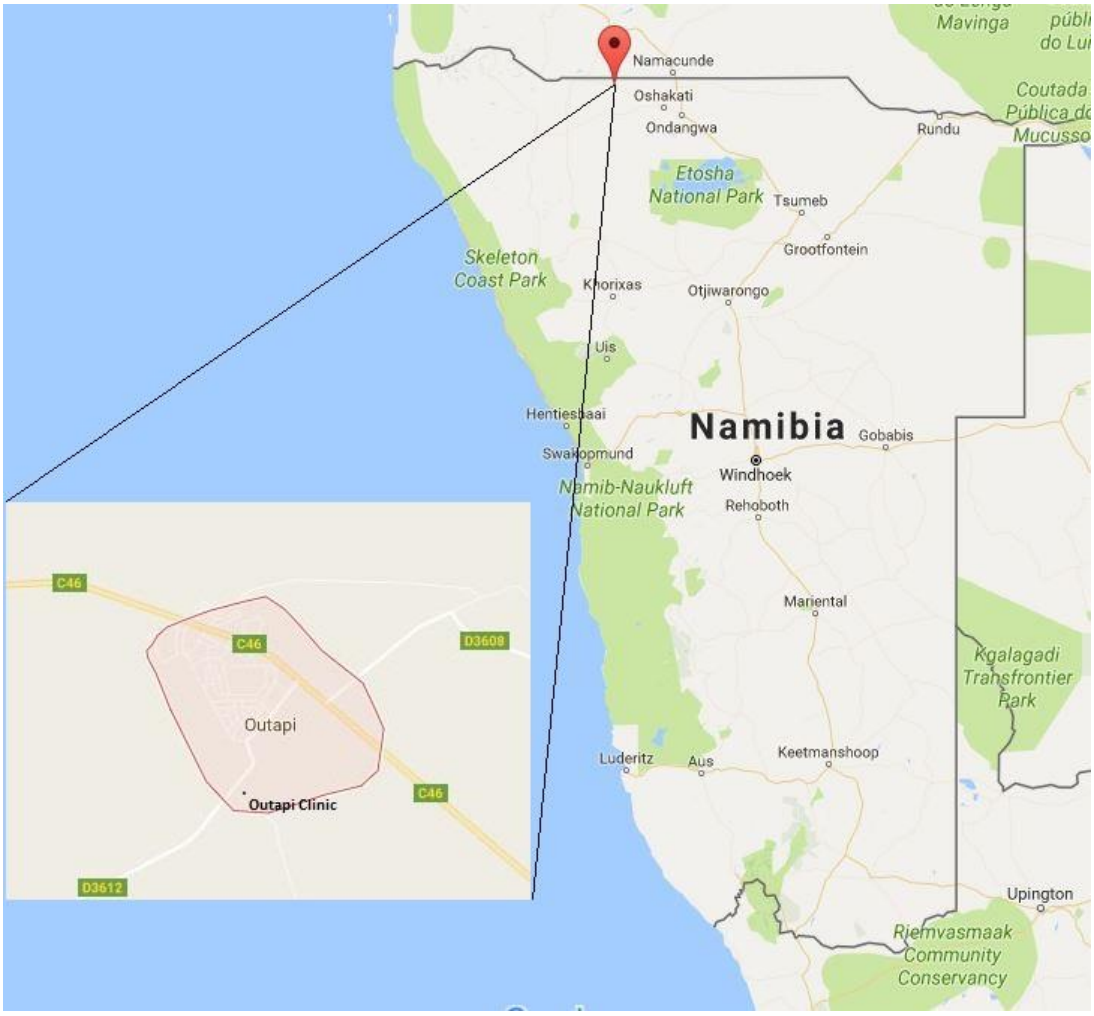

Figure 1: Map showing location of Outapi clinic in relation to the rest of Namibia.

Sample size and selection

The sample size calculated was based on the prevalence of 49.7% obtained in Botswana.(10) Botswana has almost the same culture, population and is in the same broad geographical setting as Namibia. To be within 5% of this prevalence, given 95% confidence intervals, a sample size of 385 was needed.

Women who had stayed in the catchment area of the clinic for at least six months were included regardless of nationality, race or ethnic group. Participants were selected consecutively as they attended the antenatal clinic. The research was conducted on antenatal care days, Tuesdays and Thursdays, over a 5-week period. Pregnant women were seen in a private consultation room by two nurses who took a history and then performed an obstetric examination. During this consultation, the client was asked questions that would ascertain whether she had experienced IPV or not. The clients that responded negatively were recorded as such together with the routine general socio-economic information. The clients that responded affirmatively for experiencing IPV were invited to participate in

the research. Two consent forms were available, one in English and another in Oshiwambo. The women chose the language they were comfortable with and then made a voluntary decision to participate or not.

Data collection

Data was collected using a modified version of a validated questionnaire that was used previously in a study in antenatal clinics in Soweto, South Africa.(1) Modifications included having a small section on routine data collected from all women receiving antenatal care such as gestation, age, level of education, HIV status and marital status as shown in Appendix 1. Questions on assessing IPV were not changed however occurrence was modified to during 12 months, whilst pregnant and number of times occurred. This questionnaire itself was a modified version of the WHO assessment questionnaire, which had been pretested in six countries namely Bangladesh, Brazil, Namibia, Samoa, Thailand, and the United Republic of Tanzania. A series of questions were asked to categorise IPV into physical abuse, emotional abuse, financial abuse and sexual abuse.

Two female nurses with good interpersonal skills, an interest in IPV and fluency in Oshiwambo, administered the questionnaire whilst they concurrently performed routine antenatal care as highlighted above.

Data analysis

Data was captured on an Excel sheet by a data clerk and checked for any errors by the researcher. Data was analysed with the assistance of the Biostatistics Unit at Stellenbosch University. Determination of the relationship between demographic or clinical characteristics and IPV was done using the chi-square test.

Ethical considerations

The study was approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and by the Ministry of Health and Social Services of Namibia. Confidentiality was of great importance in this study and care was taken to ensure that there was no recording of names, address or other personal details of the participants. Participants who required more assistance after taking part in the study were assessed by a social worker and only two participants requested further help. The study was conducted as per the WHO ethical and safety recommendations for research on domestic violence against

women.(17) All participants were required to sign a written informed consent, which was either in English or the local language (Oshiwambo). Privacy and confidentiality was kept at all times and the questionnaire was administered as part of the routine consultation and examination in an enclosed room.

Results

Altogether 386 pregnant women took part in this study and their mean age was 30.3 years (standard deviation of 6.0) and all accepted to take part in the study. Table I shows the frequency distribution of the participants according to variables such as age, gestation and level of education. Most women were unmarried, although may have been co-habiting with their partners, had only primary school education and were attending in their third trimester of pregnancy. Out of the 386 participants, 44 (11.4%) were teenagers and 41 (10.6%) were HIV positive.

Table I: Frequency distribution of the participants according to age, gestation, education, marital and HIV status (N=386).

Variable		n (%)	
Age (years)			
	14 – 19	44	(11.4)
	20 – 25	126	(32.6)
	26 – 31	103	(26.7)
	32 – 37	72	(18.7)
	38 – 43	38	(9.8)
	44 - 49	3	(0.8)
Gestation			
	First Trimester	19	(4.9)
	Second Trimester	130	(33.7)
	Third Trimester	237	(61.4)
Education			
	None	63	(16.3)
	Primary	215	(55.7)
	Secondary	103	(26.7)
	Tertiary	5	(1.3)
Marital Status			
	Unmarried	335	(86.8)
	Married	51	(13.2)
	Separated	0	(0.0)
	Divorced	0	(0.0)
HIV Status			

Unknown	4	(1.0)
Negative	340	(88.1)
Positive	41	(10.6)

Prevalence of IPV

Any experience of IPV was reported by 39 participants giving a lifetime prevalence of 10.1%. Table II shows the prevalence of different types of IPV and the mean number of times that abuse occurred. Emotional abuse was the commonest type of IPV amongst the participants and commonest during pregnancy.

Table II: Prevalence of IPV during lifetime, last 12 months and whilst pregnant (N=386).

	Ever occurred n (%)	Last 12 months n (%)	Whilst pregnant n (%)	Mean number of occurrences (Range)
Physical Abuse	17(4.4)	17(4.4)	13(3.4)	2.6(1.0-7.0)
Emotional Abuse	30(7.8)	27(7.0)	23(6.0)	2.7(1.0-6.0)
Financial Abuse	23(6.0)	19(4.9)	20(5.2)	3.2(1.0-10.0)
Sexual Abuse	11(2.8)	9(2.3)	6(1.6)	3.2(1.0-10.0)

Forms of IPV

Within each category different forms of IPV were assessed using specific questions. Table III shows the different forms of IPV. Failure to provide money to run the house or look after the children but having money for other things was the most common specific form of IPV with 23 (6.0%) reporting it. Severe forms of physical abuse such as burning, threatening or using a gun were not reported by the participants.

Table III: Prevalence of different forms of IPV

Forms of IPV	Ever occurred n (%)	Last 12 months n (%)	Mean number of times occurred	Whilst pregnant n (%)
Physical Abuse				
Has he ever pushed you or shoved you?	12 (3.1)	10 (2.6)	11	7 (1.8)

Has he ever slapped you or threw something at you, which could hurt you?	14 (3.6)	12 (3.1)	12	9 (2.3)
Has he ever hit you with his fist or something else that could hurt you?	11 (2.8)	10 (2.6)	10	5 (1.3)
Has he ever kicked you, dragged you?	4 (1.0)	4 (1.0)	4	1 (0.3)
Has he ever beat you up?	10 (2.6)	10 (2.6)	10	6 (1.6)
Has he ever strangled you?	3 (0.8)	2 (0.5)	3	2 (0.5)
Has he ever burnt you purpose?	0 (0.0)	0 (0.0)	0	0 (0.0)
Has he ever threatened to use or actually used a gun?	0 (0.0)	0 (0.0)	0	0 (0.0)
Has he ever threatened to use or actually knife, or another weapon against you?	0 (0.0)	0 (0.0)	0	0 (0.0)
Emotional Abuse				
Has he ever forced you to leave the place where you were living?	8 (2.1)	7 (1.8)	7	5 (1.3)
Has he ever forced your children to leave the place where you were living?	4 (1.0)	3 (0.8)	3	2 (0.5)
Has he ever insulted you or made you feel bad about yourself?	20 (5.2)	18 (4.7)	17	14 (3.6)
Has he ever belittled or humiliated you in front of other people?	13 (3.4)	9 (2.3)	10	7 (1.8)
Has he ever tried to prevent you from seeing family or friends?	7 (1.8)	7 (1.8)	7	5 (1.3)
Has he ever tried to prevent you from speaking with other men?	16 (4.1)	15 (3.9)	13	8 (2.1)
Has he ever Boasted about or brought home girlfriends?	18 (4.7)	15 (3.9)	16	13 (3.4)
Has he ever done things to scare or intimidate you on purpose, for example, by the way he looked at you, by yelling and smashing things.	6 (1.6)	3 (0.8)	2	3 (0.8)
Has he ever threatened to hurt you?	11 (2.8)	8 (2.1)	8	7 (1.8)
Financial Abuse				
Has he ever failed to provide money to run the house or look after the children but had money for other things?	23 (6.0)	19 (4.9)	17	20 (5.2)
Has he ever taken your earnings?	3 (0.8)	2 (0.5)	3	2 (0.5)
Has he ever tried to prevent you from going to work, selling, or making money in any other way	2 (0.5)	2 (0.5)	2	1 (0.3)
Has he ever forced you to do some work that you didn`t like?	1 (0.3)	0 (0.0)	0	0 (0.0)
Sexual Abuse				

Has he or any other partner ever physically forced you to have sex when you did not want to?	10 (2.6)	8 (2.1)	2	4 (1.0)
Have you ever had sex when you did not want to with your current boyfriend or husband, or any other partner, because you were afraid of what he might do?	7 (1.8)	6 (1.6)	6	4 (1.0)
Has your current boyfriend or husband, or any other partner, ever forced you to do something sexual that you found degrading or humiliating?	3 (0.8)	2 (0.5)	2	1 (0.3)

Associated factors

There was no significant relationship between the prevalence of IPV and level of education, HIV status or marital status. There was a significant association (p=0.007) between IPV and older age with mean age of those that had experienced IPV being 30.3 years (95% CI: 29.4 - 35.7) and those without an experience of IPV being 27.2 years (95% CI: 26.1 –32.4) as shown in Table IV.

Table IV: Association of age and gestation amongst women who experienced IPV (N=386).

Variables	**n(%)**	**Mean**	***p*-value**
Age (years)			
IPV occurred	39 (10.1)	30.3	0.007
IPV never occurred	347(89.1)	27.2	
Gestation (weeks)			
IPV occurred	39 (10.1)	30.0	0.098
IPV never occurred	347(89.1)	27.8	

Discussion

In this study 10.1% of pregnant women had experienced IPV during their lifetime and up to 6% during the current pregnancy. Emotional abuse was the most common type of IPV followed by financial, physical and then sexual abuse. Older pregnant women were more likely to have experienced IPV.

Prevalence of IPV

The lifetime prevalence of IPV obtained was within the range of 2.0% to 13.5% obtained in a study conducted in 19 countries from Africa, Latin America, Europe and Asia.(13) In this study, the prevalence of physical abuse was 3.4% which is similar to that obtained by the Namibian DHS of 2013 for Omusati region of 3.8%.(9) This is consistent with the finding that this region is amongst the regions in Namibia with lower rates of IPV. Of note however, is that in the Namibian DHS of 2013, only 'physical abuse' is assessed and documented in pregnancy. It remains therefore unknown how the prevalence of other types of IPV obtained in this study compares.

The rate of physical abuse during pregnancy (3.4%) was much lower than the prevalence obtained in Windhoek, Namibia of 6.1% as part of the WHO multi-country study on women's health and domestic violence against women.(2) This difference could be due to a lower prevalence in rural areas or cultural differences in the study populations. However, some of the difference could be attributed to the methodologies used. The study in Windhoek was conducted through in depth interviews and focus group discussions by well-trained female research assistants.(2) It is possible that women were less likely to disclose IPV to a nursing sister in the local antenatal clinic, especially if they felt ashamed or had previously experienced unsupportive relationships.(18) Underreporting can also be attributed to the silence that is due to the shame that women feel, their loyalty to their partners, and the stigma around IPV as a private matter. Subconscious defences such as denial and rationalization of their experiences as "normal" could also have affected their responses. Noteworthy, too, was that sexual coercion by partners was underreported since many woman believed that a male partner has a right to have sex with her whenever and however he wants it.(19)

In comparison to other African countries, the results are comparable to those obtained in Uganda and Malawi.(13,20) In comparison however to data from neighbouring countries, such as Zimbabwe, Botswana and South Africa, the prevalence was much lower.(10–12) The contrast may point to important differences in the way men respect and relate to women in Namibia versus Zimbabwe, Botswana and South Africa. More research is needed to compare male views of IPV across these countries. A cross sectional study in Zimbabwe obtained a prevalence of 61.3% during pregnancy.(12) This huge difference may be due to factors such as cultural, moral, and religious backgrounds as well as differences between urban and rural and areas.

The study in Zimbabwe was conducted in low income facilities in an urban setting, unlike this study which was conducted in one facility in a semi-rural setting. Similar studies conducted in Botswana and

Rwanda had much higher IPV lifetime prevalence of 49.7% and 35.1% respectively. The study in Botswana was done in a public hospital in a semi-urban area whereas the Rwandan study was conducted in two rural settings.(10,21) These different settings associated with a high IPV prevalence could indeed suggest that IPV prevalence in Namibia is lower. This suggests that cultural differences in these countries could play a role. However, this is an area where further evaluation will be required to explore cultural differences in IPV and whether partners in Namibia view IPV differently.

Types of IPV

This study also assessed the different types of IPV experienced by pregnant women. Emotional abuse, was the commonest type of abuse in this study which was mainly demonstrated by the partner insulting or making the woman feel bad about herself. This is in keeping with observations that in pregnancy nonphysical forms of violence tend to increase.(12) It was interesting to note that 'severe forms' of physical abuse such as burning, threatening to use a gun, knife or another weapon were not observed in this study.(2) This also implies cultural or societal norms that are less violent than neighbouring countries.

Associated Factors

The study found that there was association of IPV with an increase in age. This is in contrast with data obtained by the Namibian DHS of 2013 which highlighted that IPV was more likely to be reported by younger women compared to older ones.(9) This study assessed four types of IPV in contrast to the Namibian DHS of 2013 which only looked at 'physical abuse' in pregnancy. It could be that the association of IPV and age varies according to the type of IPV. While younger women may be experiencing more physical abuse, the same cannot be concluded for the other non-physical types of IPV. Further studies will need to be done to assess this association. Nonetheless, other studies have obtained similar data showing that respondents aged 30–39 years reported violence more commonly compared to younger women.(22) The reason for this is unknown in Namibia, though studies elsewhere have suggested that it could be younger women gaining more power as a result of pursuing education, employment, and economic independence. (20) The exact reasons in the Namibian context may need further investigation. There was no association between HIV status and IPV and a similar result was obtained in a study in Rwanda.(21) Other studies, however, have found an association between HIV and IPV. (23) The lack of association in this study could be attributed to the relatively small sample of HIV infected individuals, namely the 10.6% who participated.

The majority of participants were single (86.8%). This is not surprising as most Namibian women are involved in unmarried relationships.(24) This study found no association between IPV and marital status and level of education. A national cross-sectional household survey in eight southern African countries also found no association between IPV and level of education or marital status.(22) The Namibian DHS of 2013 however found that violence during pregnancy decreased with increasing education.(9) This is in keeping with findings from studies amongst sub Saharan women which also showed that higher level of education was associated with lower prevalence of IPV.(25) The absence of this association could be as a result of a low number of educated women who participated in this study (1% with tertiary level education).

Limitations

This study has some other limitations. Possible under-reporting has already been discussed, however, the low level of education (none or primary) in the majority of women could also be a contributing factor. In a study in Zambia, the average person who had not completed primary school was less likely to report a violent argument with a partner.(22) The study also relied upon women remembering IPV which could lead to recall bias. The frequency of abuse was most likely underreported as several women responded with statements such as “many times” or “several times”, which could not be fully quantified.

Recommendations

Due to the significant mental and physical health risks for women and their children associated with IPV, health service providers should implement the WHO’s clinical guidelines for IPV amongst women attending antenatal care.(16,26) A similar model was developed in South Africa and found to be feasible and useful, although there was poor uptake of the support groups.(27) Screening women can be done by healthcare professionals either directly asking women face-to-face or by having questionnaires in health facilities that are completed prior to consultation. These methods were found to increase the identification of women experiencing IPV in healthcare settings.(28) Operational research however will need to be conducted to identify which model of care for IPV will best work for the Namibian setup. Qualitative research could explore societal and cultural reasons for the large differences in the prevalence of IPV between communities in southern Africa.

Conclusion

The lifetime prevalence of IPV amongst pregnant women in a primary health care setting in a semi-rural area of Namibia was 10.1% and 6% during pregnancy. The study found that all types of IPV occurred in pregnancy with emotional abuse being the commonest category (commonest specific form of abuse being the partner insulting or making the woman feel bad about herself**),** followed by financial abuse. The commonest specific abusive behaviour was failing to provide money to run the house or look after the children despite having money for other things. Marital status, HIV status, gestational age and level of education did not demonstrate any association with IPV; although older pregnant women were more likely to have experienced IPV.

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Assignment 4: Dr Leonard Bikinesi 17002087

Appendix

1. Consent (English)

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

Prevalence of intimate partner violence and associated factors amongst women attending antenatal care at Outapi primary health care facility, Namibia: A descriptive survey.

Bikinesi Leonard Timothy

You are asked to participate in a research study conducted by Dr Bikinesi Leonard T. from the Department of Family Medicine at Stellenbosch University. The results of this study results will be contributed to research paper. You were selected as a possible participant in this study because you meet the criteria of participants required to help us with this study.

1. PURPOSE OF THE STUDY

The study aims to find out how many women have experienced violence or abuse from their intimate partner in our local community.

2. PROCEDURES

If you volunteer to participate in this study, we will ask you to complete a questionnaire by answering the questions that your nurse will ask you. It will take 15 minutes.

3. POTENTIAL RISKS AND DISCOMFORTS

There are no risks to completing the questionnaire and your participation and answers will be kept confidential. The nurse interviewing you is also committed to keeping your information confidential.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

The study will benefit the community as it will be able to know the extent of the problem in our local community which in turn can be used by local authorities to put in place measures to reduce and manage the problem. If you

feel that you need help with this problem as a result of answering the questions then please speak with your nurse.

5. PAYMENT FOR PARTICIPATION

There is no payment for participating in this study.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will only be disclosed with your permission or as required by law. Confidentiality will be maintained all times.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact Dr Bikinesi Leonard T; 0816515097[Names of the nurses will be included as well as their mobile numbers]

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, Elvira **Rohland,** Tel: +27 21 938 9677, E-mail: ethics@sun.ac.za at the Health Research Ethics.

SIGNATURE OF PARTICIPANT

The information above was described to me in Oshindonga and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of participant*]. She was encouraged and given ample time to ask me any questions. This conversation was conducted in Oshindonga and no translator was used.

_____ _____

Signature of Investigator Date

2. Consent (Oshindonga)

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH (Oshindonga)

Prevalence of intimate partner violence and associated factors amongst women attending antenatal care at Outapi primary health care facility, Namibia: A descriptive survey.

Bikinesi Leonard Timothy

Oto pulwa ukuthe ombinga momapekaapeko ganingwa ku Dr Bikinesi Leonard T. okuza koshikondo sho Family medicine ko Stellenborsch University. Iizemo yinasha no mapekaapeko ngano otayi ka tulwa kombapila yomapekaapeko. Owali wa hogololwa onga omukuthi mbinga tavulu momapekaapeko ngaka molwaashi owa adha/gwanithapo iipumbiwa yoo nakukutha ombinga yapumbiwa okutukwathela shinasha nomapekaapeko ngano.

1. ELALAKANO IYO MAPEKAAPEKO

Okumona kutya aakiintu yangapi ya monithwa iihuna nokuningilwa omahepeko kookuume yawo yomiihole momudhingoloko gwetu.

2. OMILANDU

Uuna wiiyamba oku kutha ombinga momapekaapeko ngano, otatu kekupula opo wu uvithe ombapila yomapulo toyamukula omapulo ngono to ka pulwa komupangi. Otashi ka kala uule woo minute omulongo nantano.

3. SHOKA TASHI VULU OKUKU TULA MOSHIPONGA

Kapena uupyakadhi oku uvitha ombapila yomapulo na ekuthombinga lyoye oshowo omayamukulo goye ota ga kakala oshiholekwa.

4. OMAUWANAWA OO MAPEKAAPEKO KOSHIGWANA

Omapekaapeko ngano otaga kwathela omudhingoloko shi tagu Kashiwa kutya uupyakadhi outhike peni wuli momudhingoloko shitashi ka eta opo galongithwe komalelo go paikandjo opo gatule po omilandu dhokushunitha noku kutha puupyakadhi. Uuna wapumbwa okukwathelwa kombinga yuupyakadhi shinasha noku yamukula omapulo popya nomupangi goye.

5. ONDJAMBI YE KUTHOMBINGA

Kapena ondjamba yekuthombinga mo mapekaapeko ngano.

6. OSHIHOLEKWA

Kehe uuyelele wa monikwapo mekwatathano iinasha noma pekaapeko ngano ota wu kutumbulilwa otau kala oshiholekwa na otau kagandjwa pauyelele papitiko lyoye ile ngashi sha uthwa koveta. Oshiholekwa otashi kalekwa po ethimbo kehe.

7. EKUTHOMBINGA/KUUYA KUTHOMBINGA

Oto hogolola ngele oto kutha ombinga ile ahawe momapekaapeko ngaka. Ngele owiiyamba ukale momapekaapeko ngaka, oto vulu okuzamo ethimbo kehe pwaana iilanduli yoludhi kehe. Oto vulu ishewe oku kala ino ya mukula omapulo ngono inohala okuyamukula na otokala mowala momapeekapeko.

8. UUYELE WAATALELI

Ngele owuna omapulo ile omalimbililo kombinga yomapekaapeko, alikana manguluka opo ukwatathane naDr Bikinesi 0816515097; meme Elizabeth Aulamba 0814655369 nameme Kalipi.

9. UUTHEMBA WOMUNTU MOSHILONGWA MAPEKAAPEKO SHIKA

Ethimbo kehe owapitikwa okuzamo nenge okuthigapo oonkundathana pwaana egeelo. Molwa ekutho mbinga iyoye momapekaapeko ngano kapena oku pula iifuta yuuthemba woye shi wakutha ombinga. Ngele owuna epulo shinasha nuuthemba woye momapekaapeko ngaka, Elvira **Rohland,** Tel: +27 21 938 9677, E-mail: ethics@sun.ac.za at the Health Research Ethics.

SIGNATURE OF PARTICIPANT

The information above was described to me in Oshindonga and I am in command of this language. I was given the opportunity to ask questions and these questions were answered to my satisfaction.
I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant **Date**

SIGNATURE OF INVESTIGATOR

I declare that I explained the information given in this document to _____ [*name of participant*]. She was encouraged and given ample time to ask me any questions. This conversation was conducted in Oshindonga and no translator was used.

_____ _____

Signature of Investigator Date

3. Questionnaire

Screening questions that could be used by the nurse to identify women

Please ask ONE of the following questions to raise the topic of intimate partner violence. Explore the answer if necessary to establish whether there is evidence of intimate partner violence or abuse (physical, sexual, psychological, emotional or financial). If there is evidence of intimate partner violence ask permission to complete the rest of the questionnaire [insert appropriate instructions on consent and who does what and where]

Asking indirectly

Are you unhappy in your relationship?
How are things going in your relationship?
Your symptoms may be related to stress. Do you and your partner tend to fight a lot?
What happens when your partner gets angry?
Does your partner have a problem with alcohol, drugs or gambling? How does it affect his behavior with you and the children?

Asking directly

In this clinic, we are asking all pregnant women if they have ever experienced any form of abuse from their partner – have you ever experienced abuse?
Sometimes when I see an injury like yours, it is because someone hit them. Did this happen to you?
Has your husband or partner ever hit you or hurt your physically?
Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?
Has your boyfriend/husband/partner ever forced you to have sex when you did not want to?
Has a boyfriend/husband/partner ever threatened your life, isolated you from your family or friends or refused to give you money?

Complete on all women screened from questions above on IPV and medical record				
Registration number				
Intimate partner violence (ever)	**Yes**		**No**	
Age (years)				
Gestation of pregnancy (weeks)				
Marital status	**Unmarried**	**Married**	**Divorced**	**Widowed**
Highest level of education completed	**None**	**Primary**	**Secondary**	**Tertiary**

Assignment 4: Dr Leonard Bikinesi 17002087

HIV status	Unknown	Positive	Negative	

Questionnaire on intimate partner violence

Complete this questionnaire after obtaining informed consent in women who have experienced intimate partner violence or abuse.

Physical abuse: "Has he or any other partner ever…"	Yes/No	Last 12months	How many times	Whilst pregnant
Pushed you or shoved you?				
Slapped you or threw something at you, which could hurt you?				
Hit you with his fist or something else that could hurt you?				
Kicked you, dragged you?				
Beat you up?				
Strangled you?				
Burnt you purpose?				
Threatened to use or actually used a gun?				
Threatened to use or actually knife, or other weapon against you?				
Any other form of physical abuse? Explain				

Emotional and psychological abuse: "Has he or any other partner ever…"	Yes/No	Last 12months	How many times	Whilst pregnant
Forced you to leave the place where you were living?				
Forced your children to leave the place where you were living?				
Insulted you or made you feel bad about yourself?				
Belittled or humiliated you in front of other people?				
Tried to prevent you from seeing family or friends?				
Tried to prevent you from speaking with other men?				
Boasted about or brought home girlfriends?				
Done things to scare or intimidate you on purpose, for example, by the way he				

looked at you, by yelling and smashing things.				
Threatened to hurt you?				

Financial abuse: "Has he or any other partner ever…"	**Yes/No**	**Last 12months**	**How many times**	**Whilst pregnant**
Failed to provide money to run the house or look after the children but had money for other things?				
Taken your earnings?				
Tried to prevent you from going to work, selling, or making money in any other way				
Forced you to do some work that you didn`t like				
Any other financial abuse? Explain				

Sexual abuse	**Yes/No**	**Last 12months**	**How many times**	**Whilst pregnant**
Has he or any other partner ever physically forced you to have sex when you did not want to?				
Have you ever had sex when you did not want to with your current boyfriend or husband, or any other partner, because you were afraid of what he might do?				
Has your current boyfriend or husband, or any other partner, ever forced you to do something sexual that you found degrading or humiliating?				
Any other form of sexual abuse? Explain.				

Would you like assistance to your problem? **YES / NO**