Intimate partner violence amongst undergraduate nursing students

A. Kordom*
Master's student

H. Julie*
e-mail: hjulie@uwc.ac.za

S. Arunachallam*
e-mail: sarunachallam@uwc.ac.za
*School of Nursing
University of the Western Cape
Bellville, South Africa

Abstract

Intimate partner violence (IPV) is reported to be rife among the student population at tertiary institutions and the general population. Yet the abuse is under diagnosed by nurses in health care settings. Research indicates that nurses' personal experiences of this type of abuse play a role in the management of survivors. Hence, this study investigated the prevalence and factors associated with IPV among the undergraduate nursing student population at a tertiary institution in the Western Cape, South Africa. A self-administered questionnaire was completed by the stratified random sample. The reported lifetime prevalence of IPV included psychological, physical, financial and sexual abuse. IPV was significantly associated with the educational status of the respondent's mother, financial support and witnessing of abuse during childhood. A support structure is thus needed to prepare the undergraduate student nurses emotionally before commencing with their training in the management of survivors of IPV.

Keywords: intimate partner violence, undergraduate student nurse, tertiary institutions, abuse, prevalence, Western Cape

INTRODUCTION

In this article, the authors argue that gender-based violence (GBV) and hence intimate partner violence (IPV) is under-diagnosed by nurses (Julie, Daniels and Adonis, 2005). The premise is that student nurses' personal experiences of IPV act as a barrier (Kim and Motsei 2002; Joyner 2009) to the effective management of IPV. IPV and associated risk factors incorporated in the ecological model warrant greater explanation as a background to the study reported on in this article.

IPV is classified as a branch of interpersonal violence according to the World Health Organisation (WHO) Report on Violence and Health (Krug, Dahlberg, Zwi and Lozano 2002, 6). This form of violence is characterised by patterns of coercive

behaviour aimed at controlling the other in an intimate romantic relationship (Gerber and Tan 2009, 1756). The perpetrator employs physical, psychological, sexual and financial abuse strategies to exert power over the intimate partner (Gass, Stein, Williams and Seedat 2011; Heise and Gracia-Moreno 2002). IPV against women has been identified as a global public health problem based on the findings of the WHO multi-country study on women's health and domestic violence (DV) against women (Ellsberg et al 2008, 1165). The findings indicate that 5–20 per cent of healthy life years are lost in women between the ages 15–44 due to IPV (Ellsberg et al 2008, 1140). Significant associations were found between lifetime IPV and walking difficulties, memory loss, dizziness, vaginal discharge and, suicidal ideation or attempts (Ellsberg et al 2008, 1168). The reported lifetime prevalence of IPV ranged from 15–71 per cent (Ellsberg et al 2008, 1168). However, the study did not investigate financial abuse.

An overview of IPV is provided based on the data from the South African Stress and Health Study, which formed part of the WHO World Mental Health Survey Initiative. The South African epidemiological study mirrored the WHO's conclusion in stating that violence is pervasive and a serious public health problem because 'studies have consistently shown high rates of violence against women and correlations with injury and adverse mental and physical health outcomes' (Gass et al 2012, 2765). However, the reported rates of IPV were significantly higher for women (29.3%) compared to that of men (20.9%) (Gass et al 2012, 2774).

It can thus be postulated that IPV will be rife amongst the student nursing population because nursing is foremost known to be a female profession; and secondly, IPV is most prevalent during dating and cohabitation. The seminal dating violence study conducted in 16 countries among 31 tertiary institutions showed that physical violence perpetrated by a dating partner in the year prior to the study ranged from 17 per cent to 45 per cent (Straus 2004). IPV findings for physical (20–30%), psychological (50–80%) and sexual (15–25%) aggression are cited for college students (Branch, Richards and Dretsch 2013, 3387). A study conducted among undergraduate health science students at three Russian universities, reported that 25.5 per cent of students had experienced physical abuse and 3.6 per cent had sustained injury because of this violence (Lysova and Douglas 2008). A study conducted among female students at tertiary institutions in Greece, reported 46.2 per cent sexual abuse prevalence (Chan, Straus, Brownridge, Tiwari and Leung 2008). A Nigerian study among university students showed that psychological abuse is the most common type of IPV, with 50.8 per cent of perpetrators being male students (Iliyasu et al 2011). No data could be located for South African tertiary institutions; hence, the reference to studies conducted in the general population. A South African study among pregnant women attending antenatal clinics at four hospitals, reported a prevalence of 67.5 per cent for psychological abuse and 13.7 per cent for financial abuse (Dunkle et al 2004). An epidemiological community-based prevalence study in three of the nine provinces of South Africa indicated that 51 per cent of women in

the Eastern Cape, 50 per cent of women in Mpumalanga and 40 per cent of women in the Northern Province were financially abused by their male intimate partners (Jewkes, Levin and Penn-Kekana 2002).

The ecological model is discussed in order to illustrate how combinations of personal, situational and socio-cultural factors contribute to the prevalence of IPV amongst the nursing student population.

Risk factors of IPV

Scholars assert that the prevalence of IPV against women in a culture or community can be used as a proxy for the status of women in that society (Uthman, Lawoko and Moradi 2009, 1472). Therefore, researchers in health and social sciences use the ecological model to explain the inter-relatedness of personal, situational and socio-cultural factors that combine to cause IPV (Ellsberg and Heise 2005; Krug et al 2002). See Figure 1 for the four levels of the ecological model as it was applied to the South African society.

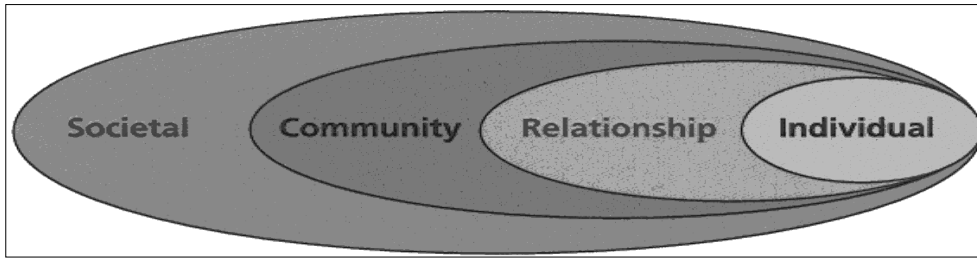

Figure 1: The ecological model adapted from Krug et al (2002, 12)

Individual factors

The most recent South African epidemiological study identified the main causes of violence at this level as the witnessing of parental violence; being abused as a child; and alcohol use by intimate partners (Gass et al 2011, 2797). Children witnessing abuse or surviving DV are regarded as strong indicators for future violence against intimate partners (Abrahams and Jewkes 2005; Gass et al 2011; Jewkes et al 2009). This hypothesis was confirmed by South African researchers who found that men who abuse women were approximately four times more likely to have been abused by their parents during childhood (Gupta et al 2008). It can thus be concluded that children learn to be aggressive from the family context.

The level of alcohol intake is also associated with aggressive behaviour and IPV (Sharps, Campbell, Campbell, Gary and Webster 2003, 1092). This factor was of special relevance to the current study because the research setting is located in a region known for the highest alcohol abuse in South Africa (Williams et al 2008, 211). Additionally, the findings of a study conducted at the research institution indicated that 64 per cent of students reported regular use of alcohol (Rich 2004).

Relationship factors

The factors identified as predictors of violence during an intimate relationship include: marital or relational conflict; male control of wealth; and decision making in the family or relationship (Heise, Ellsberg and Gottemoellet 1999; Krug et al 2002).

Marital or relational conflict is one of the main causes of IPV due the dominating and controlling behaviours displayed by the male partner framed by a patriarchal value system (Selokela 2005, 3). Hence, any challenge to patriarchal norms will result in violence.

Community factors

The most consistent markers of violence across countries are: social inequity; low economic development; and high levels of gender inequality (Jewkes et al 2009). All these markers, which are prevalent in South Africa, often result in feelings of low self-esteem of the affected males which are directed into anger, frustration, and eventually violence towards the perceived powerless (Jewkes et al 2009). When the male partner can no longer financially support or control his female partner, conflict occurs, and eventually results in IPV (Jewkes, Levin and Penn-Kekana 2002). A study conducted on rape perpetration by young males in the Eastern Cape and KwaZulu-Natal, South Africa, reported that 8.4 per cent of men admitted to raping a female partner during an intimate relationship (Jewkes et al 2006).

Societal factors

At this level, the factors identified as predictors of violence during an intimate relationship are: societal acceptance of violence as a way to resolve conflicts; rigid gender roles; and masculinity that is linked to attributes of dominance and aggression (Krug et al 2002). Societal acceptance or tolerance is regarded as the strongest predictor of IPV (Uthman et al 2009, 1473). The unacceptably high level of workplace violence against nurses in South Africa is ascribed to the societal and interpersonal violence that penetrate the workplaces (Kajee-Adams and Khalil 2010, 188). However, scholars are asserting that workplace violence in nursing is perpetuated by workplace cultures that do not protect nurses against different types of violence (AbuAlrub and Al-Asmar 2011, 157). Type 4 workplace violence has relevance to the current study because in this type of violence the perpetrator has a personal relationship with the employee but not necessarily with the organisation. In the study, it refers to the IPV that tends to spill over into the nurses' workplace (Kennedy and Julie 2013, 2).

PROBLEM STATEMENT

Public health personnel are often the first contact point, if not the only one, for survivors of IPV (Kramer, Lorenzon and Mueller 2004). Therefore, nurses are in a unique position to identify and manage IPV (Barber 2008; Du Plat-Jones 2006).

Unfortunately, GBV (and hence IPV), is underreported and inadequately diagnosed by nurses (Julie et al 2005) due to personal and informational barriers (Joyner 2009; Kim and Motsei 2002).

The study conducted at the research institution, cites that the student nurses' personal experiences of GBV negatively affected their ability to render effective nursing care to these survivors (Julie et al 2005). These IPV experiences thus pose challenges for the training of the nursing students (Gerber and Tan 2009, 1756).

To take remedial steps it was necessary to get an overview of the magnitude of the problem. Hence, the aim of the study was to investigate the prevalence of and the socio-demographic factors associated with IPV among the undergraduate nursing student population at a tertiary institution in the Western Cape, South Africa. The study therefore explored IPV perpetrated during the student nurses' lifetime and the 12 months prior to the survey. IPV was defined as physical, sexual, psychological and financial abuse perpetrated by spouses or intimate partners. Intimate partners referred to current and former boyfriends, girlfriends, husbands and wives.

METHODOLOGY

A quantitative, descriptive survey was used in order to answer the research objectives of the study (Burns and Grove 2007, 241–242) from the random stratified sample in Table 1.

Table 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

The data collection instrument

The WHO's instrument, designed to measure IPV, was used (Garcia-Moreno et al 2005) and was adapted to include questions on financial abuse with the assistance of a statistician. The 57-item questionnaire was sub-divided into the demographic information of the respondent, the family history, the substance use history of the respondent and the IPV sections. The Cronbach's alpha co-efficient of 0.950 indicated that this instrument had a high internal consistency. Table 2 shows the reliability estimates for the IPV components of the questionnaire.

Table 2: Cronbach's alpha reliability coefficient

Subscale alpha	Number of items	Cronbach's alpha
Psychological abuse	6	0.887
Physical abuse	8	0.921
Sexual abuse	5	0.907
Financial abuse	9	0.938

Descriptive and inferential statistical analysis using SPSS 20 was done with the assistance of a statistician.

RESULTS

The following socio-demographic results were obtained:

Age and gender

The results of the age groups showed that 151 (62.7%) of the respondents were in the 18 to 24 years age group; 62 (25.7%) in the 25 to 34 years age group; 22 (9.1%) in the 35 to 44 years age group; and six (2.5%) in the age group 45 to 54 years. Most, that is, 18 (74.1%) of the respondents were females and 63 (25.9%) were males.

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

The sample comprised 169 (69.5%) blacks; 57 (23.5%) coloureds; and 16 (6.6%) whites. The religions were 219 (90.1%) Christian; 12 (4.9%) Muslim; and six (2.5%) ancestral worship.

The majority of the respondents, that is 188 (77.4%), were single; 39 (16%) were married; nine (3.7%) were co-habiting; three (1.2%) were separated; and four (1.6%) were divorced. Most of the respondents, that is 152 (62.8%), did not have any children; and 90 (37.1%) reported that they had at least one child or more.

Place of residence and current siblings

Table 3 shows that 128 (53.1%) of the respondents were living at home; 105 (43.8%) with their family; and 39 (16.3%) with a partner.

Table 3: Place of residence and current siblings

Variable Percentage	Category	Frequencies	
Place of residence	University	76	31.5
	Home	128	53.1
	Private	37	15.4
Current siblings living with	Alone	70	29.2
	Family	105	43.8
	Partner	39	16.3

Educational and employment status of partner and monthly household income

The findings indicated that 122 (52.8%) of the respondents' partners had attended a tertiary institution; 72 (31.2%) had attended a secondary school; and 19 (8.2%) had either attended a primary school or had no formal education. However, 98 (42.1%) of the respondents' partners were employed; 80 (34.3%) were still students; while 46 (19.7%) were unemployed at the time of data collection. The monthly household income status of respondents indicated that 95 (41.3%) earned less than R2 000; 82 (35.6%) earned between R2 000 to R5 999; and 53 (23%) reported an income of R6 000 and higher.

Socio-demographic factors and IPV

The results shown in Table 4 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 18 to 24 age group. The study year level (p = 0.001*) was significantly related to IPV. The highest mean rank for IPV was among the fourth-year respondents and the lowest mean rank among the first-year respondents. Similarly, the results indicated that marital status (p = 0.021*) was also significantly associated with IPV. 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 further indicates that the number of children ($p = 0.077$); ethnic origin ($p = 0.843$); religion ($p = 0.611$); place of current residence ($p = 0.610$); people residing with responent ($p = 0.289$); educational status of partner ($p = 0.546$); employment status of partner ($p = 0.159$); and monthly household income (0.744) were not statistically significant because the *p*-values were more than five per cent therefore not associated with IPV.

PREVALENCE OF INTIMATE PARTNER VIOLENCE

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' referred to any of the following: husbands and wives, boyfriends and girlfriends, dating partners (whether current or former at the time of data collection). Figure 2 illustrates the prevalence of the different types of IPV reported for the 12-month period prior to data collection or for the nursing students' lifetime. The lifetime prevalence was the highest for psychological abuse; almost equal for physical and financial abuse; and the lowest for sexual abuse. However, the 12-month prevalence indicated that psychological abuse was closely followed by financial abuse.

The frequency of psychological abuse

The findings summarised in Figure 3 indicate that 141 (58%) of the undergraduate student nurses had been insulted or made to feel bad about themselves by their intimate partner and 97 (40%) had been belittled or humiliated in the presence of other people. A total of 107 (44%) also indicated that their partners had intimidated or intentionally scared them; whilst 87 (35%) acknowledged that their intimate partners had threatened to hurt them.

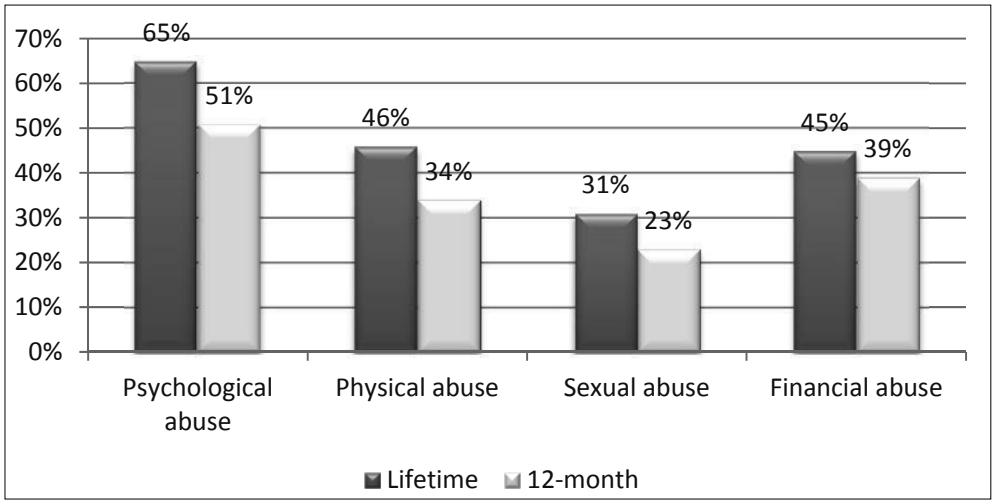

Figure 2: Lifetime and 12-month prevalence of IPV

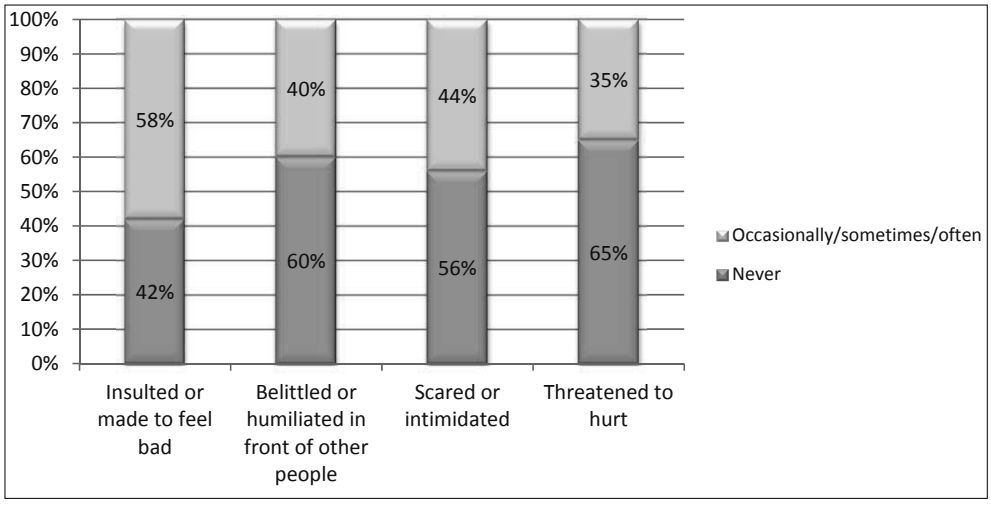

Figure 3: Frequency of psychological abuse

Table 4: Socio-demographic factors and IPV

Variable							Chi square	df	Test 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	0.771
Place of current residence	University	Home	Private						
Mean Score IPV	116.93	121.09	129.05				0.988	2	0.610
People residing with	Alone	Family	Partner						
Mean Score IPV	116.93	121.09	129.05				3.697	2	0.157
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						
Mean Score IPV	98.09	120.02	111.58				4.693	2	0.096
Monthly household income	< R2 000	R2 000–R2999	R3 000–R3 999	R4 000–R4 999	R5 000–R5 999	> 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

Physical abuse

The reported lifetime and 12-month prevalence of physical abuse was 46 per cent and 34 per cent, respectively. The different types of physical abuse the undergraduate nurses experienced are summarised in Figure 4. Of these, the highest reported prevalence was 95 (39%) for being slapped or having something thrown at them that could have hurt them. For the second most prevalent type of physical violence, 93 (38%) indicated that their intimate partners had pushed or shoved them, or pulled their hair. The lowest reported prevalence of 35 (14%) was for being choked or intentionally burnt by their intimate partners.

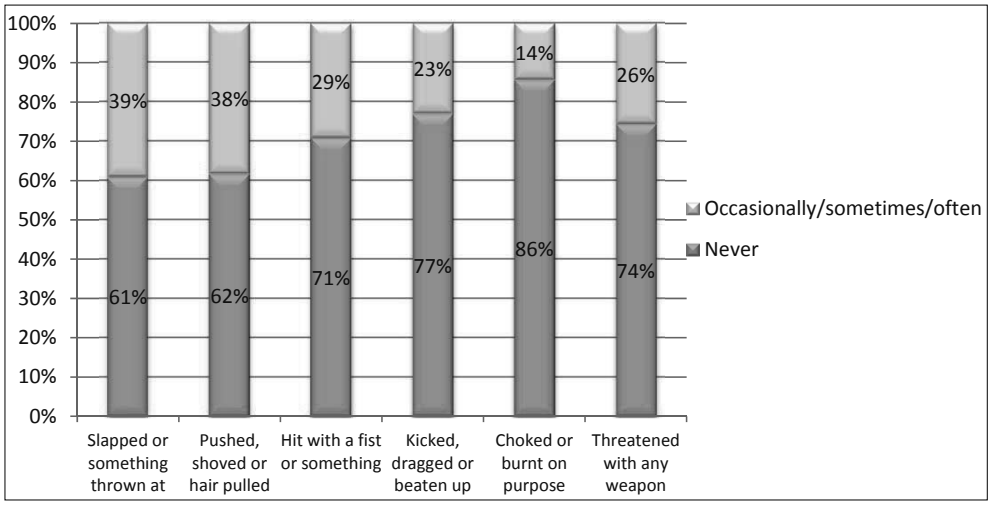

Figure 4: Types of physical abuse

Financial abuse

The reported lifetime and 12-month prevalence of physical abuse were 45 per cent and 39 per cent, respectively. The findings in Figure 5 indicate that intimate partners taking money from the respondent's purse without consent was the most prevalent form of financial abuse for 83 (34%) of the respondents. This was closely followed by 78 (32%) who experienced intimate partners concealing or preventing the respondents from accessing the family income; hence forcing 77 (32%) of their respondents to ask the intimate partners for money. However, only 59 (24%) respondents had been prevented from earning an income; whilst 23 (13%) were prevented from accessing income-earning resources.

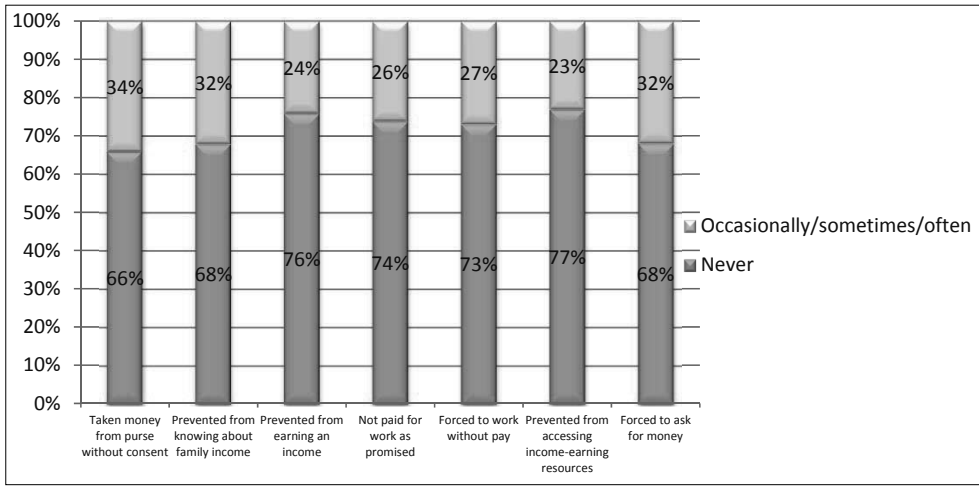

Figure 5: Types of financial abuse

Sexual abuse

The lifetime and 12-month prevalence of sexual abuse were 23 per cent and 31 per cent, respectively. Figure 6 illustrates that 57 (23%) of the undergraduate student nurses had been physically forced to have sexual intercourse against their will. Another 46 (19%) reported that they had been forced to engage in sexual intercourse because they feared reprisal from their intimate partners. Similarly, 46 (19%) had been forced to engage in sexual intercourse which they found degrading or humiliating.

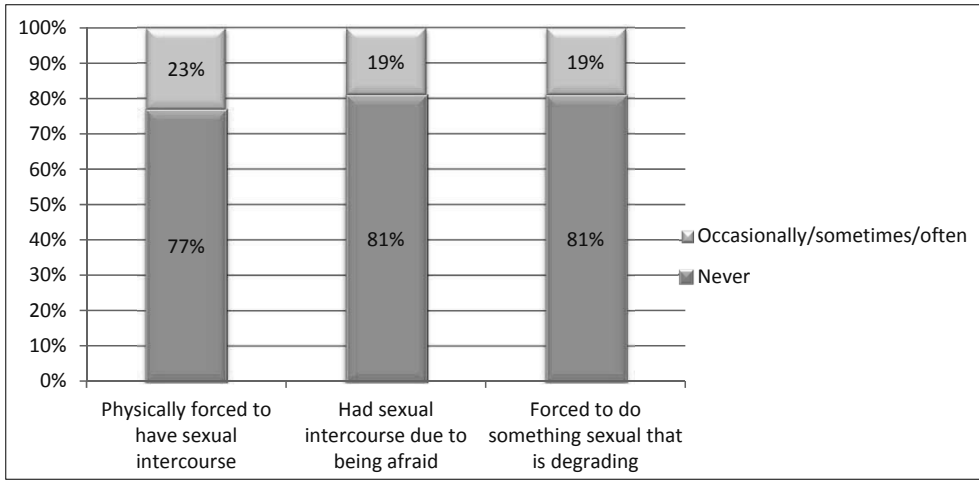

Figure 6: Types of sexual abuse

DISCUSSION

Socio-demographic factors and intimate partner violence

Age

The results in Table 4 indicate that IPV was significantly associated with age (p = 0.009*). The findings of the current study correspond with earlier research studies that show a significant relationship between age and IPV (Arnold et al 2008; Heise and Ellsberg 2005; Iliyasu et al 2011; Krug et al 2002). However, studies on the relationship between age group and IPV present mixed results. Although the aforementioned studies suggest that survivors of IPV are usually young, the findings of the current study show that undergraduate student nurses within the 35–44 years age group experienced much higher levels of IPV than other age groups.

The possible reason for the lower IPV prevalence for the 18–24 years age category might be the presence of protective factors against IPV. The majority of the undergraduate student nurses were relatively young, single and still living at home with their families, despite being in a dating relationship.

By contrast, the higher levels of IPV, almost 25 per cent, among the 35–44 years age group could be ascribed to the fact that 39 (16%) were married; nine (3.7%) were cohabiting; three (1.2%) were separated; and four (1.6%) were divorced (Table 4). All of these factors are regarded as risk factors for IPV according to Jewkes et al (2002).

Marital status

In the study marital status (p = 0.021*) was also significantly associated with IPV. According to the results of the 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). The findings of the present study are consistent with the findings of Zungu, Salawu and Ogunbanjo (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 couples, while the lowest prevalence was 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 that these women openly admit to IPV only after they have left the abusive relationship. By contrast, women who are still in an abusive relationship might be scared to report IPV for fear of what their partner might do. Instilling fear is one of the tactics that the perpetrators might use to prevent the women from reporting IPV to the appropriate authorities.

Year level of study

The study found that IPV was significantly associated with year level of study (p = 0.001*). The fourth-year undergraduate student nurses had the highest mean

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). Previous research studies have suggested that IPV is most prevalent among the least educated survivors (Arnold et al 2008; Heise and Ellsberg 2005; Iliyasu et al 2011; Jewkes 2002; Krug et al 2002; Zungu et al 2010). The findings of the current study are inconsistent because according to the results, 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 can possibly be due to their higher educational level. This is further supported by Krug et al (2002) who emphasise 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 partner is more educated, which can be viewed as an indirect challenge to patriarchal norms, this usually predisposes the female to violence (Garcia-Moreno et al 2005; Krug et al 2002). The basis for this violence is due to the partner's feelings of low self-esteem, which are directed into anger and frustration.

Gender

According to the results of the current study, gender (0.001*) was associated with sexual abuse. It is evident from the results that more females are sexually abused than males which is in many respects not surprising. In the study, the majority of the undergraduate student nurses were female which confirms the assertion that nursing is predominantly a female profession. The results of the study are consistent with the findings of a study done in Russia among female and male students. According to the results of the study, female students are more likely to be sexually abused than their male counterparts (Lysova and Douglas 2008).

Sexual abuse in South Africa is widespread (Jewkes and Abrahams 2002), therefore, it would be expected for such violence to infiltrate tertiary institutions. The reasons for the high rates of sexual abuse in the country can be explained against the backdrop of a highly patriarchal society. In such a society, females are regarded as inferior to males and intimate relationships are marked by male dominance (Uthman et al 2009, 1472).

PREVALENCE OF IPV

The results from the current study show that 42 per cent of undergraduate student nurses experienced some form of IPV during their lifetime. The finding from the current study is lower than a study conducted in Botswana where 49.7 per cent of women attending a public hospital experienced IPV (Zungu et al 2010). Similarly, in Malawi the overall prevalence of IPV accounted for 48 per cent of women during their lifetime (Pelser et al 2005).

Psychological abuse

The high prevalence of psychological abuse (65%) reported by the undergraduate student nurses is similar to the findings of a study in Russia which started that 61.6 per cent of the students reported being survivors of psychological abuse perpetrated by an intimate partner (Lysova and Douglas 2008). However, the study findings are lower than the prevalence rates of psychological abuse which were reported by male (86.5%) and female (83%) students in the United States (US) (Fass et al 2008). Similar results on the high prevalence rate of psychological abuse were found in Chile among university students, 79.9 per cent among males and 67.3 per cent among female university students (Lehrer et al 2009). The high prevalence rate of psychological abuse might be due to the inclusion of the entire student population which yielded a larger sample size. The results of the current study are lower than the findings from a South African study among women attending a health facility in the Western Cape which revealed that 82.7 per cent of women were survivors of psychological abuse (Joyner and Mash 2012). The high rate of psychological abuse in the current study and in previous research (Iliyasu et al 2011; Kramer et al 2004) has been found to be a predictor of physical violence.

Physical abuse

Physical abuse among the undergraduate student nurses accounted for 34 per cent and 46 per cent during the 12 months before the study was conducted and during the students' lifetime, respectively. The results of the study are comparable with the findings of the International Dating Violence (IDV) study that was conducted by Straus (2004) in 16 countries among 31 tertiary institutions. The results from that study showed that physical violence perpetrated by a dating partner in the year before the study was conducted ranged from 17 per cent to 45 per cent (Straus 2004). According to the IDV study, the results of the current study are lower than those reported for the USA (44.7%), Mexico (42.0%) and India (39.0%). However, the results of the current study are higher than those reported for Germany (24.5%), Canada (23.0%) and Australia (21.3%) as shown in the IDV study (Straus 2004). The possible reasons for these results may be the local context in which these studies were conducted. Lysova and Douglas (2008) acknowledge that well-developed Western countries, such as Germany, Greece and Switzerland, have fairly low intimate femicide rates and thus lower overall IPV prevalence rates in comparison with developed countries, such as South Africa, which has the highest femicide rates across the globe. It would thus be expected that South Africa 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.

The findings of the current study are comparable with an epidemiological community-based prevalence study in three of the nine provinces of South Africa, namely, the Eastern Cape, Mpumalanga and the Northern Province. The study results show that between 19 per cent and 28 per cent of women have suffered from

some form of physical abuse perpetrated by an intimate male partner (Jewkes, Levin and Penn-Kekana 2002). The results of the current study are also comparable with findings from Tanzania in the WHO-Multi Country Study, where physical violence perpetrated by an intimate male partner was reported by 47 per cent of the women.

Sexual abuse

Sexual abuse in the current study was recorded as 23 per cent over the 12 months before the study was conducted and 31 per cent during their lifetime among undergraduate student nurses. Almost identical findings were reported in a study conducted among college students in Chile where 31 per cent of the female students reported that they had experienced some form of sexual abuse since the age of 14 and 17 per cent reported that they had been sexually abused in the 12 months before the study was conducted (Lehrer et al 2007).

The results of the present study are comparable with a previous study conducted by Sobti and Biwas (2008) among medical and student nurses in India. According to the results of that study, 32.1 per cent of medical and nursing students reported at least one episode of sexual abuse during their lifetime. The results of the current study are lower than the prevalence rate reported by an international study conducted by Gebreyohannes (2007) in Ethiopia, but higher than the prevalence rate reported by Lysova and Douglas (2008) in Russia.

In terms of the results from the international 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 30.7 per cent of survivors experienced sexual abuse during their lifetime (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). Although the current study revealed a high lifetime rate of the prevalence of sexual abuse among undergraduate student nurses, the rate of sexual abuse might still be even higher 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 personal views about sexual abuse, which is seen as a confidential matter; therefore, these survivors are not eager to report such violence to the appropriate authorities (Jewkes and Abrahams 2002).

Financial abuse

There is a paucity of reliable statistics on the prevalence of financial abuse among students attending tertiary institutions even though financial abuse is one of the controlling behaviours within an intimate relationship (Fawole 2008). Therefore, the current study included questions on financial abuse.

The results of the current study show that 39 per cent and 45 per cent of the undergraduate student nurses experienced some form of financial abuse during the past 12 months and during their lifetime, respectively. The results of the current study

show a higher rate than that of a national study conducted in Malawi, which showed that 28 per cent of females were financially abused by their male intimate partners (Pelser et al 2005). The high prevalence of financial abuse among undergraduate student nurses might be because these students receive financial assistance in the form of a bursary from the Provincial Administration of the Western Cape. Hence, student nurses are vulnerable to financial abuse by their intimate partners.

CONCLUSION

The research indicates that IPV is under-diagnosed by nurses because their personal experiences of IPV limit their therapeutic intervention in such cases. The results of the current study showed that the rate of prevalence of IPV is high among undergraduate student nurses at a tertiary institution in the Western Cape. The most common forms of violence perpetrated by an intimate partner include psychological, physical and financial abuse.

RECOMMENDATIONS

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 the undergraduate student nurses emotionally before commencing with their training in the management of survivors of IPV. Since this is the first such study to have been conducted among undergraduate student nurses in South Africa, the authors advocate for replica studies at other tertiary institutions that would allow for a comparative analysis of IPV among this population.

REFERENCES

Abrahams, N. and R. Jewkes. 2005. Effects of South African men's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. *American Journal of Public Health* 95(10): 1811–1816.

Abrahams, N., R. Jewkes, L. J. Martin, S. Mathews, L. Vetten and C. Lombard. 2009. Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and Victims* 24(4): 546–56.

AbuAlRub, R. F. and A. H. Al-Asmar. 2011. Physical violence in the workplace among Jordanian hospital nurses. *Journal of Transcultural Nursing* 22(2): 157–165.

Arnold, D., B. Getaye, M. Goshu, Y. Berhane and M. A. Williams. 2008. Prevalence and risk factors of gender-based violence among female college students in Awassa, Ethiopia. *Violence and Victims* 23(6): 787–800.

Barber, C. 2008. Domestic violence against men. *Nursing Standard* 22(51): 35–39.

Branch, K. A., T. A. Richards and E. C. Dretsch. 2013. An exploratory analysis of college students' response and reporting behavior regarding intimate partner violence victimization and perpetration among their friends. *Journal of Interpersonal Violence* 28(18): 3386–3399.

Campbell, J. C., D. Webster, J. Koziol-McLain, C. Block, D. Campbell, M. A. Curry and K. Laughon. 2003. Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health* 93(7): 1089–1097.

Chan, K. L., M. Strauss, D. A. Brownridge, A. Tiwari and W. C. Leung. 2008. Prevalence of dating partner violence and suicidal ideation among male and female university students worldwide. *Journal of Midwifery* and *Women's Health* 53(6): 529–537.

Dunkle, K., R. Jewkes, H. Brown, G. Gray, J. McIntyre and S. Harlow. 2004. Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *Lancet* 363: 1415–1421.

Du Plat-Jones J. 2006. Domestic violence: The role of health professionals. *Nursing Standard* 21(14–16): 44–48.

Ellsberg, M. and L. Heise. 2005. *Researching violence against women: A practical guide for researchers and activist*. Geneva: World Health Organisation.

Ellsberg, M., H. A. Jansen, L. Heise, C. H. Watts and C. Garcia-Moreno. 2008. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *Lancet* 371(9619): 1165–1172.

Fass, D. F., R. I. Benson and D. G. Legget. 2008. Assessing prevalence and awareness of intimate partner relationships of college students using internet sampling. *Journal of College Student Psychotherapy* 22(4): 66–75.

Fawole, O. I. 2008. Economic violence to women and girls: Is it receiving the necessary attention? *Trauma, Violence and Abuse* 9(3): 167–177.

Garcia-Moreno, C., H. A. F. M. Jansen, M. Ellsberg, L. Heise and C. Watts. 2005. *WHO multi-country study on women's health and domestic violence against women*. Initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organisation.

Gass, J. D., D. J. Stein, D. R. Williams and S. Seedat. 2011. Gender differences in risk for intimate partner violence among South African adults. *Journal of Interpersonal Violence* 26(14): 2764–2789.

Gebreyohannes, Y. 2007. Prevalence and factors related to gender-based violence among female students of higher learning institutions in Mekelle Town, Tigray, Northern Ethiopia. Master's thesis in Public Health, Addis Ababa University, Addis Ababa.

Gerber, M. and A. K. W. Tan. 2009. *Lifetime intimate partner violence exposure, attitudes and comfort among Canadian health profession students*.

Gupta, J., J. G. Silverman, D. Hemenway, D. Acevedo-Garcia, D. J. Stein and D. R. Williams. 2008. Physical violence against intimate partners and related exposures to violence among South African men. *Canadian Medical Association Journal* 179(6): 535–541.

Heise, L. and C. Garcia-Moreno. 2002. Violence by intimate partners. In *World report on violence and health*, ed. E. Krug, L. L. Dahlberg, J. A. Mercy, A. B. Zwi and R. Lozano, 87–121.Geneva: World Health Organisation.

Heise, L. L., M. Ellsberg and M. Gottemoellet. 1999. *Ending violence against women. Population reports* 27(4). Washington: Population Information Program, Center for Communication Programs, Johns Hopkins University, School of Public Health.

Iliyasu, Z., I. S. Abubakar, M. H. Aliyu, H. S. Galadanci and H. M. Salihu. 2011. Prevalence and correlates of gender-based violence among female university students in Northern Nigeria. *African Journal of Reproductive Health* 15(3): 123–133.

Jewkes, R. and N. Abrahams. 2002. The epidemiology of rape and sexual coercion in South Africa: An overview. *Social Science and Medicine* 55: 1231–1244.

Jewkes, R., N. Abrahams, S. Mathews, M. Seedat, A. van Niekerk, S. Suffla and K. Ratele. 2009. *Preventing rape and violence in South Africa: Call for leadership in new agenda for action.* Pretoria: Gender and Health Research Unit, MRC Policy Brief.

Jewkes, R., K. Dunkle, M. P. Koss, J. B. Levin, M. Nduna, N. Jama and Y. Sikweyiya. 2006. Rape perpetration by young, rural South African men: Prevalence, patterns and risk factors. *Social Science and Medicine* 63: 2949–2961.

Jewkes, R., J. Levin and L. Penn-Kekana. 2002. Risk factors for domestic violence: Findings from a South African cross-sectional study. *Social Science and Medicine* 55: 1603–1617.

Jewkes, R., L. Penn-Kekana, J. Levin, M. Ratsaka and M. Schrieber. 2002. Prevalence of emotional, physical and sexual abuse of women in three South African provinces. *South African Medical Journal* 91(5): 421–428.

Joyner, K. 2009. Health care for intimate partner violence: Current standard of care and development of protocol management. PhD thesis in Social Science Methods, University of Stellenbosch, Stellenbosch.

Joyner, K. and B. Mash. 2012. Recognizing intimate partner violence in primary care: Western Cape, South Africa. *PLoS One* 7(1): 1–5.

Julie, H., P. Daniels and T. Adonis. 2005. Service-learning in nursing: Integrating student learning and community-based service experience through reflective practice. *Health SA Gesondheid* 10(4): 41–54.

Kajee-Adams, F. and D. Khalil. 2010. Violence against community health nurses in Cape Town, South Africa. In *Workplace violence in the health sector*, ed. I. Needman, K. McKenna, M. Kingma and N. Oud, 187–188. Proceedings of the second international Conference on Workplace Violence in the Health Sector – from Awareness to Sustainable Action, 29 October, Maastricht, Netherlands.

Kennedy, M. and H. Julie. 2013. Nurses' experiences and understanding of workplace violence in a trauma and emergency department in South Africa. *Health SA Gesondheid* 18(1): Article 663. http://dx.doi.org/10.4102/hsag.v18i1.663 (accessed 14 September 2013).

Kim, J. and M. Motsei. 2002. 'Women enjoy punishment': Attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science and Medicine* 54(8): 1243–1254.

Kramer, A., D. Lorenzon and G. Mueller. 2004. Prevalence of intimate partner violence and health implications for women using emergency departments and health care clinics. *Women's Health Issues* 14(1): 19–29.

Krug, E., J. Dahlberg, M. Zwi and R. Lozano. 2002. *Violence by intimate partners: World report on violence and health*. Geneva: World Health Organisation.

Lehrer, J. A., V. L. Lehrer, E. L. Lehrer and B. Oyarzun. 2007. Prevalence of and risk factors for sexual victimization in college women in Chile. *International Family Planning Perspectives* 33(4): 168–175.

Lehrer, J. A., E. L. Lehrer and Z. Zhao. 2009. Physical and psychological dating violence in young men and women in Chile: Results from a 2005 survey on university students. *International Journal of Injury, Control and Safety Promotion* 16(4): 205–214.

Lehrer, J. A., E. L. Lehrer and Z. Zhao. 2010. Physical dating violence victimization in college women in Chile. *Journal of Women's Health* 19(5): 893–902.

Lysova, A. and E. M. Douglas. 2008. Intimate partner violence among male and female Russian university students. *Journal of Interpersonal Violence* 23(11): 1579–1599. http://jiv.sagepub.com/content/23/11/1579.full.pdf+html (accessed 25 January 2012).

Mathews, S., N. Abrahams, L. J. Martin, L. Vetten, L. van der Merwe and R. Jewkes. 2004. *Every six hours: A national study of female homicide in South Africa*. MRC Policy Brief 108.

Norman, R., D. Bradshaw, M. Schneider, R. Jewkes, S. Matthews, N. Abrahams, R. Matzopoulos and T. de Vos. 2007. Estimating the burden of disease attributable to interpersonal violence in South Africa in 2000. *South African Medical Journal* 97(8).

Pelser, E., L. Gondwe, C. Mayamba, T. Mhango, W. Phiri and P. Burton. 2005. *Intimate partner violence: Results from a national gender-based violence study in Malawi*. Malawi: Crime and Justice Statistical Division, National Statistical Office.

Rich, E. G. 2004. Alcohol use and unsafe sex practices among students (17-25-year-olds) at the University of the Western Cape. Master's thesis, University of the Western Cape, Bellville.

Seedat, M., A. van Niekerk, R. Jewkes, S. Suffla and K. Ratele. 2009. Violence and injuries in South Africa: Prioritising an agenda for prevention. *Lancet* 374(9694): 1011–1022.

Selokela, O. 2005. African women overcoming patriarchy.:A study of women in apostolic faith mission (AFM) church in Rustenburg, South Africa. MTheology thesis,. University of KwaZulu-Natal, Pietermaritzburg.

Sobti, P. and G. Biswas. 2008. Prevalence of sexual abuse among adolescent medical and nursing students in a college in Punjab. *Supplement to Pediatrics* 121(2) Supplement 2.

Straus, M. 2004. Prevalence of violence against dating partners by male and female university students worldwide. *Violence Against Women* 10(7): 790–811.

Uthman, O. A., S. Lawoko and T. Moradi. 2009. Factors associated with attitudes towards intimate partner violence against women: A comparative analysis of 17 sub-Saharan countries. *BMC International Health and Human Rights* 9(1): 14.

Wasserman, C. 2003. *Dating violence on campus: A fact of life.* Washington, DC: National Center for Victims of Crime.

Widyono, M. 2009. *Strengthening understanding of femicide: Using research to galvanize action and accountability*. Washington, DC: Program for Appropriate Technology in Health (PATH), InterCambios, Medical Research Council of South Africa (MRC), and World Health Organisation (WHO).

Williams, D. R., A. Herman, D. J. Stein, S. G. Heeringa, P. B. Jackson, H. Moomal and R. C. Kessler. 2008. Twelve-month mental disorders in South Africa: Prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine* 38(2): 211–220.

Zungu, L. I., A. O. Salawu and G. A. Ogunbanjo. 2010. Reported intimate partner violence amongst women attending a public hospital in Botswana. *African Journal of Primary Health Care and Family Medicine* 2(1): 1–6.