



# Conspicuous by its absence: Domestic violence intervention in South African pre-hospital emergency care

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## ABSTRACT

*Domestic violence (DV) is common globally. In South Africa, emergency care providers (ECPs) lack a clear policy framework and the necessary training to identify DV and intervene when it is encountered. We investigate the knowledge, attitudes and beliefs of ECPs towards DV, and identify factors affecting early identification and its appropriate management in South Africa. A survey of 154/266 registered operational ECPs of different qualification levels and employed by a provincial emergency medical service was conducted. Each participant voluntarily and anonymously self-completed a customised questionnaire. Some 75 (49%) ECPs had an acceptable understanding of DV, although those with higher level qualifications were significantly more knowledgeable ( $p = 0.017$ ). Most (147,97%) identified that alcohol and drugs were the main cause of DV. A few ECPs (15, 10%) reported having had experience of safety-focused and appropriate gender-sensitive handling of DV victims. The ECPs' qualification levels were not significantly associated with their knowledge of the legislation about DV or with whether they had referred victims of DV. Only 49 (22%) ECPs reported having occasionally referred victims. By their own admission these ECPs expressed inadequate ability to assess and manage DV cases in current ECP practices. There was poor understanding of the extent, nature, detection and referral of DV cases by ECPs relative to their incidence. This may be due to incorrect beliefs or myths about DV, inadequate training and problematic emergency system design. Our findings support the need for a comprehensive emergency care response to guide and standardise DV management with better understanding of gender-based violence in order for the emergency medical service to play a more preventive and holistic role in its responses.*

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## INTRODUCTION

Domestic violence (DV) is a global phenomenon (World Health Organization, 2013) defined by the Domestic Violence Act in South Africa (116 of 1998) as any controlling, abusive, fear-inducing act that threatens to harm the health, well-being or safety of a person in a domestic relationship (Republic of South Africa, 1998). DV entails gender-based violence or threats of violence resulting in physical, sexual or psychological harm or suffering to women. It includes threats, coercion or depriving women of their liberties in public or private life (United Nations, 1993). This violence is contextualised within a past or present relationship, generally perpetrated by a male partner and is experienced by the woman as harmful and destructive to herself, physically, emotionally, socially and psychologically (Family Violence Prevention Fund, 1999).

In South Africa, DV is a public health priority owing to the high number of cases reported and its negative consequences for individuals, families and society in general. The national study of female homicide in South Africa found that DV-related mortality was alarming in that 9 per 100 000 women aged 14 years and older were killed by an intimate partner in 1999 (Mathews et al., 2004). This presents the highest reported femicide rate globally and implies that four women per day are killed by an intimate partner. Where women were killed by someone they knew, one in two perpetrators was an intimate partner. In a 2009 mortality survey, intimate partner violence (IPV) was the leading cause of death of women homicide victims with 56% of female homicides being committed by an intimate partner (Abrahams, Mathews, Jewkes, Martin, & Lombard, 2012) and one every eight hours [with the reduction probably due to firearm legislative reforms (Jaynes, 2013)]. The global context, preceding fatalities, similarly shows how a third of the world's women have been sexually or physically abused by a partner (Gulland, 2013). The high frequency of mortality and serious non-fatal outcomes, including associated medical complaints (Heise, Pittaguy, & Germain, 1994) emphasises the need for pre-hospital responsiveness and more active responses in general from the health sector.

The responsiveness of health providers, in terms of confidence building, routinely enquiring about abuse and facilitating non-judgemental access to care, may influence the healthcare-seeking behaviour and impact on the long-term experiences of DV victims. Health facilities are intended for meeting the needs of abused persons, but the response of the health sector to the problem of DV remains a challenge. Pre-hospital emergency medical services (EMSs)

are also a health resource, but they are operated by medical systems designed to respond to emergencies in the tertiary sense of health promotion rather than primary prevention or early detection. The lack of primary prevention or early detection mechanisms by any health entity undermines South Africa's primary healthcare policy on which healthcare delivery is founded. There have been no DV protocols to guide ECPs, so clinical decision making and discretion in DV intervention by ECPs is likely to be guided by their existing knowledge, attitudes and beliefs concerning DV. The Professional Board for Emergency Care (PBEC) of the Health Professions Council of South Africa (HPCSA) is currently contemplating the implementation of DV intervention guidelines by ECPs and has "*challenged other professional boards to appraise their ethical and professional role as healthcare providers in addressing both the consequences and causes of domestic violence*" (Vinassa, 2013, pp. 30–1). The implied guidelines for the design and development of a pre-hospital medical protocol for DV victims for the ECP are cogently articulated in *Screening for Domestic Violence: A Policy and Management Framework for the Health Sector* (Martin & Jacobs, 2003). The HPCSA may enable individuals under its jurisdiction to do more, but it is the above framework that has most relevance for the EMS implementation. Notwithstanding these developments in the larger health sector, how EMSs currently respond to DV in their routine work is not documented. This study presents findings from a survey of EMS staff to assess their self-reported understandings of and responses to DV in their day-to-day emergency service work.

An ECP refers to a healthcare professional registered with the PBEC, HPCSA. Their duty is to treat and care for all patients presenting to the EMS (Health Professions Council of South Africa, 2003b). This includes being able to identify women who have experienced IPV, and to provide an appropriate and helpful response when DV is recognised. This requires training on gender, screening for gender-based violence and listening to and supporting afflicted women (Dunkle et al., 2003). In the context of DV, it is assumed that practitioners understand the dynamics of such abuse and the needs of abused patients, and that they have the capacity to serve the public with impartiality (Public Service Commission, 2002). Qualifying this assumption forms the object of this paper.

Recent studies conducted in the Western Cape find that recognition of women experiencing IPV is very low in primary care (less than 10%) and argue for selective case finding (Joyner & Mash, 2012a; 2012b). The lack of support for universal screening (World Health Organization, 2013) does not appear to be in direct relation to pre-hospital emergency care. Universal screening usually implies the mass screening of the whole population. The emergency care patient cohort is already at a higher probability of DV than the general population as the health consequences of DV manifest. Screening all women that present to EMSs is therefore both 'selective' and 'universal' for EMSs. Patients are

frequently 'discharged' in the pre-hospital setting due to the emergency care system of sorting and prioritising patients (triage). This has the potential to deliberately leave victims of abuse in the abusive home – oblivious to their level of risk, if not screened for DV. In the context of emergency care, the screening guidelines by Martin and Jacobs (2003) have not been surpassed by Joyner's Intimate Partner Violence Model (Joyner & Mash, 2012a). The forensic focus of the former aligns well with the ECP forensic role. ECPs, like hospital trauma unit staff, may encounter survivors of DV in the "open window" (Joyner et al., 2007) immediately after an acute DV incident. To not routinely enquire about abuse in cases where DV is not the presenting complaint constitutes a lost opportunity for early detection. The recontextualisation of DV for EMSs (Naidoo, 2007) has led to the HPCSA endorsing the forensic ECP role and the recommendations presented in the Martin and Jacobs guideline (Vinassa, 2013).

The Bill of Rights entrenched in Chapter 2 of the Constitution (Republic of South Africa, 1996) protects the health rights of women and their rights to equality, dignity, life, healthcare, food, water, social security and freedom. These rights remain 'paper rights' unless societal institutions champion them. This begs the question: are emergency service organisations social or health institutions? "*Social justice is a matter of life and death*" (CSDH, 2008, p. ii). Collaborating with other sectors to promote an effective socio-medical response is central to the EMS purpose. The above is better understood in terms of institutional and gender justice which is the prerogative of all state institutions. "*Procedural fairness*" (Sen, 2010, p. 64), as an element of organisational justice, requires that EMS organisations not only ensure that they are not discriminating against women on the basis of their gender (or gender-related health risks), but also actively promote gender justice. Another element of justice, the *difference principle*, "indicates the importance of equity in social arrangements so that attention is drawn particularly to the predicament of the worst off people" (Sen, 2010, p. 64). EMS, as an organ of social justice, has a moral and legal duty to enhance both.

Historically, there appears to be little direct regulatory influence over ECPs to treat DV victims appropriately. Ethical codes not specific to DV, such as the Hippocratic Oath, Declaration of Helsinki of 1948, Declaration of Geneva of 1948, the International Code of Medical Ethics of 1949, the Declaration of Oslo of 1970 and the Declaration of Tokyo of 1975 are also not directed at ECPs but to medical practitioners (McQuoid-Mason, Pillemer, Friedman, & Dada, 2002). The management protocols issued to all members of the PBEC do not make reference to an appropriate response to victims of DV (Health Professions Council of South Africa, 2003b). Their response to DV is therefore subject to practitioner discretion, albeit discretion informed by personal experience and dominant societal values (Naidoo, 2007). The HPCSA, as the regulator, quality assurer and standards-generating

body, requires that practitioners provide for the safety of their patients (Republic of South Africa, 2007). As DV patients have threats to their physical safety and health concerns, every healthcare practitioner is professionally and constitutionally obliged to care for victims of DV. In other words, failure to provide appropriate care constitutes a secondary crime against DV victims as it violates the Constitution.

There is limited literature on the pre-hospital response to DV (Naidoo, 2007). Our study's contribution is to document the prevailing attitudes, knowledge and beliefs of a sample of South African ECPs to victims of DV in the process of providing pre-hospital emergency care. The paper makes the case for pre-hospital intervention and further development of the emergency services to appropriately intervene in early, acute and late cases of DV and informs universal screening, responsive treatment and appropriate referral. Our findings have the potential to inform clinical or system changes to improve the emergency care response to DV as well as to provide a baseline measure for subsequent evaluation studies of DV interventions.

## **METHODOLOGY**

A descriptive, cross-sectional study design was used to quantitatively survey and measure the self-reported ECPs' knowledge of DV and their current emergency care response. Both male and female ECPs, registered with the HPCSA, across all academic and professional levels, were sampled to determine if knowledge was nuanced by qualification and clinical scope.

This study intended to document the ECP knowledge of DV and their current and possible responses to DV in the interest of informing emergency care practitioner agency and the improvement of role definition in cases of DV. The scope of practice for each ECP qualification differs, but medical ethics applies equally to all under the Health Professions Act (56 of 1974). The full staff complement comprised 313 ECPs but only operational personnel were included in the study population. Those personnel who were non-operational (due to being seconded elsewhere, on sick leave, on vacation, injured on duty, on leave without pay, or on study leave) were excluded. All remaining 266 ECPs included in the study sample were requested to self-complete an anonymous questionnaire with both open-ended and closed questions.

The initial development of the questionnaire focused on crisis intervention elements (such as the debunking of myths or incorrect beliefs) that were considered requisite by a local NGO, the Advice Desk for the Abused (Padayachee & Singh, 2010). This was aligned with the documented epidemiological, theoretical and contextual evidence for DV. The questionnaire

was validated by external review (by an MRC gender-based violence expert and the Chairperson of the PBEC, HPCSA). It was then piloted. The protocol was approved by the Biomedical Research Ethics Committee of the University of KwaZulu-Natal and the study site and protocol approval was granted by the Emergency Medical Service of the provincial government of the Western Cape. Fully informed written consent was obtained from each participant and they were promised confidentiality and anonymity and the right to withdraw at any point in the study without any penalty. They were also offered anonymous telephonic counselling if desired. The response rate was 58% (154) with several repeated briefings and collection points at the EMS bases. The coded data was captured on an Excel® spreadsheet and submitted for statistical analysis by the MRC.

Certain methodological limitations need to be acknowledged. There is a possibility of participant selection bias in that 'non-operational' emergency staff were excluded since they do not perform a clinical function. Other excluded staff were those who were physically absent from the study site and therefore inaccessible. The non-participation (42%) by those who did receive the questionnaire was initially of concern. Upon further probing, it emerged that some EMS stations were over-researched by researchers of varying disciplines from different universities. The demographic and professional profile of the non-responders was not known, with the effect of limiting the claim to generalisation. The generalisability of findings is further limited with regard to rural emergency care practice since this study was focused only on city-based participants and DV and emergency care dynamics may differ from urban practice.

## RESULTS

The sample (N = 154) was representative of the metropole and provincial EMSs in terms of the distribution for race,<sup>2</sup> gender and qualification (Table 1) ( $p \leq 0.01$ , 0.01, 0.031, respectively). This denominator (154), however, does vary where respondents did not answer all the questions. The claim to representivity, therefore, cannot hold where non-responses to questions are high. Some 42% (63/154) of the sample had between 2 and 5 years of experience in EMS.

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2 We use this term to refer to the historical classifications of apartheid of black, coloured, Asian and white South Africans, which still have salience for contemporary South Africa, particularly for purposes of redress.

**Table 1: Qualification in the sample population of ECPs, the regional (metropole) and provincial EMS**

Qualification	Basic		Intermediate		Advanced		N
	n	%	n	%	n	%	
Provincial EMS ECP	404	46	395	45	88	10	878
Metropole EMS ECP	93	35	138	52	35	13	266
Sample EMS ECP	62	40	72	47	20	13	154

Chi square,  $p=0.0309$

Only half (49%, 75/154) of the sample could correctly define DV in accordance with the WHO, UN and DV legislation definitions as presented in the introduction. When non-responses are excluded for this question, this alters to 71% (75/106) [Table 2]. The qualification of ECPs was associated with an ability to define DV. The more qualified ECPs were more likely to define DV correctly (chi square:  $p = 0.017$ ).

**Table 2: Frequency of correct and incorrect definitions of DV by ECPs of different qualification levels ( $p = 0.017$ )**

DV definition	Basic N = 38		Intermediate N = 55		Advanced N = 13	
	n	%	n	%	n	%
Correct	21	28	42	56	12	16
Incorrect	17	55	13	42	1	3

Most respondents held some incorrect beliefs or myths about DV, in particular, the popular notion that DV is caused by alcohol and drug use (Table 3). The ECPs' understanding of societal precursors (Winett, 1998), not as causal, but as contributory, is central to breaking their own denial of responsibility and represents the first step in acting for the victim in untraditional remedies. The need for the intersection of DV intervention with EMS scope has never been more profound (Aschman, Meer, & Artz, 2012; Naidoo, 2008; Vetten, 2008). An overwhelming 97% (147/152) believed that alcohol and drugs were the main cause of DV. While the link of alcohol with DV and the high rate of alcohol abuse in South Africa (Jewkes et al., 2009) is not in dispute, researchers and activists have pointed out how sober men also abuse and some drunken men may be rendered affectionate, not violent (Padayachee & Singh, 2010). Moreover, there is a large body of work that foregrounds

the role of gender power inequalities and hegemonic masculinities in understanding male violence towards women (Britton, 2006; Jewkes & Abrahams, 2002; Jewkes et al., 2009; Jewkes, Sikweyiya, Morrell, & Dunkle, 2009; Morrell, Jewkes, & Lindegger, 2012).

The belief in the centrality of alcohol and other myths such as the class-based nature of DV, the notion that violence and love cannot co-exist, that men who beat their wives are mentally ill and cannot control their violence and that abused women can leave home whenever they want to, as presented in Table 3, suggests that ECPs are oblivious to the evidence that DV cannot be understood outside of gender power relations, normative gender roles and male power over women in relationships and that DV is prevalent across racial and class differences. The assumption of mental illness contributes to the 'othering' of male abusers and enhances 'plausible deniability'. The fallacious belief that women can leave an abusive relationship at will allocates blame to the victim for her own abuse. The false belief held by 42% (70/152) of respondents that physical abuse is worse than emotional abuse is reflective of the bias toward physical injury (probably due to their everyday exposure to trauma) and a devaluation of the impact of emotional abuse. Predicating any healthcare response upon such lack of understanding is likely to compound the problem.

To aid the above conceptualisation, hegemonic masculinity can be described as practices by both men and women within societal institutions to perpetuate the subordination of males over females (Connell & Messerschmidt, 2005; Ratele, 2008). Hence, alcohol and drug abuse, in the context of DV perpetration, should be seen as one of those practices prescribed by and symptomatic of hegemonic masculinity and not causal of DV, but rather strongly associated with it and an exacerbating factor. The further rationale for problematising the deterministic assumption of alcohol, drug and mental illness causing DV is that the notion serves to advance a denialist ideology that shifts accountability for the DV from the perpetrator to the substance abuse (Padayachee & Singh, 2010). Proponents of this logic argue that the systematic, non-random and targeted nature of DV displays elements of cognitive choice and/or behavioural conditioning rather than chemical-induced loss of control.

**Table 3: ECPs' responses to DV myths**

STATEMENT (OF MYTH)	N	Disagree n (%)	Agree n (%)	Blank/ missing data
Women who do not listen to their partners deserve to be abused.	153	147 (96)	6 (4)	1

STATEMENT (OF MYTH)	N	Disagree n (%)	Agree n (%)	Blank/missing data
A woman who nags is asking to be abused.	151	131 (87)	20 (13)	3
Women who are abused enjoy it or are mentally ill.	152	120 (79)	32 (21)	2
Domestic violence is a private matter.	150	119 (79)	31 (21)	4
Only poor, uneducated and mostly black or coloured women are abused.	153	108 (71)	45 (29)	1
Physical abuse is worse than emotional abuse.	152	88 (58)	70 (42)	2
Abused women can leave home whenever they want.	150	70 (47)	80 (53)	4
Men who beat their wives are mentally ill and cannot control their violence.	149	61 (41)	88 (59)	5
Violence and love cannot co-exist in one home.	151	52 (34)	99 (66)	3
Alcohol and drugs are the main cause of domestic violence.	152	4 (3)	148 (97)	2

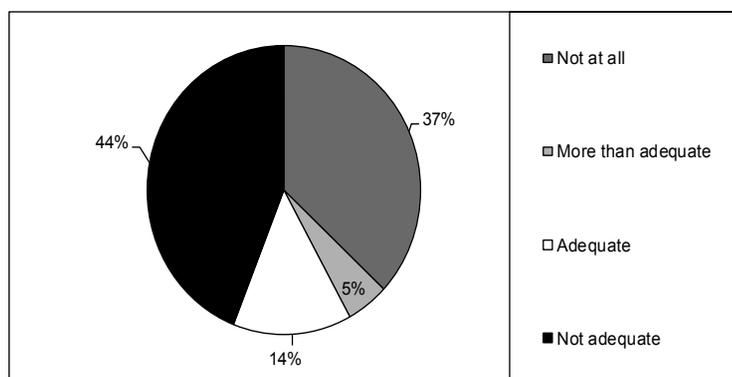
Given the incidence, prevalence and brutality of DV in South Africa, it was surprising to note that a total of 81% of respondents (117/144) had recognised fewer than 30 DV calls in the preceding six months. Whilst there is no data to suggest what the recognition rate norm is, this would appear considerably low, suggesting a possible masking of the extent of DV by healthcare users through their failure to capture the full extent (because of confidence or capacity) by the healthcare providers. The information system of the EMS is not designed to monitor and quantify the DV burden to the EMS. A stabbed chest remains a stabbed chest and is not escalated to a case of DV at any time. The majority (90%, 134/149) reported having no experience of safety-focused and appropriate gender-sensitive handling of DV victims. This diagnostic deficiency results in a ‘don’t look-don’t find’ scenario which is likely to explain the poor DV recognition.

As to questions about where one would detect DV in the pre-hospital environment, 57 (37%) respondents answered “*upon arrival at a domestic violence scene*”, but 24 (16%) answered “*at a hospital or police station*”. Only 7% (n = 11) suggested the use of “*an index*”

*of suspicion*". Differences in respect of ECP training were evident in reported detection capacity. Of those with basic ECP training, only 34 (22%) felt they could detect DV at the scene, compared with 72 (47%) of those with intermediate ECP training who detected DV at the scene. Of those with advanced ECP training, 55 (36%) detected DV at the scene [Fisher's Exact Test:  $p = 0.012/ 52$  (34%)]. Non-responses to this question are excluded from the sample].

No association could be found (Chi square:  $p = 0.23$ ) between qualification and knowledge of the DV legal framework, suggesting that an ECP's qualification was no predictor of his/her knowledge about legal protection from abuse. A noticeable 81% (125/154) could not list knowledge of any laws which relate to DV. Furthermore, qualification could not be positively associated with the referral of DV victims (Chi square:  $p > 0.05$ ). Treatment of victims upon arrival at a scene ( $p = 0.076$ ) and during medical management ( $p = 0.016$ ) was associated with qualification in that more highly qualified ECPs provided care more aligned with the needs of DV victims. There was no positive association between qualification and patient assessment.

The majority of respondents revealed inadequate knowledge of assessment and management of DV victims (Figure 1). Four out of five respondents reported unacceptable knowledge and practices of victim assessment. This appraisal was by their self-assessment of their knowledge and their own practices of victim assessment. For 34% of participants (52/153) the reason given for not reporting DV was that "*victims were ashamed or afraid to report abuse*".



**Figure 1: ECPs' knowledge of training having prepared ECPs in the Western Cape to manage DV (N = 145)**

The majority of ECPs indicated that their emergency care training was inadequate and did not prepare them to intervene in DV, although 94% (145/154) reported feeling comfortable to ask about abuse during the diagnostic assessment. Half (49%, 44/90) of ECPs that responded felt that more training and sensitivity for early identification of victims was needed and that this was not being implemented in the EMS. Nineteen per cent (17/89) identified “*information dissemination and support*” as lacking in the current EMS modus operandi.

## **DISCUSSION**

This study highlights a range of deficiencies in current ECP responsiveness to DV. It is accepted that health personnel, in general, have an integral role to play in DV situations (Saunders, 2001). In the context of primary healthcare, this role could involve prevention, early detection, risk assessment and responsive treatment. In South Africa, save for reference to primary healthcare providers, we could not find direct research into the pre-hospital emergency care provider’s role regarding DV. An adequate means of assessment of pre-hospital care requires the development of indicators (MacFarlane & Benn, 2003). Much has been written about the response of the police, courts and social workers to victims of abuse, but none of the empirical literature includes first responders as interventionists. An impact study on violence against women in metropolitan South Africa (Bollen, Artz, Vetten, & Louw, 1999) neglects to mention ECPs as role players and is therefore unable to measure their impact. The authors do, however, suggest that emergency rooms, clinics and district surgeons require a change in attitude and greater sensitivity. In an urban American study, like our South African study, primary care providers did not have appropriate attitudes, practices and beliefs regarding the early diagnosis and management of DV victims (Sugg, Thompson, Thompson, Maiuro, & Rivara, 1999). The latest WHO clinical and policy guidelines also make no direct reference to pre-hospital ECPs, indicative of the research relevance of this study type (World Health Organization, 2013).

### **EMERGENCY CARE, PRIMARY CARE AND FORENSIC PRACTICE**

An epidemiological perspective (knowing who, what, where, why and how) on gender-based violence prevention (Katzenellenbogen, Joubert, & Abdool-Karrim, 1999; Mathews et al., 2008) is lacking amongst ECPs. Less than half of our respondents could correctly define DV. Belief in myths and deterministic explanations, such as alcohol and drugs as the main cause of gender-based violence (GBV) and that perpetrators are mentally ill, is indicative of poor understanding of the nature of the problem which impacts on the quality of the emergency care response (King & Ryan, 1989). Such beliefs may serve as barriers to appropriate care by resulting in a lack of empathy and a blaming discourse towards victims. Non-responses to some questions probing understanding is also telling of knowledge gaps. There appears

to be poor identification, referral and treatment of victims. The possible explanation for this is the lack of training of practitioners as DV interventionists. In addition, the respondents are themselves shaped by patriarchal society and in the absence of sensitisation, are likely to draw on dominant societal paradigms (such as hegemonic masculinity) that disempower women and, in so doing, condone the cycle of abuse. The high exposure to violence as citizens and as health workers also has the risk of normalising its occurrence.

The EMS system has had no effective methodology for addressing abuse, and is inconsistent and reactive in approach. The emergency care curricula do not give adequate expression to the issue of violence, with the exception of emergency treatment of the critically injured. ECPs, when in 'rescue' mode, are focused on responding with little space for empathy and reflection. This is efficient and in the patients' best interest when patients present in a critical medical state. The same approach is disempowering and not in the patients' best interest when there is no imminent danger but rather a need for facilitation and best practice outcomes. The insidious nature of DV implies that overt physical violence is not always apparent and may represent a prolonged period of exposure to escalated abuse. Saunders (2001) recommends that primary care providers increase their awareness, screen routinely, build trust, document diligently, treat associated complications, assess for safety and refer responsibly. The dichotomy of basic and advanced skill levels amongst ECPs reinforces the argument presented earlier that the EMS, by design, is suited to universal screening but that the advanced providers could implement selective screening by way of clinical case finding.

## **IMPEDIMENTS TO AN APPROPRIATE EMERGENCY CARE RESPONSE**

Barriers to appropriate care for DV within the framework of emergency care responses appear to be linked primarily to a lack of comprehensive and nuanced understandings and knowledge as well as a belief in certain GBV myths that are not conducive to effective and holistic management of victims of DV. Most prevailing attitudes may contribute to further disempowerment, inadequate safety assessments and superficial management of victims of DV. The development of a pre-hospital medical protocol and curriculum with capacity for training is likely to empower ECPs to respond appropriately in terms of crisis intervention and referral and thereby meet the emergency and other needs of DV victims. The harbouring of myths was identified as a potential barrier to the implementation of a pre-hospital protocol for DV management. An ECP's qualification may not be a predictor of his/her legal knowledge about abuse. The EMS training does not adequately inform DV knowledge. When one considers that 89% (N = 154) reported that there was no (or they did not know of any) special handling of DV calls, in terms of call taking, dispatch and clinical response in EMSs, it is evident that neither the practitioner nor the EMS system is responsive to victims of DV.

In summary, insight into DV was severely lacking amongst ECPs who have a high rate of problematic assumptions and myths about DV. Emergency care practice is characterised by inadequate assessments for patient safety, inconsistent and superficial management of victims of DV with multiple missed opportunities for intervention. By their own admission, participants did not feel adequately prepared to assess and respond to victims of GBV. Fundamentally, the current training and clinical practice are inadequate to meet the emergency and health promotion needs of DV victims in the pre-hospital environment. Participants reported the above EMS characterisations as barriers to the implementation of a pre-hospital protocol for DV management.

The impediments to improved responsiveness for DV include current emergency care training that is deficient in providing knowledge about the context of DV, including facilitating factors and epidemiology as well as intervention options. The emergency care system is intended to be responsive, but is undermined by narrow conceptions of emergency care and a disproportionate focus on occult risk.

## **PREVENTION IMPLICATIONS AND RECOMMENDATIONS**

For South African EMS systems to empower providers to be more responsive to DV, it is imperative that practice be expanded to include health promotion. The HPCSA, as the custodian of health professions, should determine professional obligations for DV intervention, the adoption of a bio-psycho-social and forensic view to DV-related medicine and emergency care educational programmes that support pre-hospital intervention and promote responsible referrals.

The WHO recommends the development of a comprehensive health sector response (World Health Organization 2006; 2013). The document *Screening for Domestic Violence: A Policy and Management Framework for the Health Sector* (Martin & Jacobs, 2003) has influenced the development of emergency care guidelines but does not suffice. The EMS response to DV should be congruent with that of the health sector and should include routine screening (asking about DV routinely), clinical case finding, comprehensive physical and psychological care for those patients who disclose abuse, a safety assessment and safety plan, the documentation of past and present incidents of abuse, the provision of information about patients' rights and the DV Act and referral to resources (Martin & Jacobs, 2003).

A protocol and enabling curriculum guiding the standardised practices and knowledge of ECPs in DV situations is crucial. This should include the definition and dynamics of DV, the clarification of any legal requirements for health workers, screening and management guidelines, intervention strategies, the procedure for collection of forensic evidence and

medical record documentation, safety assessment and planning guidelines and referral information (Martin & Jacobs, 2003). The WHO recommendations on DV prevention in the developing world inform the content of emergency care education (World Health Organization, 2013). The global position is that the health sector, and by representation the EMS, must ensure that:

- (a) Women who have experienced violence are not stigmatised or blamed when they seek help from health institutions;
- (b) Women will receive appropriate medical attention and other assistance;
- (c) Confidentiality and security will be ensured;
- (d) Training should aim, among other things, to ensure that providers are appropriately sensitised to issues of abuse, treat women with respect, maintain confidentiality and do not reinforce women's feelings of stigma or self-blame, as well as being able to provide appropriate care and referral as needed;
- (e) Research on the causes, consequences and costs of violence against women and effective prevention measures is supported (World Health Organization, 2006).

## CONCLUSION

“EMS operates at the intersection of health care, emergency care and public safety and therefore has overlapping roles and responsibilities” (Committee on the Future of Emergency Care in the United States Health System, 2007, p. 29). This statement about the American EMS is particularly true for EMSs in the developing world context where these services are not always well developed and frequently poorly distributed. Exploiting every opportunity for intervention by every health sector is likely to render the health system more responsive to the overt and covert needs of African healthcare users who are subjected to one of the highest rates of interpersonal violence in the world and where homicide rates are almost three times the global average (World Health Organization, 2010). Interpersonal violence dominated the South African injury profile in 2000 with mortality rates seven times the global rate and was the second leading cause of healthy years of life lost (Norman, Matzopoulous, Groenewald, & Bradshaw, 2007).

There is compelling justification for pre-hospital systems in Africa to provide an appropriate emergency response to DV. The EMS should be seen as an agent of change and as a societal organisation. The challenge that remains is to infuse this body of evidence into medical curricula and the healthcare agenda. Further research is needed on how health practitioners can develop a sense of coherence (Naidoo & Nadvi, 2013) and moral action (Pera & Van Tonder, 2011) in their response to DV. Notably, this paper presented findings from an urban sample. The DV and EMS dynamic in the rural context is likely to

nuance prevention opportunities. The EMS research agenda must therefore include rural contexts of DV intervention as well. The argument that health and emergency services are overburdened emphasises the case for a focus on prevention. After all, stopping the bleeding does not begin to stop the abuse.

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