AN EMANCIPATORY MODEL FOR NURSES WORKING WITH GENDER-BASED VIOLENCE IN A SEMI-RURAL AREA IN TSHWANE

by

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RESEARCH DISSERTATION

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SEFAKO MAKGATHO HEALTH SCIENCES UNIVERSITY

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CO-SUPERVISOR: Dr. Y Havenga

January 2017
DECLARATION

I declare that:

An emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane

hereby submitted to Sefako Makgatho Health Sciences University for the degree of Philosophiae Doctor has not previously been submitted by me for a degree at this or any other university; that it is my own work in design and in execution, and that all material contained herein has been duly acknowledged.

E.M. Joubert (Mrs)  
Student Number: 201015312  
8 January 2017  
Date
Dedicated to my husband, Francois, my children, Elzanda and Dawid, my son-in-law, Riaan, my granddaughter, Clarise, and my mom, Bettie.
ACKNOWLEDGEMENTS

My gratitude and appreciation to the following persons who assisted me in the realisation of this project:

Firstly, I want to acknowledge that without God’s strength this project would not have been possible.

The Sefako Makgatho Health Sciences University and the UNEDSA project that gave me a bursary to study at the Medunsa Campus: they gave me the opportunity to increase my knowledge in the field of gender-based violence.

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ABSTRACT

Nurses are currently seen as an oppressed group (Freire, 1972:36; Mooney & Nolan, 2006:241; Scarry, 1999:424; Wittmann-Price, 2004:437) and are usually the first members of the health care team who come in contact with survivors of gender-based violence. It can be assumed that oppressed nurses will deliver oppressed care and will therefore compromise the physical, emotional and social well-being of the survivors if they are not emancipated to deal with them.

The purpose of this study was to construct an emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane and to develop guidelines for implementation of the model.

The objectives of the study were:

1) To explore and describe experiences of nurses working with gender-based violence in a semi-rural area in Tshwane.
2) To construct an emancipatory model for nurses working with gender-based violence.
3) To develop guidelines for the operationalisation of the emancipatory model for nurses working with gender-based violence.
4) To evaluate the model for nurses working with gender-based violence and revise it if indicated.

The findings of this research revealed two main themes:

• Theme one: Experiences related to the self of the nurse when working with gender-based violence.
• Theme two: Nurses’ need for an enabling environment when working with gender-based violence.

The model, “Emancipatory model for nurses working with gender-based violence”, together with its guidelines, was constructed followed a qualitative approach with a descriptive, explorative, contextual design (Creswell, 2009:176; Mouton, 1996:133; Polit & Beck, 2012:126, 727; Struwig & Stead, 2001:12).

Model construction was done using the following three phases of theory generation as described by Chinn and Kramer (2011:215-217):
**Phase 1: Construction of Conceptual Meaning**

Step 1: Concept selection  
Step 2: Concept definition  
Step 3: Concept classification  

**Phase 2: Construction and Contextualisation of the Model**

Step 4: Description of the relationship statements  
Step 5: Description and evaluation of the model  

**Phase 3: Description of Guidelines**

Step 6: Description of guidelines for the operationalisation of the model  

The model, “Emancipatory model for nurses working with gender-based violence”, shows emancipation through an empowered self of the nurse in an enabling environment.  

The uniqueness of this study is to bring forward another side of gender-based violence, namely, to describe nurses’ experiences working with gender-based violence.
KEYWORDS

Gender-based violence

Model

Secondary traumatisation

Experiences of nurses

Attitudes of nurses

Compassion fatigue

Abused women and children
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBO</td>
<td>Community-Based Organisation</td>
</tr>
<tr>
<td>HVS</td>
<td>High Vaginal Swab</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>SANC</td>
<td>South African Nursing Council</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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CHAPTER 1
OVERVIEW AND RATIONALE OF THE STUDY

1.1 INTRODUCTION

Working with gender-based violence is a challenge as it is emotionally and physically draining to work with survivors and perpetrators of gender-based violence on a daily basis. This challenge led to the purpose of this study, namely, to construct an emancipatory model for nurses working with gender-based violence.

In this chapter, the researcher discusses the background, problem statement, research question, and the purpose and objectives of the study. The setting where the study took place is also described. The paradigmatic perspective of the study and theoretical framework are discussed and the research design is described.

1.2 BACKGROUND OF THE STUDY

Gattegno, Wilkens and Evans (2016:1) state that inequality between genders can manifest in different ways. Gender-based violence is a problem globally – according to the World Health Organization (WHO), 35% of women worldwide have experienced either physical or sexual violence (WHO, 2013a:2). Gender-based violence is a serious problem in South Africa, and Jewkes and Dartnall (2017:491) state that sexual violence is endemic and that no society will be free from rape. KPMG (2014) did a study in 2014 which found that the economic cost of violence against women is huge and can drain between R28.4 billion and R42.4 billion each year from the country. According to the Institute for Security Studies’ assault and sexual crime statistics for 2014/2015, out of every 100 000 people in South Africa, 637.1 were victims of assault (Africa Check, 2015).

In 1998, South Africa adopted the 16 Days of Activism campaign as one of the intervention strategies to create a society free of violence. This campaign takes place every year from 25 November (International Day for the Elimination of Violence Against Women) to 10 December (International Human Rights Day). Included in this period is Universal Children’s Day and World Aids Day (South African Government, 2016).
Human Rights Day on 21 March 2013 was marked around the country with calls for action against violence perpetrated against woman and children. Inkatha Freedom Party leader, President Mangosuthu Buthelezi, said that the brutal gang-rape, mutilation and murder of Anene Booysen had ignited a national outcry. Mangosuthu Buthelezi further said that, statistically, during the three-week period from her death until the day of his speech, another 82 000 women would have been raped, but their names went unrecorded and their voices were silent (Ndenze & SAPA, 2013:1).

The guidelines for gender-based violence interventions in humanitarian settings (Inter-Agency Standing Committee, 2005:7-8) explain that the concept ‘gender-based violence’ is often used interchangeably with the term ‘violence against women’. The terms ‘survivor’ and ‘victim’ refer to a person who has experienced gender-based violence. The guideline for gender-based violence interventions in humanitarian settings (Inter-Agency Standing Committee, 2005:8) explain further that ‘victim’ is a term often used in the legal and medical sectors and ‘survivor’ is the term generally preferred in psychological and social support services. For the purpose of this study, the researcher uses the terms ‘gender-based violence’ and ‘survivor’.

In 1993, the UN Declaration on the elimination of violence against women (1993:2) offered the first official definition of the term gender-based violence as follows:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

South Africa is signatory to this declaration. Various definitions of gender-based violence have been made by authors but all of them are similar and broadly describe gender-based violence as an act that includes violence that is directed at an individual and can include physical, sexual, psychological or economic deprivation, whether it occurs in public or in the individual’s private life (Heise, Ellsberg & Gottmoeler, 2002:S6; Henttonen, Watts, Roberts, Kaducu & Borchert, 2008:122).
Gender-based violence takes on various forms as outlined in the training material of The National Centre for Knowledge on Men’s Violence against Women (Ploug & Hultqvist, 2011:19) shown in Table 1.1.

Table 1.1: Different forms of gender-based violence

<table>
<thead>
<tr>
<th>Physical</th>
<th>Sexual</th>
<th>Psychological</th>
<th>Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hitting</td>
<td>Forced sexual activity</td>
<td>Threats</td>
<td>Control of money</td>
</tr>
<tr>
<td>Kicking</td>
<td>Injury to genitals</td>
<td>Verbal abuse</td>
<td>Restriction of food</td>
</tr>
<tr>
<td>Punching</td>
<td>Rape</td>
<td>Destruction of property</td>
<td>Prevention of or forced work</td>
</tr>
<tr>
<td>Shaking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulling out hair</td>
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The Bill of Rights in the Constitution of the Republic of South Africa (1996) enshrines the rights of all people in South Africa, including the right to equality, the right to privacy, the right to dignity, the right to freedom and security of the person, which incorporates the right to be free from all forms of violence from either public or private sources, and the right of children to have their best interests considered to be of paramount importance.

In its introduction, the Domestic Violence Act (1998:2) acknowledges that:

*Domestic violence is a serious social evil; that there is a high incidence of domestic violence within South African society; that victims of domestic violence are among the most vulnerable members of society; that domestic violence takes on many forms; that acts of domestic violence may be committed in a wide range of domestic relationships; and that the remedies currently available to the victims of domestic violence have proved to be ineffective. It is the purpose of this Act to afford the victims of domestic violence the maximum protection from domestic abuse that the law can provide; and to introduce measures which seek to ensure that the relevant organs of state give full effect to the provisions of this Act, and thereby to convey that the State is committed to the elimination of domestic violence.*
The Children’s Act (2005:9-10) defines abuse as following:

‘abuse’, in relation to a child, means any form of harm or ill-treatment deliberately inflicted on a child, and includes –

a. Assaulting a child or inflicting any form of deliberate injury to a child;

b. Sexually abusing a child or allowing a child to be sexually abused;

c. Bullying by another child; or

d. Exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007:3-4) deals with all legal aspects relating to sexual offences in a single piece of legislation and covers issues such as:

• rape, which applies to all forms of physical penetration without consent, irrespective of gender;

• sexual assault, which applies to all forms of sexual violation without consent;

• criminalising certain compelled sexual acts; and

• providing specific services to certain victims of sexual offences, including affording a victim of certain sexual offences the right to apply that the alleged perpetrator be tested for his or her HIV status and the right to receive this information.

It is the purpose of the Criminal Law (Sexual Offences and Related Matters) Act (2007) to afford complainants of sexual offences the maximum and least traumatising protection that the law can provide, to introduce measures which seek to enable the relevant organs of state to give full effect to the provisions of this Act and to strengthen the State’s commitment to eradicating the pandemic of sexual offences committed in the Republic or elsewhere by its citizens.
The Criminal Law (Sexual Offences and Related Matters) Act (2007:4) acknowledges that women and children are particularly vulnerable to sexual offences, including prostitution, and that South African common and statutory law fails to deal with activities associated with sexual offences in an effective and non-discriminatory manner, thereby failing to provide adequate protection against sexual exploitation to complainants of such activities. Therefore, the Criminal Law (Sexual Offences and Related Matters) Act (2007:4) states that:


The WHO (1997:1) states that the health system has an important role to play with other sectors, such as judicial, police and social services, to recognise signs of gender-based violence. The WHO (1997:1) further states that health care workers must be trained to recognise gender-based violence and to meet women’s health needs in this regard.

In 2009, the Scottish government introduced a national programme of work across Scotland’s National Health System to improve and identified gender-based violence. According to Henderson and Cosgrove (2009:1), gender-based violence is a major public health issue that causes immense pain, injury and suffering to women and children, and health care workers have a unique and crucial role in identifying and supporting those who are affected by it.

From the literature consulted and the findings from a situational analysis of sexual assault services in South Africa that was done in October 2003 by Christofides, Webster, Jewkes, Penn-Kekana, Martin, Abrahams and Kim (2003:1), it was acknowledged that sexual assault is a public health issue in South Africa and that health care providers have an important role to play in the management of a sexual assault patient after the assault.
According to WHO clinical and policy guidelines (2013b:1), nurses are often the first professional contact for survivors of gender-based violence. The researcher agrees with Guruge’s (2012:1) statement that nurses are one of the largest health care workforces globally and that they are more likely to interact with women and children who experience gender-based violence. This statement is acknowledged by Van der Wath, Van Wyk and Janse van Rensburg (2013:2242), who state that nurses have the opportunity to intervene with survivors of gender-based violence when they are most receptive to interventions. Jamieson and Lake (2013:25) state that nurses have a major role to play in the prevention, identification, diagnosis and referral of violence against children. Häggblom, Hallberg and Möller (2005:235) emphasise that there should be strategies in place to train nurses dealing with women who have been subjected to gender-based violence.

Nurses working with gender-based violence have to adhere to international guidelines when working with survivors of gender-based violence. Such nurses are guided by the WHO’s (2003:3) guidelines for the medico-legal care for victims of sexual violence. Within these roles and frameworks, nurses working with gender-based violence have various interventions that they have to do on a daily basis. These include the identification, assessment and management of survivors of gender-based violence. They also have a legal and ethical responsibility towards survivors and perpetrators of gender-based violence. The Department of Health in South Africa has national directives and instructions on how to conduct a forensic examination on survivors of sexual offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007). These directives must be adhered to in order to ensure a holistic, coordinated, efficient and supportive response to survivors of gender-based violence.

Nurses working with gender-based violence have to identify and acknowledge abuse towards women and children to help end the cycle of violence. This is confirmed by the Utah Department of Health guidelines (2008:7) which state that identifying and acknowledging the abuse may help to break the cycle of violence and increase the health and welfare of survivors. The codes of medical ethics are based on the principles of doing “good” and not “doing harm” (WHO, 2003:19).
This means that nurses working with gender-based violence must use their professional skills in an ethical manner, as adherence to these codes of conduct is particularly relevant when dealing with survivors of interpersonal violence who may suffer abuse by a person in a position of power (WHO, 2003:19).

The guidelines of the WHO (2003:19) describe that, in most countries, local protocols, rules or laws govern the provision of medico-legal services to survivors of gender-based violence. The guidelines describe that it might include certification of the health worker, use of official documentation, an obligation to report any allegations to the appropriate authorities, procedures for the collection and handling of specimens and access to a range of therapeutic interventions (such as emergency contraception). If nurses working with gender-based violence fail to comply with local regulations, they may compromise future investigations or court hearings. That is why it is essential that nurses working with gender-based violence have a good understanding of the local protocols, rules and laws that govern the field of gender-based violence.

Nurses working with gender-based violence must be aware of their attitudes towards survivors of gender-based violence, to prevent survivors from feeling that they are victimised twice, first by their abuser and again by the staff of the health care facility that they visit (Kim & Motsei, 2002:1251).

According to WHO guidelines (1997:1), at a minimum, health care workers should:

- be attentive to possible symptoms and signs of abuse and follow them up;
- where feasible, routinely ask clients about their experiences of abuse as part of normal history taking;
- provide appropriate medical care and document in the client’s medical record instances of abuse, including details of the perpetrator;
- refer patients to available community resources;
- maintain the privacy and confidentiality of client information and records; and
- create a supportive, non-judgemental environment.
The WHO (2013b:10) recommends that nurses working with gender-based violence should be able to recognise the signs thereof and that they must respond appropriately and safely. The WHO (2013b:10) further states that women who have been exposed to gender-based violence require “comprehensive, gender-sensitive health-care services that address the physical and mental health consequences of their experience and aid their recovery from what is a traumatic event.”

Häggblom et al. (2005) did a study to assess nurses’ knowledge, training and practices regarding care of abused women and found that strategies and related training should be implemented to help nurses deal with survivors of gender-based violence (Häggblom et al., 2005:235). As early as 1996, Orloff (1996:479) mentioned that nurses need training on gender-based violence so that they can effectively help survivors. In a study that was done by Vieira, Perdona, De Almeida, Nakano, Dos Santos, Daltoso and De Ferrante in Brazil (2009:3-6), it was found that 9.5% of the participants were categorised as having very low general knowledge about gender-based violence, 34.8% had low knowledge, 34.45% had good knowledge and only 21.3% had high knowledge. As a result of the recent recognition of the status of gender-based violence, those authors felt that there was an urgent need to train health care professionals.

Folkman and Moskowitz (2004:746-747) define coping as “thoughts and behaviours that people use to manage internal and external demands of situations that are appraised as stressful.” They mention that they have also found that coping is strongly associated with the regulation of emotion, especially distress, throughout the stress process. Lois Jensen (2006:36-37) gave out a booklet titled Ending Violence against women, in which he quoted a medical doctor and participant from the municipality of Yondo, Colombia as saying (Jensen, 2006:36-37):

As a doctor, I used to evaluate the women, examine the women and forget about her. Now I care about the person. I put myself in her place and inquire about other aspects of her life. I am more subjective, I go beyond my duties.

Nurses who work with gender-based violence and listen to the trauma experience of survivors could develop vicarious traumatisation.
Moulden and Firestone (2007:67) state that it is challenging for individuals who work in caring professions to work with people who have experienced physical or emotional harm and, accordingly, it can be said that nurses who deal with the after-effects of the traumatic experiences of survivors of gender-based violence can be negatively affected. Goldblatt (2009:1645) states that nurses who encounter abused women can have emotional, cognitive and behavioural influences, known as vicarious traumatisation; therefore, nurses treating survivors need to be aware of their own attitudes, emotions and differential responses during these interactions.

Nurses working with survivors of gender-based violence can also be at high risk for burnout unless preventive measures are implemented (Pross, 2006:1). Burnout is also a symptom of emotional exhaustion that can result from job strain. In Lois Jensen’s (2006:56-57) booklet, a project psychologist said the following: “You can’t expect great performance or brilliant ideas from staff who may be dealing with their own issues of domestic violence.” This viewpoint relates to the concept of personal knowledge in the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377). Nurses have to be self-aware and must have the ability to understand themselves, as this will influence their personal feelings towards survivors of gender-based violence.

Pross (2006:2) comments that nurses working with gender-based violence can also experience symptoms far beyond the usual burnout and may develop symptoms of posttraumatic stress disorder. So far, there have been few studies of burnout and vicarious traumatisation among those who work with survivors of extreme violence. Nurses are often witnesses of physical and psychological violence and they frequently care for survivors of gender-based violence. They also work with perpetrators of violence. Nurses should be aware of assessment methods and nursing interventions so that they can assist in interrupting and preventing the cycle of violence (American Association of Colleges of Nursing, 2000:63). According to the WHO (1997:3), research has shown that nurses often have neither the time nor the training to effectively identify symptoms of gender-based violence. Kim and Motsei (2002:1244) suggest that there is a need to first understand and address the experiences of nurses before promoting training as a strategy to address gender-based violence.
The question of how nurses’ personal experiences with gender-based violence impact on their management thereof may arise. In a study by Christofides and Silo (2005:9), 212 nurses were interviewed in two South African health districts. The purpose of the study was to determine whether nurses’ personal experiences of domestic violence influenced their management of domestic violence and rape cases. The study showed that 39% of nurses had experienced either physical or emotional abuse. Christofides and Silo (2005:9) concluded that experiencing domestic violence did not have any influence on the identification and management of domestic violence. They found in their study that nurses who had experienced domestic violence themselves were more likely to provide better care for victims of domestic violence than nurses who had no personal experience of domestic violence.

The researcher agrees with this statement and believes that the self of the nurse influences her care of survivors of gender-based violence. It is important that nurses are adequately emancipated to care for survivors of gender-based violence. Nurses working with gender-based violence must be able to make emancipated decisions to assess survivors of gender-based violence and provide appropriate care. Bradley-Springer (2010:289-290) states that, for nurses to contribute to health care change, their power must be enhanced so that they are able to speak up more and to advocate for the profession. Bradley-Springer (2010:289-290) is of the opinion that nurses’ skills and abilities will also be better understood and, in the process, they will be able to demand their proper place at the decision-making tables.

1.3 PROBLEM STATEMENT

Nurses are currently seen as an oppressed group (Freire, 1972:36; Mooney & Nolan, 2006:242; Scarry, 1999:424; Wittmann-Price, 2004:437) and need to understand the need for emancipation. Nurses working with gender-based violence are likely to be the first contact for a survivor of gender-based violence (WHO, 2013b:1). They are in a unique position and need to be emancipated to address the health and psychosocial needs of women and children who experience gender-based violence (WHO, 2013b:1). Nurses who are emancipated are more able to empower the survivors they care for, which in turn has the potential to lead to better health outcomes (Laschinger, Gilbert, Smith & Leslie, 2010:5).
Due to the high number of patients that are currently admitted to a specific public hospital in a semi-rural area in Tshwane, the hospital management opened a crisis centre in October 2009. The crisis centre and casualty department currently provide a 24-hour service to survivors exposed to violence.

A situational analysis and needs assessment was done by the University of Limpopo (Medunsa Campus) in September 2008 and the Director of Nursing Services of a specific public hospital in a semi-rural area in Tshwane.

The following needs and concerns were identified with regard to staff involved in service rendering at the public hospital, crisis centre and community clinics:

a) Improvement of counselling and crisis-intervention skills for staff.
b) Support for staff to prevent burnout.
c) Debriefing of personnel on the rendering of services.

In the researcher’s personal experience of working with gender-based violence in a psychiatric hospital and casualty department, it is emotionally and physically draining to work with survivors of gender-based violence on a daily basis. The researcher did an assessment of what gender-based violence involved, looked at the situational analysis that was done by the University of Limpopo and realised that the nurses working with gender-based violence need to be emancipated to do so.

In addressing this gap, the construction of an emancipatory model for nurses working with gender-based violence and the development of guidelines for the implementation of the model could be utilised. In order to construct such a model, the following research questions were posed:

1) What are the experiences of nurses working with gender-based violence in a semi-rural area in Tshwane?
2) How can an emancipatory model for nurses working with gender-based violence be constructed?
3) What guidelines can be described for the operationalisation of such an emancipatory model?
4) How can a model be evaluated for nurses working with gender-based violence and can it be revised if indicated?

1.4 PURPOSE AND OBJECTIVES OF THE STUDY

1.4.1 Purpose

The purpose of this study was to construct an emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane and to develop guidelines for implementation of the model.

1.4.2 Objectives

1) To explore and describe experiences of nurses working with gender-based violence in a semi-rural area in Tshwane.

2) To construct an emancipatory model for nurses working with gender-based violence.

3) To develop guidelines for the operationalisation of the emancipatory model for nurses working with gender-based violence.

4) To evaluate the model for nurses working with gender-based violence and revise it if indicated.

1.5 OPERATIONAL DEFINITIONS

The operational definitions of the terms used in this study are set out below.

1.5.1 Emancipatory model

According to Chinn and Kramer (2011:252), a model is a:

symbolic representation of empiric experience in words, pictorial or graphic diagrams, mathematic notations, or physical material (such as a model airplane). When represented in written language, models are a form of knowledge within the empiric pattern.

An emancipatory model will emancipate nurses working with gender-based violence and help them to make emancipated decisions.
1.5.2 Nurse

According to the Nursing Act (2005), a “professional nurse” is a person registered as such in terms of section 31. A “staff nurse” means a person registered as such in terms of section 31.

Registration as prerequisite to practise

According to section 31 of the Nursing Act (2005):

(1) Subject to the provisions of section 37, no person may practise as a practitioner unless he or she is registered to practice in at least one of the following categories:

(a) Professional nurse;
(b) Midwife;
(c) Staff nurse;
(d) Auxiliary nurse; or
(e) Auxiliary midwife.

According to section 37 of the Nursing Act (2005):

A receipt issued by or on behalf of the Council in respect of the payment of registration fees will be proof, in legal proceedings, that such person is registered according to the provisions of this Act, but in the case of any person whose name-

(a) Appears in such register and who is unable to produce such receipt, certification under the hand of the Registrar is proof that such person is registered in terms of this Act; or

(b) Has been removed from the register since the date of issue of such receipt and has not been restored to the register, certification by the Registrar that such name has been removed from the register is proof that such person is not registered in terms of this Act.
1.5.3 Gender-based violence

Gender-based violence includes sexual violence, sexual exploitation and abuse, and intimate partner violence. Gender-based violence has a health effect on the survivor which includes various injuries like gynaecological disorders and can also result in mental distress and death (Henttonen et al., 2008:122). This study focuses on the nurses working with women and children who are subjected to gender-based violence.

1.5.4 Semi-rural setting

The Free Dictionary (Farlex, 2015, s.v. ‘semi-rural’) defines semi-rural as “having both rural and urban characteristics.” The Collins dictionary (n.d., s.v. ‘semi-rural’) defines semi-rural as “between rural and urban; somewhat but not wholly characteristic of rural areas.”

1.6 SETTING OF THE SEMI-RURAL AREA IN TSHWANE

The semi-rural area where the study was conducted is also known as Region 2 of Tshwane and is bordered by the Magaliesberg mountain range to the south and the Mabopane freeway (PWV9) to the west. The national freeway (N1) runs through the middle of the region, which borders the Tswaing nature reserve (City of Tshwane, 2015). The semi-rural area where the study took place is situated about 30 km north from the City of Tshwane.

The setting is discussed in more detail in Chapter 2.

1.7 PARADIGMATIC PERSPECTIVE

In this section, the researcher explains the “basic set of beliefs” (Lincoln & Guba, 2000:157) that guided the construction of an emancipatory model for nurses working with gender-based violence. Guba (1990:17) describes it as “a basic set of beliefs that guide action”, but Creswell (2009:6) chooses to use the term “worldview”, which carries the same meaning.

The paradigm of the study is described with reference to meta-theoretical assumptions, theoretical framework and methodological assumptions.
1.7.1 Meta-theoretical assumptions

The meta-theoretical assumptions in this study are based on the advocacy and participatory worldview (Creswell, 2009:9). The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:17) defines an advocate as “a person who publicly supports or recommends a cause or policy” or a “person who argues a case on someone else’s behalf.” The researcher believes that everybody has a worldview, but in this particular study the worldview focused on nurses working with gender-based violence.

These nurses go through the same experiences when working with survivors of gender-based violence; therefore, they can develop a bond and can have the same perspective when they reflect on certain situations as well as their responses to the situations. Orloff (1996:473-474) states that nurses are knowledgeable about the legal system and obstacles that survivors of abuse can encounter and are therefore in a unique position to provide support, information, encouragement and referrals to the survivors. The WHO (2003:10) guidelines for medico-legal care for victims of sexual violence state that it is important for nurses to understand the dynamics of gender-based violence so that they can offer empathetic, objective and optimal care to survivors.

According to Creswell (2009:9), research grounded in the advocacy worldview can change the lives of the participants, the institution in which they work and the life of the researcher. With the construction of an emancipatory model, the researcher strived to change the lives of participants through the knowledge that they would gain, to make their experience when they work with gender-based violence positive and to give them freedom of choice to make emancipated decisions.

In this study, the researcher attended to some of the important issues as described by Creswell (2009:9), namely, those of the emancipation and oppression of nurses. These two issues started as the focal point of the study to guide the researcher to achieve the objective and the purpose of the study. The participants helped the researcher to understand the phenomenon under study and, once understood, the researcher constructed an emancipatory model for nurses working with gender-based violence.
Fletcher (2006:51) states that nurses are still challenged by negative stereotypes that they are not emancipated. The researcher supports this statement and belief by constructing an emancipatory model for nurses working with gender-based violence so that they will be emancipated. To achieve this, the model was constructed by adhering to the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:442). This theory was linked to Kanter's Structural Empowerment Theory (Lethbridge, Andrusyszyn, Iwasiw, Laschinger & Fernando, 2011:637) and Spreitzer's Psychological Empowerment Theory (Spreitzer, 1996:484).

The researcher believes in Bradbury-Jones, Sambrook and Irvine's (2008:261) 'worldview' that emancipation for nurses has different meanings depending on the context in which the nurse is working; therefore, to emancipate nurses working with gender-based violence will differ from other disciplines in nursing. Bradbury-Jones et al. (2008:261) further argue that nurses may be relatively powerless in certain circumstances but will be powerful in others. The researcher supports and believes that this argument is a true reflection of nurses working with gender-based violence. The researcher believes that nurses working with gender-based violence will react emotionally differently when working with survivors of gender-based violence, especially children, compared to when they work with perpetrators of gender-based violence.

1.7.2 Theoretical framework

According to Creswell (2009:61), researchers use theories to explain behaviour and attitudes. Theories also provide a lens through which the researcher looks at the research problem and the research questions asked, and guide the researcher in determining what issues are important (Creswell, 2009:49, 61, 62). Polit and Beck (2012:128) describe a framework as the conceptual underpinnings of a study and state that, in a study that is based on a theory, the framework will be a theoretical framework; they further state that, in a study that has its roots in specified conceptual model, the framework will be a conceptual model. However, Polit and Beck (2012:128) state that the terms conceptual framework and theoretical framework are frequently used interchangeably in a study.
The theoretical framework for this study was based on three theories, namely, the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:442), Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484) and Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637). Of these three theories, the predominant theory used to inform the study was the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:442). The Wittmann-Price Theory of Emancipated Decision-Making guided the interview questions.

As this theory relates to emancipated decision-making, the researcher had to broaden the theoretical basis of the study to include the work environment of the nurses; therefore, two additional theories were included to support the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:442).

1.7.2.1 Wittmann-Price Theory of Emancipated Decision-Making

The goal of the Wittmann-Price Theory of Emancipated Decision-Making is to promote free choice, to make nurses aware of oppressive systems and to promote professional growth (Wittmann-Price, 2004:438). According to Wittmann-Price (2006:379), “all decision-making theories or models are based on an assumed disruption in a person’s normal pattern and that change has several possible alternatives.” Wittmann-Price (2004:437) states that the professional nursing role in promotion of emancipated decision-making is an important concept in the paradigm of shared decision-making about health care alternatives. The Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:378) is grounded in the Critical Social Theory and the Feminist Theory (Wittmann-Price, 2004:440), and therefore concepts of emancipation were based on the critical social theory. The five sub-concepts of emancipated decision-making, namely, empowerment, flexible environment, personal knowledge, reflection and awareness of social norms, were used to guide the semi-structured interview schedule.
The Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377) was proposed as a new theoretical model for nursing care. Wittmann-Price did a study in 2006 to test the five sub-concepts of emancipated decision-making, namely, empowerment, flexible environment, personal knowledge, reflection and awareness of social norms (Wittmann-Price, 2006:377). The five sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making are described below.

(a) Empowerment

Wittmann-Price (2004:441) describes empowerment as a positive process that promotes autonomy and independence. Wittmann-Price (2004:442) also describes empowerment as part of the emancipation process; however, it will not ensure freedom of choice on its own. Kuokkanen and Leino-Kilpi (2000:237) state that “where there is power, there is also knowledge and power begets knowledge.” Knowledge is needed to make informed decisions (Wittmann-Price, 2006:379). According to Kuokkanen and Leino-Kilpi (2000:237), empowerment can also be interpreted as professional knowledge when there is interaction and a relationship between a nurse and a survivor. With this study, the researcher strived to emancipate nurses working with gender-based violence through the gaining of knowledge.

(b) Flexible environment

Wittmann-Price and Bhattacharya (2008:226) describe that an environment can be internal and external and that it is intertwined with sources of power, obvious and obscure; it can be used for positive or emancipating outcomes, or negative or oppressive outcomes, depending on the intent. The person cannot be separated from the environment and the environment cannot be separated from the person. Wittmann-Price and Bhattacharya (2008:227) state that a flexible environment is needed for women who have to make decisions that are comfortable, and that the environment must also be resilient and responsive. Wittman-Price (2008:227) describes nursing as a professional role that can foster a flexible environment.
(c) Personal knowledge

Personal knowledge is self-awareness and the ability to understand oneself. Because people are different, personal knowledge influences how they react in certain situations (Polanyi, in Wittmann-Price, 2004:441). In this study, the researcher wants to explore and describe the experiences of nurses working with gender-based violence. By defining the different concepts that came out of the focus groups about how nurses react towards survivors of gender-based violence, an emancipatory model was constructed to make nurses more self-aware so that they can develop the ability to understand themselves. Personal knowledge is therefore important for nurses to make emancipated decisions in their treatment of survivors of gender-based violence.

(d) Reflection

Wittmann-Price (2006:378) describes reflection as a technique that requires critical thought either by oneself or in a group. According to Johns (1999:241), it is a self-analytical process to identify what one intends to achieve in a situation and the way one is behaving. Reflection requires all the information and knowledge that is available to a person to make decisions. Penney and Warelow (1999:263) explain reflection as behaviour: “it is like stepping out of one self and freeze framing the moment to understand it better.” In this study, the researcher encouraged the participants in the focus groups through semi-structured questions to describe their experiences working with survivors and perpetrators of gender-based violence, thereby encouraging reflection.

(e) Awareness of social norms

Part of emancipation is also to recognise that knowledge development occurs in a social context and that it can influence individual perceptions (Berragan, 1998:209). Nurses must be aware of the social norms in the areas where they work, because this will influence their decision-making choices as well as the way society places value on the alternatives being considered (Wittmann-Price, 2004:442).
Figure 1.1 below illustrates emancipated decision-making in women’s health care.

Figure 1: Emancipated decision-making in women’s health care (Wittmann-Price, 2004:443)

1.7.3 Methodological assumptions

According to Mouton (1996:124), methodological assumptions are assumptions about the nature of the research process and about the most appropriate methods to be used. The researcher adopted a qualitative design which was descriptive, exploratory and contextual in nature (Babbie & Mouton, 2001:272; Burns & Grove, 2009:25; Polit & Beck, 2012:727; Struwig & Stead, 2001:12).

1.8 RESEARCH DESIGN

This study followed a qualitative approach with a descriptive, explorative, contextual design (Creswell, 2009:176; Mouton, 1996:133; Polit & Beck, 2012:126, 727; Struwig & Stead, 2001:12). The research design is discussed in more detail in Chapter 2.
1.9 MODEL CONSTRUCTION

Model construction was done using the following three phases of theory generation as described by Chinn and Kramer (2011:215-217):

Phase 1: Construction of conceptual meaning
Step 1: Concept selection
Step 2: Concept definition
Step 3: Concept classification

Phase 2: Construction and contextualisation of the model
Step 4: Describing the relationship statements
Step 5: Description and evaluation of the model

Phase 3: Description of guidelines
Step 6: Description of guidelines for the operationalisation of the model

The three phases are briefly described in the paragraphs that follow.

1.9.1 Phase 1: Construction of conceptual meaning

Conceptual meaning was constructed in two steps, namely, concept selection (step one) and concept definition (step two).

1.9.1.1 Concept selection

Concepts were identified by searching for words or groups of words that represented the phenomenon of this study (Chinn & Kramer, 2011:188). Concepts were selected by exploring and describing the experiences of nurses working with gender-based violence in a semi-rural area in Tshwane. The setting, population and sample, data collection, data analysis, and literature control are briefly described.

(a) Setting

The proposed research site was the crisis centre and casualty department at a public hospital in a semi-rural area in Tshwane, as well as four surrounding community clinics, all of which provide a service for survivors of gender-based violence.
(b) Target population and sampling procedure

Nurses working with gender-based violence in this semi-rural area in Tshwane were the target population (Polit & Beck, 2012:274) of the study. This implies all nurses employed at the crisis centre, casualty department and four surrounding community clinics working with survivors of gender-based violence.

The staff allocation of the crisis centre, casualty department and four surrounding community clinics is described below. This staff allocation was the target population for the research study and the inclusion criteria were applicable to them.

Crisis centre: five professional nurses, one operational manager (also a professional nurse), six counsellors from non-governmental organisations (NGOs) and one sessional doctor for after hours, weekends and public holidays.

Casualty department: 13 professional nurses, one operational manager (also a professional nurse), 10 enrolled nurses, two casualty officers, and four sessional doctors for night shifts, public holidays and weekends.

Four surrounding clinics: one operational manager (also a professional nurse) each, and an average of 10 professional nurses and three enrolled nurses.

This research population was selected because it had the knowledge, experience, perceptions and views of the phenomenon under study (Burns & Grové 2011:84).

A purposive sampling procedure as described by Strydom and Delport (2011:392) was the most applicable for this qualitative study. The sample was collected based on the researcher’s knowledge of the population, its elements and the purpose of the study (Babbie, 2007:184). Through the purposive selection of participants, the participants assisted the researcher in understanding the research phenomenon (Creswell, 2009:178), namely, their experiences working with gender-based violence in a semi-rural area in Tshwane. The objectives of the study were achieved by purposive selection as only nurses working with gender-based violence were used as participants.
Sampling continued until data saturation was reached (Polit & Beck, 2012:275). Saturation was declared when the researcher, supervisors and independent coders agreed that saturation had been reached.

The inclusion criteria for the study were professional and enrolled nurses working with gender-based violence in the crisis centre, community clinics and casualty department. The nurses had to have worked in the crisis centre, community clinics or casualty department for more than six months and only female nurses were included. The nurses were all involved with the direct care and treatment of women and children exposed to gender-based violence. Nurses in the crisis centre were also exposed to the perpetrators of gender-based violence. Exclusion criteria were nurses who had been working with gender-based violence for less than six months, male nurses and nurses who did not consent to participate in the study.

After ethical clearance had been received for the proposed study and permission had been obtained to conduct the study at the intended sites (See Annexures A, B, C, D and E), the researcher went to the research sites and gave out invitations to the Unit Managers of the Unit, and asked them to select nurses who would adhere to the criteria for the study and invite them to the workshops and focus groups.

Sampling is discussed in more detail in Chapter 2.

(c) Data collection

Biographical data (see Annexure G) collected from nurses included their professional qualifications and their work-related experience.

Focus groups were held with participants for one to two hours and the questions were semi-structured (Polit & Beck, 2012:574-576). Three to 12 participants participated in each focus group at a student learning centre at the public hospital in the semi-rural area in Tshwane.
Open-ended questions, followed by probing questions, were used, according to an interview schedule (see Annexure G). These questions were focused around the five sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making (2006:377). Video and audio recording of the focus groups was done (Esterberg, 2001:111-112) and detailed field notes were made (Esterberg, 2001:107). The focus group discussion was held in English – a language in which the nurses were fluent. For the purpose of triangulation of data during focus groups, data were collected from the nurses through semi-structured individual interviews.

According to Greeff (2011:347-348), semi-structured individual interviews can be organised around areas of particular interest. Individual interviews lasted between 45 and 60 minutes, and the interview schedule as indicated for the focus groups was utilised (see Annexure G) in the participants’ work environment.

Data collection is discussed in more detail in Chapter 2.

(d) Data analysis

All focus groups and individual interviews were transcribed verbatim and field notes were included. The researcher chose not to make use of a software package which focuses on topic coding, as manual coding enabled her to pick up on underlying themes and make interpretations about the deeper meaning of the data, a form of coding referred to as analytic coding (Richards, 2009:99-104). Tesch’s coding guidelines, as described in Creswell (2009:186-190), was used for the coding of the study.

Data analysis is discussed in more detail in Chapter 2.

(e) Literature control

A literature control was done after the findings had been described, in order to make comparisons with the existing findings in the literature (Creswell, 2009:27-28). In this study, the researcher looked at the Wittmann-Price Theory of Emancipated Decision-Making as well as at other related theories to relate them to the problem under study.
1.9.1.2 Concept definition

Chinn and Kramer (2011:158) define the term concept as “a complex mental formulation of experience.”

Concept definition is discussed in more detail in Chapter 2.

1.9.1.3 Concept classification

Dickhoff, James and Wiedenbach’s (1968:435) elements of practice theory were applied to classify the identified concepts.

Concept classification is discussed in more detail in Chapter 6.

1.9.2 Phase 2: Construction and contextualisation

The guidelines described by Chinn and Kramer (2011:195-205) were used to describe the purpose of the model, the development of relationship statements, the structure of the model and the assumptions of the model (Chinn & Kramer, 2011:195-205).

Relationship statements and model description are described in more detail in Chapter 2.

After the description of the model, guidelines for the operationalisation of the model were developed.

Phase 2 is discussed in more detail in Chapter 2.

1.9.3 Phase 3: Description of guidelines

Guidelines were developed for the operationalisation of the emancipatory model in order to identify the central concepts.

Description of guidelines for the operationalisation of the model is discussed in more detail in Chapter 2.
1.10 TRUSTWORTHINESS

In qualitative research, the quality of research is measured against its credibility, dependability, confirmability and transferability (Polit & Beck, 2012:724-744), and authenticity (Tobin & Begley, 2004:392). Guba’s model of trustworthiness (Lincoln & Guba, 1985:301-331) was used in this study. The following criteria were used: credibility, transferability, dependability, confirmability and authenticity. These criteria are discussed in detail in Chapter 2.

1.11 ETHICAL CONSIDERATIONS

To ensure that the study complied with ethical standards, the proposed study was reviewed and approved by the School of Health Care Science Research Ethics Committee and the Medunsa Research Ethics Committee of the University of Limpopo (Medunsa Campus) (see Annexure A).

They ensured the ethical soundness of the proposed study and an ethical clearance certificate was issued before the researcher obtained permission from the medico-legal clinic’s unit manager, the chief executive officer (CEO) of the public hospital and the chairperson of the research assessment committee of the Gauteng Department of Health before data collection was started (see Annexure B).

Throughout the study, the following rights of participants were adhered to: the right to self-determination, privacy, anonymity and confidentiality, full disclosure about the research, and protection from discomfort and harm. Measures to ensure these rights were adhered to and are discussed in more detail in Chapter 2.

1.12 SIGNIFICANCE OF THE STUDY

With this study, the researcher wants to make a difference in the lives of nurses working with gender-based violence. The researcher also strives with this study:

a) To contribute to new knowledge. Unit managers will have better knowledge of how nurses experience working with gender-based violence. With this information, they will be enabled to understand why certain nurses cannot work with gender-based violence. This knowledge can assist with placement of nurses and career planning.
b) To make it applicable for future research. After completion of the study and writing of the thesis, it will be available at the library of the Sefako Makgatho Health Science University. There will also be paper presentations at conferences and publication of articles in peer-reviewed journals.

c) To make it useful for education, so that nursing training institutions will realise that there is a shortcoming in the curriculum and add new models, for example, a model for forensic nursing.

d) This research is a unique contribution because, to the researcher’s knowledge, no other study has led to the construction of an emancipatory model for nurses working with gender-based violence.

e) The study will be available on the research database of the UNEDSA project.
1.13 STUDY OUTLINE

The outline indicates the arrangement of the discussions.

Chapter 1: Overview and rationale of this study
Chapter 2: Research design and methodology
Chapter 3: Legal ethical framework and guidelines for the management of gender-based violence in the hospital setting
Chapter 4: Findings of the study and literature control
Chapter 5: Construction of conceptual meaning
Chapter 6: Construction of the model, contextualisation and guidelines
Chapter 7: Overview, recommendations, limitations and conclusion

1.14 SUMMARY

Chapter 1 discussed the overview of the study, including the background and rationale that led to the research problem statement. The purpose of the study was expressed and objectives for the study to achieve were set. This chapter also presented the frame of reference of the study. In addition, the research method was briefly outlined, ethical considerations and trustworthiness were mentioned and an overview was given. Chapter 2 focuses in detail on the research methodology that was used in the research study. Ethical considerations and measures to ensure trustworthiness are also discussed.
CHAPTER 2
RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

This study was based on the assumption that nurses need to be emancipated to work with gender-based violence. The purpose of this study, namely, to construct an emancipatory model for nurses working with gender-based violence, developed out of this question. In Chapter 1, the overview and rationale of the study were provided. In Chapter 2, the research methodology for this study is discussed. The research design, the methods used to collect and analyse data, and the appropriateness of the methods employed are discussed.

2.2 RESEARCH DESIGN

This study followed a qualitative approach with a descriptive, explorative, contextual design (Creswell, 2009:176; Mouton, 1996:133; Polit & Beck, 2012:126, 727; Struwig & Stead, 2001:12). The purpose of this study was to construct an emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane and to develop guidelines for implementation of the model. A model provides the overall framework of how a person looks at reality, tells the person what reality really is and what basic elements it contains (ontology), and tells the person what the nature and status of knowledge are (epistemology) (Silverman, 2010:436). After model construction, guidelines were developed for the operationalisation of the model. The definitions that explain the study design are discussed below.

2.2.1 Qualitative

A qualitative approach was chosen because, in this particular study, it allowed the researcher to understand the nuances and details of complex social phenomena from the participants’ point of view (Creswell, 2009:176; Ellsberg & Heise, 2005:55). Qualitative research is a systematic, subjective approach that can be used to describe the life experiences of participants and to give them significance; it is also a way for the researcher to gain insight through discovering meanings (Burns & Grove, 2009:51). Therefore, qualitative research was suitable for this study as the researcher wanted to explore and describe the experiences of nurses working with gender-based violence.
The researcher believes that individuals actively participate in social actions, that these actions are based on previous experience and that, through these, they will come to know phenomena in different ways (Streubert Speziale & Carpenter, 2003:17).

2.2.2 Descriptive

According to Burns and Grove (2009:25), descriptive studies offer researchers a way to discover new meanings, describe what exists, determine the frequency with which something occurs and categorise information. In this study, the researcher strove to explore and describe the experiences of nurses working with gender-based violence. When a literature study was done, the researcher discovered that much information was available about gender-based violence, but little was known about the experiences of nurses who work with gender-based violence every day of their lives.

2.2.3 Explorative

Polit and Beck (2012:727) define exploratory research as “a study that explores the dimensions of a phenomenon or that develops or refines hypotheses about relationships between phenomena.” Through an explorative design, the researcher can familiarise herself with the topic of interest and gain insight where she lacks basic information (Babbie, 2010:93; Babbie & Mouton, 2001:79; Fouché & De Vos, 2011:95-96). In this study, the researcher did her exploration of the topic through focus groups and individual interviews. Since little is known about the experiences of nurses working with gender-based violence, the data obtained will serve as a foundation for further research.

2.2.4 Contextual

The study was contextual as it focused on nurses working with gender-based violence in a semi-rural area in Tshwane and specifically nurses working at the crisis centre and casualty department at the public hospital in the semi-rural area and the surrounding clinics. The researcher believes that one person’s experience of gender-based violence differs from another’s. In this study, the researcher strove to acknowledge and respect each participant’s experiences, perceptions and the meaning they attached to their experiences of gender-based violence.
The researcher tried to understand and to identify concepts of what was similar and what was different in each participant’s experience of gender-based violence. The environment where the study took place also played a role in the findings of the study, because the behaviours of participants were related to the environment where they were situated.

It was thus necessary to do a comprehensive description of the environment of the research participants, as the behaviours of individuals were related to the environment where they were situated (Struwig & Stead, 2001:12). Mouton (1996:133) explains that, in a contextual strategy, researchers study phenomena because of their intrinsic and immediate contextual significance. The researcher’s aim for this study was to explore and describe the experiences of nurses working with gender-based violence in the concrete, natural context in which they occur, and in doing so, come to an understanding thereof (Babbie & Mouton, 2001:272). If the researcher could understand events against the background of the whole context and understand how such a context conferred meaning to the event concerned, the researcher could truly say that she understands how nurses experience working with gender-based violence in a semi-rural area in Tshwane.

The study was conducted in a semi-rural area in Tshwane and included the crisis centre and casualty department at the public hospital, as well as the surrounding community clinics in the semi-rural area. This semi-rural area is also known as Region 2 of Tshwane and is bordered by the Magaliesberg mountain range to the south and the Mabopane freeway (PWV9) to the west. The national freeway (N1) runs through the middle of the region, which borders the Tswaing nature reserve (City of Tshwane, 2015). The semi-rural area where the study took place is situated about 30 km north from the City of Tshwane.

2.3 MODEL CONSTRUCTION

The process chosen for constructing the model was done using the three phases of theory generation as described by Chinn and Kramer (2011:215-217). Walker and Avant (2011:57-58) explain that theory development by nurses is needed to enrich research in nursing and that clear and explicit methods of theory construction will help to facilitate the development of concepts, statements and theories.
Chinn and Kramer (2011:252) describe a model as a symbolic representation of words, pictorial or graphic diagrams, mathematic notations, or physical material that is a form of knowledge within the empiric pattern when represented in written language. Two processes are used for conceptualising and structuring empiric phenomena, namely, creating conceptual meaning, and structuring and contextualising theory. At the onset of the study, there was no model to emancipate nurses and to guide them to work with gender-based violence; therefore, the fundamental reason for constructing a model for nurses was to help them to create expert and effective nursing practices when working with gender-based violence. In this study, the empirical knowledge was generated by answering the research question: What are the experiences of nurses working with gender-based violence?

The model was developed in three phases: (1) construction of conceptual meaning, (2) construction and contextualisation of the model, and (3) description of guidelines.

Under each phase, certain steps were followed:

**Phase 1: Construction of conceptual meaning**
Step 1: Concept selection
Step 2: Concept definition
Step 3: Concept classification

**Phase 2: Construction and contextualisation of the model**
Step 4: Describing the relationship statements
Step 5: Description and evaluation of the model

**Phase 3: Description of guidelines**
Step 6: Description of guidelines for the operationalisation of the model

The three phases are described in the paragraphs that follow.
2.3.1 Phase 1: Construction of conceptual meaning

According to Mouton and Marais (1990:138), when scientific statements are integrated into frameworks, familiar structures of science, namely, theories and models, will be found. Chinn and Kramer (2011:157) explain it by saying that concepts are created to draw together different aspects that are relevant to a complex situation. The concepts were developed by selecting them.

2.3.1.1 Step 1: Concept selection

Chinn and Kramer (2011:176-180) explain that, to structure a theory, one first has to select the concepts that will form the basic components of the theory. Concepts were selected by searching out words or groups of words that represented the phenomenon of this study (Chinn & Kramer, 2011:188). Concept selection was done by achieving objective one of the study, namely, to explore and describe experiences of nurses working with gender-based violence in a semi-rural area in Tshwane.

This was done as follows:

(a) Setting

The proposed research site was the crisis centre and casualty department at a public hospital, as well as the surrounding community clinics in a semi-rural area in Tshwane. Four community clinics that provide a service for survivors of gender-based violence were chosen.

The four community clinics were chosen because they are situated in the semi-rural area where the research was done. The operational manager of the crisis clinic advised the researcher to use these four community clinics as the crisis centre receives referrals from these clinics. These clinics were also accessible to the researcher.

(b) Population

In research, the term population is generally considered as the group of people the researcher wants to study (Babbie, 2010:199). The population also signifies all who meet the criteria of inclusion (Burns & Grove, 2009:43), in other words, the entire aggregation of cases that the researcher is interested in (Polit & Beck, 2012:273).
Nurses working with gender-based violence in the semi-rural area in Tshwane were the target population of the study. Burns and Grove (2009:724) describe a target population as a “group of individuals who meet the sampling criteria and to which the study findings will be generalized.” According to Burns and Grove (2009:721), “the sampling criteria are the characteristics essential for membership in the target population.”

In this research, the population implies all nurses employed at the crisis centre, casualty department and four surrounding community clinics working with gender-based violence. The total population of nurses working with gender-based violence in the above areas was described in Chapter 1.

(c) Sampling procedure

A purposive sampling procedure was used with reference to Strydom and Delport (2011:391-393), as according to them it would be the most applicable for this study as the design of the study was qualitative and the sample was selected based on the researcher’s knowledge of the population and its elements, as well as the purpose of the study (Babbie, 2007:184). By purposefully selecting the participants, participants were selected who assisted the researcher in understanding the research phenomenon (Creswell, 2009:178), namely, their experiences working with gender-based violence in a semi-rural area in Tshwane. The objectives of the study were also achieved by purposive selection as only nurses working with gender-based violence were used as participants.

Burns and Grove (2009:312) state that, in qualitative research, the researcher selects the setting, the population and the phenomenon of interest. As this study was qualitative in nature, the researcher used the purposive sampling method and selected participants who would provide rich information on the central concept of the study. The researcher used her judgement to purposefully select participants who were suitable for the purposes of the study. Only participants who consented to participate in the study were sampled.
There are no fixed rules for a sample size in qualitative research and it should be based on informational needs. A guiding principle is data saturation, which means that the researcher has to do sampling to a point where no new information is obtained and redundancy is obtained (Polit & Beck, 2012:521). De Vos (2011:391) suggest that researchers will know that they have enough participants when they realise that the data are saturated. Saturation was declared after 18 participants had been interviewed. The researcher, supervisors and two independent coders agreed that saturation had been reached.

The criteria for participation in the research study were as follows:

- **Inclusion criteria**

Female professional and enrolled nurses working with women and children exposed to gender-based violence in the crisis centre and casualty department at the public hospital, as well as surrounding community clinics, were included. The nurses were involved with the direct care and treatment of women and children who were survivors of gender-based violence.

- **Exclusion criteria**

Nurses not working with gender-based violence, male nurses and nurses who did not consent to participate in the study were not included. Once ethical clearance had been received for the proposed study and permission had been obtained to conduct the study at the intended sites, the researcher went to the research sites and obtained permission from nurses who were willing to participate in the study. Nurses who were able to help the researcher to understand the problem and who might contribute the most valuable information to the research study were approached (Creswell, 2009:178). The researcher stayed in contact with the crisis centre, casualty department and four community clinics until the objectives of the study were met.
(d) Data collection

Data collection took place between June 2011 and May 2012. Three focus groups and five individual interviews were held. Field notes were taken. A pilot study was conducted prior to this.

(e) Pilot study

According to Strydom (2011b:236), a pilot study is a way for researchers to orientate themselves about the project they have in mind. Strydom (2011b:241) further states that a pilot study is conducted to improve the success and effectiveness of the investigation and that the pilot study must be conducted in the same manner as the planned main investigation. Mouton (2001:103) says that one of the most common errors that occurs with interviews is that no pilot study is done.

A pilot study was conducted to test the clarity of the questionnaire for the focus groups and the individual interviews. By conducting a pilot study, the researcher tested the research study. The researcher made use of a facilitator to conduct the pilot study in the form of a focus group.

In this study, a pilot study was done in the form of a focus group. However, the information that came out of the pilot workshop and pilot focus group was so rich in data that it was included in the main research.

(f) Focus groups

Biographical data (see Annexure G) that were collected from nurses included their professional qualifications and their work-related experience. This information was collected before the start of the focus groups and individual interviews.

Krueger and Casey (2009:179) point out five advantages of focus groups, namely, that the technique is a socially-oriented research method capturing real-life data in a social environment, it has flexibility, it has high face validity, it gives speedy results and it is low in cost. Krueger and Casey (2009:179) also note a disadvantage of the focus group method, namely, that focus groups afford the researcher less control than individual interviews; however, the researcher did not find it difficult because she made use of a skilled facilitator who knew how to control the focus groups.
A facilitator requires special skills, which was why the researcher made use of a skilled facilitator. Differences between groups can be troublesome; however, because of the nature of the study, the dynamics of the groups were the same and some of the participants even came back for a follow-up focus group. In this study, assembling the groups was a real problem. Invitations were given out to the different units with detailed descriptions of what the focus group was about and to ask permission from the unit manager to send participants who adhered to the inclusion criteria. Eight invitations were given out per focus group. However, the focus groups varied between three and 12 participants who attend the focus groups.

The researcher held the focus groups at a student learning centre at the public hospital in the semi-rural area in Tshwane.

The centre was away from the working environment of the participants and was large enough for the focus groups.

- Open-ended questions, followed by probing questions, were used. An interview schedule was used to guide the facilitator and researcher with the questions they wanted to ask to get the relevant data applicable for the study (see Annexure G). The questions focused on the five sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377). Video and audio recordings were made of the focus groups in order to identify who was speaking and to have the ability to replay sessions during analysis (Cohen & Crabtree, 2006:1).

- The researcher made use of a skilful facilitator who was trained in qualitative methods to help guide the focus group so that maximum information could be gained from the participants.

- Saturation of data was not reached during focus groups and the joint interview, and additional data were collected from the nurses through semi-structured individual interviews. According to Morse (1991:189), semi-structured interviews can be organised around areas of particular interest. Interviews lasted between 45 and 60 minutes, utilising the interview schedule as indicated for the focus groups (see Annexure G).
The focus groups varied in size between three and 12 nurses. Reimbursement in the form of money was not provided, but each participant received a small gift from the researcher after the focus groups and interviews were conducted as a token of appreciation for their participation. Tea and lunch were also provided for the focus groups. Each focus group had a facilitator that guided the discussion. The first focus group, which was the pilot study, had an observer who took field notes during the discussion. The observer was a master’s student who wanted to learn more about focus groups. The researcher acted as the assistant facilitator and took field notes during all three focus groups.
The facilitator conducted the focus groups in four phases:

First, there was an **introduction phase** – during this phase, the facilitator explained the research to the participants and made the objectives clear. She made sure that the participants understood the purpose of the study. They were invited to take part in the study and it was made clear that they could withdraw at any stage if they wanted to. Permission was also asked from the participants to make an audio recording and a video recording of the group.

The second phase was the **rapport building phase** where the participants introduced themselves. They explained where they worked and for how long they had been working in that area.

The third phase was a **deep discussion phase** and a semi-structured questionnaire (see Annexure G) was followed. The facilitator started the questions with an open-ended question where the participants were invited to share their experiences of working with gender-based violence with each other. After an initial shyness, the participants opened up and described their experiences very clearly. The description of rape cases and how they felt about them was sometimes very graphic and even shocking. During this phase, the researcher did not take a great deal of field notes as she could feel the pain and emotions of the participants and could, in some cases, identify with them.

The fourth phase was the **summary and conclusion phase**. The facilitator made an effort to make sure that what the participants said and what she understood were the same. The facilitator also asked the participants if they wanted to be debriefed and was willing to stay and talk them through it. However, at all the focus groups, the participants said that the session itself was a debriefing session for them and that they felt relieved.

**(g) Individual interviews**

Individual interviews were held after the focus groups and were conducted between October 2011 and May 2012. During individual interviews, the same principles were followed as with the focus groups. The researcher did not make use of video recording during the individual interviews; only audio recording was used.
(h) Field notes

Field notes are written accounts of what the researcher hears, sees, experiences and thinks during the course of data collection (Greeff, 2011:372). Field notes were taken throughout the day by the researcher and facilitator while the workshop and focus groups were conducted. Arkava and Lane (in Strydom, 2011a:335) suggest that field notes should contain chronological descriptions about what happens to the participants. Field notes helped the researcher to explore and remember the process of the focus groups (Greeff, 2011:360). Field notes are a written reflection of the data obtained during the day and can serve a number of different purposes:

- **Methodological notes** are reflections of what the researcher observed.

- **Theoretical notes** document what the researcher was thinking and make sense of what was going on.

- **Personal notes** are comments about the researcher’s own feelings because, inevitably, when hearing experiences from what the participants experienced it gave rise to the researcher’s own personal emotions (Greeff, 2011:372; Polit & Beck, 2012:549). The researcher had to acknowledge these feelings so that they did not influence of what was being observed and what was being done in the participant’s role (Polit & Beck, 2012:549).

The field notes that were taken included seating arrangements, verbal and non-verbal communication (Greeff, 2011:372).

(i) Preparation of data

A critical step in preparing data for analysis is verbatim transcription of the audio recordings. Researchers need to ensure that transcriptions are accurate and that they validly reflect the interview experience (Polit & Beck, 2012:557).
The data were prepared for analysis by verbatim transcriptions of the audio and video recordings of each focus group and individual interview. Transcriptions were done in dialogue form and each focus group and interview was transcribed separately. Field notes were written about each focus group and interview next to the appropriate dialogue. The complete set of data was utilised for analysis by the researcher and the two independent coders.

(j) Data analysis

Data analysis is the process of bringing order, structure and meaning to the collected data (Schurink, Fouché & De Vos, 2011:397). According to Campbell and Gregor (2004:86), qualitative data analysis is about making some particular meaning from the data. Esterberg (2001:79) states that she thinks of data analysis as answering some questions, for example: “So what?” “Why is your research interesting or important?” “Why should people care about it?” “What is the larger sociological significance of your study?” All these questions add meaning to the collected data. Streubert and Carpenter (2011:45) state that the amount of data collected and the style in which data have been stored either facilitate or impede data analysis. Therefore, analysis of qualitative research is a hands-on process (Streubert & Carpenter, 2011:45).

On completion of all the focus groups and individual interviews, the data were analysed. Data analysis is the description of what was found during the focus groups and the individual interviews. The field notes that the researcher made during the focus groups and the individual interviews became part of data analysis (Streubert & Carpenter, 2011:42). The researcher took the data and reorganised them in such a way that sense could be made out of the data. The data were interpreted and conclusions were drawn that reflected the experiences of nurses working with gender-based violence (Babbie, 2010:117).
(k) Coding data

Polit and Beck (2012:722) describe coding as a process of transforming raw data in a standardised form for data processing and analysis and state that, in qualitative research, this is the process of identifying and indexing recurring words, themes or concepts within the data. Coding is a formal system to organise data and to uncover and document additional links within and between concepts and experiences described in the data (Bradley, Curry & Devers, 2007:1761).

The researcher as well as two independent coders analysed the data and reached consensus about the categories and sub-categories identified in the data (Creswell, 2009:191). The five sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making were used to analyse the data and to put them in categories. Main concepts were identified.

Tesch’s coding guidelines, as described by Creswell (2009:186-190), were used for the coding of the research. The researcher chose not to make use of a software package which focuses on topic coding, as manual coding enabled her to pick up on underlying themes and make interpretations about the deeper meaning of the data, a form of coding referred to as analytic coding (Richards, 2009:99-104). The following steps were followed (Creswell, 2009:186):

1) The researcher got a sense of the whole by reading through all the transcriptions and writing down ideas as they came to mind.

2) The researcher picked one focus group which was the most interesting. She went through it and asked herself what it was all about; she also thought about the underlying meaning and wrote down her thoughts. After picking one focus group and reading carefully through it, the researcher went through all the focus groups and the individual interviews to write down her thoughts and to start making a list of all the topics that were found.

3) A list was made of all the topics that were found. Similar topics were clustered together. These topics were formed into columns and were put under major topics and unique topics.
4) This list was taken back to the data, the topics were abbreviated as codes and the codes were written next to the appropriate segments of the text.

5) The most descriptive wording for the topics was found and turned into categories. The total list was then grouped together into topics that related to each other.

6) A final decision was made on the abbreviation of each category and the categories were alphabetised.

7) A preliminary analysis was done with all the data that belonged together and placed under categories.

8) A second coder was also used to code the data. The first coder was a psychology master’s student who was busy with her studies and who was used by a company for coding qualitative studies. After the coding, the researcher and the coder reached consensus about the themes. However, when the researcher started to group the themes together, she realised that a great deal was about the emotional and psychological impact on nurses from the viewpoint of a psychologist and decided to use a doctor in nursing who was also a coder to do the coding out of a nursing perspective. The findings of these two coders, along with the researcher’s own coding and the coding of the two supervisors, were grouped together for the final findings of the research study.

9) The researcher as well as the independent coders performed an analysis of the data and reached consensus about the themes, categories and sub-categories identified in the data (Creswell, 2009:191).

(I) Literature control

A literature control was done after the findings of the study had been described, in order to make comparisons with the existing findings in the literature (Creswell, 2009:27-28). The literature control also contributes to the trustworthiness of the study. The literature control is discussed in Chapter 4 of the study.
2.3.1.2 Step 2: Concept definition

Chinn and Kramer (2008:197) explain that one way of providing information about conceptual meaning is by definitions and word usages of the concept being explored. The central statement and concepts derived from the findings and the literature control of the study are discussed in Chapter 5 of the study.

2.3.2 Phase 2: Construction and contextualisation of the model

2.3.2.1 Describing the relationship statements

Relationship statements were written between the concepts in order to specify the relationship between two or more of the concepts based on evidence (Walker & Avant, 2005:87). This evidence came from the findings of the study and literature. Evidence can also come from literature-based sources such as literature reviews (Walker & Avant, 2005:87) and relevant theoretical frameworks.

The way these relationships emerge provide clues to the theoretic purposes and the assumptions on which the theory is based. Relationship statements are discussed in Chapter 6.

2.3.2.2 Description and evaluation of the model

Chinn and Kramer’s (2011:195-205) guide for the description of the model was used in this study. They propose six questions that can be used for describing the model:

- **What is the purpose of this study?** This addresses why the model was formulated.
- **What are the concepts of this theory?** This identifies the ideas that are structured and related within the model.
- **How are the concepts defined?** This clarifies the meaning of concepts within the model.
- **What is the nature of relationship?** This addresses how concepts are linked together.
- **What is the structure of the theory?** This addresses the overall form of the conceptual interrelationships.
• *On what assumptions does the theory build?* This addresses the basic truths taken to underlie theoretic reasoning.

After the model was described, guidelines for the operationalisation of the model were developed.

**2.3.3 Phase 3: Description of guidelines**

**2.3.3.1 Step 6: Description of guidelines for the operationalisation of the model**

Guidelines were developed for the operationalisation of the model in order to identify the central concepts. Phase 3 is described in more detail in Chapter 6.
2.4 TRUSTWORTHINESS

In qualitative research, the quality of research is measured against its credibility, dependability, confirmability and transferability (Polit & Beck, 2006:332), as well as authenticity (Tobin & Begley, 2004:392). Guba’s model of trustworthiness (Lincoln & Guba, 1985:301-331) was used in the research. Table 2.2 below presents the criteria for trustworthiness.

Table 2.1: Diagrammatic representation of criteria for trustworthiness

<table>
<thead>
<tr>
<th>Credibility</th>
<th>Transferability</th>
<th>Dependability</th>
<th>Confirmability</th>
<th>Authenticity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accuracy of the data and interpretation</td>
<td>Thick and rich descriptions</td>
<td>Stability of data</td>
<td>Bracketing</td>
<td>Bracketing</td>
</tr>
<tr>
<td>Prolonged engagement</td>
<td></td>
<td>Prolonged engagement</td>
<td>Reflective notes</td>
<td>Reflective notes</td>
</tr>
<tr>
<td>Triangulation</td>
<td></td>
<td>Independent coder</td>
<td>Confirmability audit trial</td>
<td>Confirmability audit trial</td>
</tr>
<tr>
<td>Member checking</td>
<td></td>
<td>Triangulation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reflective journals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4.1 Credibility

Credibility refers to the accuracy of the data and the interpretation thereof (Polit & Beck, 2012:585). Schurink et al. (2011:419) state that this is the alternative to internal validity. Multiple strategies, as described by Creswell (2009:191), were used to ensure the accuracy of the data. This was achieved in this study by the researcher’s prolonged engagement in the research field as data were collected until saturation was reached, and the researcher periodically discussed her research progress with her supervisors. Prolonged engagement refers to spending sufficient time in the crisis centre to promote trust (Lincoln & Guba, 1985:301). The researcher visited the crisis centre while she was conducting the research. The researcher also supported the awareness of child abuse week and got two schools involved with donations to the crisis centre when they did a community project. With the researcher’s persistent observation, an in-depth understanding of the phenomenon under study was obtained (Creswell, 2009:192).

Triangulation added further credibility to the study and was achieved by collecting data from multiple participants, using multiple sources of data, such as focus groups, individual interviews and field notes (Creswell, 2009:191), including literature, and using two independent coders (Polit & Beck, 2006:547).
Member checking is a process whereby data, interpretations and conclusions are checked with the members from whom the data were collected (Lincoln & Guba, 1985:314). Member checking was done by providing feedback to participants and the purpose was to determine the accuracy of the findings (Creswell, 2009:191; Polit & Beck, 2006:545). During and after the focus groups, the facilitator summarised what she heard and asked the participants to comment on it to see if she heard correctly.

2.4.2 Transferability

Transferability refers to the alternative to external validity or generalisability (Lincoln & Guba, 1985:316). Lincoln and Guba (1985:316) describe transferability as the burden that a researcher has in demonstrating the applicability of one set of findings to another context. Transferability was enhanced by using rich and thick descriptions of the methodology and the findings of the study to convey the findings. These descriptions gave the participants an element of shared experiences and, through that, the results became more realistic and richer (Creswell, 2009:191-192).

2.4.3 Dependability

Dependability is concerned with the stability of data throughout the research process (Polit & Beck, 2006:335). This is also the alternative to reliability (Schurink et al., 2011:420). Schurink et al. (2011:420) state that this is where a researcher attempts to account for changing conditions of the phenomenon and research design because of refined understanding of the phenomenon. The researcher must spend a prolonged time in the field of the research, which will help the researcher to develop an in-depth understanding of the phenomenon under study because, the more experience the researcher has in the field of study, the more accurate or valid the findings will be (Creswell, 2009:192). Multiple sources of data collection, namely, focus groups and interviews, were used and continued until data saturation was reached.
2.4.4 Confirmability

Confirmability has to do with the objectivity of the data to such a point that independent people will agree with the “accuracy, relevance or meaning” of the data (Polit & Beck, 2012:585). According to Lincoln and Guba (1985:316), the question is whether the findings of the study can be confirmed by another. Bracketing, where the researcher isolates preconceived ideas about the research subject, and reflective notes also increased the study’s confirmability (Polit & Beck, 2012:495, 589-590).

In this study, the researcher kept observational, reflective, methodological and personal notes (Polit & Beck, 2012:548-549). This was done throughout the data collection process. The researcher’s personal perspectives and experiences as a nurse working with gender-based violence could have been an influence when the data were collected and analysed and when meaning was created. The researcher identified how she would react in certain situations so that she was aware of it and would not be influenced by it. The researcher identified personal biases early in the research process as suggested by Polit and Beck (2012:176), as these can influence the research findings. To prevent personal biases from interfering with the research findings, the researcher used an interview guide. The researcher also made use of a facilitator during the focus groups. The interview guide ensured that the researcher and facilitator only probed for answers that were relevant to the research. It also helped the researcher not to guide participants towards the responses that she wanted. The researcher also used bracketing (Polit & Beck, 2012:495), which refers to the process of identifying and setting apart preconceived beliefs and opinions about the phenomenon under study. Polit and Beck (2012:495) state that bracketing will never be achieved totally; however, the researcher strived to confront the data in their pure form. The researcher kept a reflective journal and followed the 10 tips described by Ahern (in Polit & Beck, 2012:495).

The researcher has secured a confirmability audit trail by safekeeping all recordings and material associated with the study for five years.
2.4.5 Authenticity

Denzin and Lincoln (2000:390) explain that the researcher has the opportunity to treat all the data equally through the process of bracketing. Reflective field notes were also taken, and descriptions of the findings, including direct quotes from the participants, were taken down.

Authenticity also conveys the feeling and tone of the participants (Polit & Beck, 2012:585). The participants described some stories and experiences of working with gender-based violence so vividly that it drew the researcher into their world of working with gender-based violence. These stories and descriptions will also enable the readers to develop a heightened sensitivity to the issues being discussed.

2.5 ETHICAL CONSIDERATIONS

The research proposal was reviewed and approved by the Medunsa Research Ethics Committee of the University of Limpopo (Medunsa Campus) to ensure ethical soundness of the proposed study before it commenced (see Annexure A). Approval was also gained from Tshwane Metsweding Region Research Ethics Committee (see Annexure B). Permission to access the research site and its nurses was obtained from the crisis centre unit manager, CEO of the public hospital, chairperson of the research assessment committee of the Gauteng Department of Health and area manager of the community clinics before the data collection began (see Annexures C, D and E). The rights of participants that were adhered to throughout the study are described below.

2.5.1 The right to self-determination

The participants had the right to decide voluntarily whether or not to participate in the study without the risk of penalty or prejudicial treatment (Polit & Beck, 2012:154). In this study, the facilitator introduced the study and its purpose to the participants in the focus groups and the researcher explained it to the participants in the individual interviews and the joint interview. The participants were asked if they had signed the consent form and the different roles of the facilitator and the researcher were explained. After the research study had been explained, the facilitator asked the participants whether they agreed to the norms and rules of the group and whether they wanted to add anything.
The facilitator explained to them that, if they did not want to participate in the study, they were welcome to leave and nothing would be held against them.

2.5.2 The right to privacy

The facilitator and researcher ensured that the participants’ privacy was maintained continuously. Privacy of the participants was safeguarded and data were not collected without the participants’ knowledge and consent. Participants were kept nameless in relation to their participation in the study. Participants also have the right to expect that their data will be kept in strictest confidence (Polit & Beck, 2012:156). No names of participants were written on documents and audio-visual recordings have been locked up in a safe place for five years and will be destroyed after they have served their purpose in the mentioned audit trail. Video recordings were only viewed by the researcher. No visual material was included in any reports and ground rules were laid down before the beginning of the focus groups (Esterberg, 2001:111).

2.5.3 The right to full disclosure about the research

The researcher introduced the study to the participants and the purpose of the study was explained to them. Their right to refuse to participate was also explained to them (Polit & Beck, 2012:154).

Participants were required to sign informed consent before participating in the research. A participant information leaflet (see Annexure F) accompanied the consent form and specified the researcher, contact persons and contact numbers for enquiries. Participants were informed that interviews would be audio and video recorded.

2.5.4 The right to protection from discomfort and harm

The type of questions the participants answered could have caused emotional discomfort to the participants and the researcher needed to be aware of the nature of intrusion on participants’ psyches (Polit & Beck, 2012:153). The service of a psychologist was offered after the focus groups, joint interview and individual interviews, should the participants need it. The facilitator of the focus groups and the researcher were also experienced psychiatric nurses who were able to deal with immediate emotional discomfort.
The researcher tried to minimise the impact on service delivery when interviewing the participants by doing so when the unit was quiet and by having three focus groups away from the work environment. Invitations were sent out to possible participants so that the focus groups and interviews that were held did not interfere with the service rendering of the units. The researcher also made use of an assistant facilitator to help with the focus groups. The facilitator was an experienced psychiatric nurse and was able to deal with immediate emotional discomfort. The facilitator also offered her services after the focus group to stay and counsel the participants; however, this was not necessary and no participants stayed.

2.6 SUMMARY

This chapter discussed the research design and methodology, the processes of data collection and data analysis, measures to ensure trustworthiness, and ethical considerations.

Chapter 3 outlines the legislative framework that is applicable to nurses working with gender-based violence.
CHAPTER 3
LEGAL FRAMEWORK AND GUIDELINES FOR THE MANAGEMENT OF GENDER-BASED VIOLENCE IN THE HOSPITAL SETTING

3.1 INTRODUCTION

Chapter 2 provided a detailed discussion of the research design and methodology used in this study. The design of the study, methods of sampling, data collection and the analysis of the data were discussed. In this chapter, the researcher aims to give an overview of the legal framework of the study, including the Acts, policies and guidelines that are applicable to nurses working with gender-based violence.

3.2 ROLE OF THE NURSE

Nurses working with gender-based violence are expected to be able to fulfil certain roles and to adhere to certain Acts, policies and guidelines. Geyer (1998:28) states that nurses play an important role in the delivery of primary health care services in South Africa and that nurses should be emancipated to practise within legal and ethical boundaries.

The Nursing Act (2005) states that:

*nursing is a regulated profession comprising a body of scientific knowledge and skills practiced by persons referred to in section 30 of the Act and registered in terms of section 31 of the Act. The Act, the regulations, rules and codes made in terms of the Act provide the legal and ethical framework for the practice of nursing.*

Other Acts that have an influence on nurses working with gender-based violence are the following:

(c) No. 38 of 2005: Children’s Act.
(d) No. 32 of 2007: Criminal Law (Sexual Offences and Related Matters) Amendment Act.
(e) No. 41 of 2007: Children’s Amendment Act.
Nurses working with gender-based violence are guided by the WHO’s (2003) guidelines for medico-legal care for victims of sexual violence.

Women and children subjected to gender-based violence can seek help in the casualty department, community clinic and crisis centre. Therefore, it is crucial for those nurses who may come in contact with survivors of gender-based violence that they are able to manage the survivors’ emotional/psychological condition and physical/medical condition, and that they do the correct referrals and follow-ups of the survivor. Nurses should be competent to act accordingly when they suspect that a survivor has been subjected to gender-based violence. It is very important that survivors of gender-based violence are cared for and that the examinations are carried out correctly. Nurses working with gender-based violence also deal with the perpetrator and it is crucial that nurses have the knowledge and skills to carry out the necessary tests that are expected of them.

Nurses working with gender-based violence have to identify and acknowledge abuse towards women and children to help end the cycle of violence. This is confirmed by the Utah Department of Health guidelines (2008:7) which state that identifying and acknowledging the abuse may help to break the cycle of violence and increase the health and welfare of survivors.

Nurses working in the casualty department and community clinics must have the knowledge to identify cases of gender-based violence when they attend to a survivor. Here, they also have the opportunity to intervene if they suspect gender-based violence. Nurses working in the casualty department and community clinics play a fundamental role in the identifying gender-based violence. During this period following abuse, survivors are the most receptive to interventions. This statement is confirmed by Van der Wath et al. (2013:2242).

Nurses are in a unique position to identify gender-based violence, mainly because of the trust the survivor has in them. The WHO (2013b:1) confirms that health professionals can provide assistance in cases of gender-based violence by facilitating disclosure, offering support and referral, and providing the appropriate medical services and follow-up care. These nurses have to gather forensic evidence, particularly in cases of sexual violence.
Management includes the **survivor** of gender-based violence as well as the **perpetrator** of gender-based violence. Survivors of gender-based violence have a right to be treated in a private place and with confidentiality. Sometimes, nurses working with gender-based violence will be confronted to deal with a survivor who is brought in by the perpetrator. This usually happens when there is inter-partner violence. They must be careful not to be judgemental, especially when it is the second or third time that the same survivor and perpetrator come to the crisis centre.

A study that was done in Brazil by Vieira et al. (2009:3) found that nurses are often supportive towards women who experience violence, but that they are sometimes insecure in the handling of such cases. A survivor of gender-based violence requires emotional/psychological and physical/medical care. Survivors also need to be referred, when needed, to the right people. Survivors have to be followed up after episodes of abuse.

When a survivor of gender-based violence is identified at the casualty department or at a community clinic and referred to the crisis centre, assessment of the survivor will mainly happen in the casualty department or in the community clinic. Sometimes, nurses working with gender-based violence have to decide whether the survivor was exposed to gender-based violence according to the history that they take. Nurses working with survivors of gender-based violence must be able to meet the legal needs of the survivor and have to collect specimens for forensic investigation.

According to the guidelines of the WHO (2003:19), the codes of medical ethics are based on the principles of doing “good” and not “doing harm”. Nurses working with gender-based violence must use their professional skills in an ethical manner and must observe the law of the community. The WHO (2003:19) describes that adherence to these codes of conduct is particularly relevant when dealing with survivors of interpersonal violence who may suffer abuse from a person in a position of power.

Nurses working with gender-based violence also have to deal with the court. Here, they must be careful not to give too much information and to concentrate on facts.
The guidelines for gender-based violence interventions in humanitarian settings (Inter-Agency Standing Committee, 2005:66) state that nurses working with gender-based violence must be aware of the relevant laws and policies that govern health care providers in cases of sexual violence and that they must know that they will interact with the police in cases where the survivor wishes to pursue legal justice. Nurses working with gender-based violence must also know how to complete the relevant forms.

3.3 CHARACTERISTICS OF GENDER-BASED VIOLENCE

Various definitions of gender-based violence have been made by authors, but they are all similar. The characteristics that identify gender-based based violence are also similar and broadly describe gender-based violence as any act that includes violence that is directed at an individual and can include physical, sexual, psychological or economic deprivation, whether it occurs in public or in the person’s private life (Heise et al., 2002:S6; Henttonen et al., 2008:122).

3.3.1 Gender-based violence

The UN Declaration on the elimination of violence against women (1993:2), to which South Africa is signatory, offered the first official definition of the term gender-based violence:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.

The guidelines for gender-based violence interventions in humanitarian settings (Inter-Agency Standing Committee, 2005:7) describe gender-based violence as a broad term for any harmful act that is perpetrated against a person’s will which is based on gender differences between males and females.
3.3.2 Nature of gender-based violence

The guidelines for gender-based violence interventions in humanitarian settings (Inter-Agency Standing Committee, 2005:7) explain that the nature and the extent of specific types of gender-based violence vary across different cultures, countries and regions. These guidelines provide examples of gender-based violence, namely:

- sexual violence, including sexual exploitation or abuse and forced prostitution;
- domestic violence;
- trafficking;
- forced or early marriage; and
- harmful traditional practices, such as female genital mutilation, honour killings, widow inheritance and others.

3.4 ACTS AND POLICIES

3.4.1 Nursing Act (No. 33 of 2005) and the rights of nurses

The South African Nursing Council (SANC) acknowledges that nurses have rights too. In carrying out their duty to patients, nurses operate within the ethical rules governing the profession and their career scope of practice.

The confirmation of the rights of nurses is therefore not an end in itself, but a means of ensuring improved service to patients. To enable nurses to provide safe, adequate nursing, they have the right to (SANC, n.d.):

1. *practise in accordance with the scope which is legally permissible for their specific practice*;
2. *a safe working environment which is compatible with efficient patient care and which is equipped with at least the minimum physical, material and personnel requirements*;
3. *proper orientation and goal-directed in-service education in respect of the modes and methods of treatment and procedures relevant to their working situation*;
4. *negotiation with the employer for such continuing professional education as may be directly or indirectly related to their responsibilities*;
5. *in the case of a registered person, equal and full participation in such policy determination, planning and decision-making as may concern the treatment and care of the patient;*

6. *advocacy for and protection of patients and personnel for whom they have accepted responsibility;*

7. *conscientious objection, provided that:*  
   o *the employer has been timeously informed in writing; and*  
   o *it does not interfere with the safety of the patient and/or interrupt his/her treatment and nursing;*

8. *refuse to carry out a task reasonably regarded as outside the scope of their practice and for which they have insufficient training or for which they have insufficient knowledge or skill;*

9. *not to participate in unethical or incompetent practice;*

10. *written policy guidelines and prescriptions concerning the management of their working environment;*

11. *refuse to implement a prescription or to participate in activities which, according to their professional knowledge and judgement, are not in the interest of the patient;*

12. *have disclosed to them the diagnosis of patients for whom they accept responsibility;*

13. *a working environment which is free of threats, intimidation and/or interference;*

14. *a medical support or referral system to handle emergency situations responsibility.*

In addition to the above, nurses are entitled to their rights in terms of the Constitution of the Republic of South Africa (1996) and relevant labour legislation, provided that the exercising of such rights does not put the life or health of patients at risk.

### 3.4.2 Domestic Violence Act (No.116 of 1998)

The Domestic Violence Act (1998:2) states that the South African government recognises that gender-based violence is a serious problem and that there is a high incidence of gender-based violence within South African society. Women and children are among the most vulnerable members of our society.
The government further recognises that gender-based violence takes on many forms, as shown below (Domestic Violence Act, 1998:2):

To provide for the issuing of protection orders with regard to domestic violence; and for matters connected therewith.

PREAMBLE

RECOGNISING that domestic violence is a serious social evil; that there is a high incidence of domestic violence within South African society; that victims of domestic violence are among the most vulnerable members of society; that domestic violence takes on many forms; that acts of domestic violence may be committed in a wide range of domestic relationships; and that the remedies currently available to the victims of domestic violence have proved to be ineffective;

AND HAVING REGARD to the Constitution of South Africa, and in particular, the right to equality and to freedom and security of the person; and the international commitments and obligations of the State towards ending violence against women and children, including obligations under the United Nations Conventions on the Elimination of all Forms of Discrimination Against Women and the Rights of the Child;

IT IS THE PURPOSE of this Act to afford the victims of domestic violence the maximum protection from domestic abuse that the law can provide; and to introduce measures which seek to ensure that the relevant organs of state give full effect to the provisions of this Act, and thereby to convey that the State is committed to the elimination of domestic violence.
3.4.3 Children’s Act (No. 38 of 2005) amended by the Children’s Amendment Act (No. 41 of 2007)

The Children’s Act (2005: 9-10) defines abuse as follows:

‘abuse’, in relation to a child, means any form of harm or ill-treatment deliberately inflicted on a child, and includes –

a. Assaulting a child or inflicting any form of deliberate injury to a child;

b. Sexually abusing a child or allowing a child to be sexually abused;

c. Bullying by another child; or

d. Exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

The Children’s Amendment Act (2007:44) states the following regarding the reporting of suspected child abuse:

110. (1) Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official.
3.4.4 Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007)

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007:3-4) deals with all legal aspects relating to sexual offences in a single piece of legislation and covers issues such as:

- rape, which applies to all forms of physical penetration without consent, irrespective of gender;
- sexual assault, which applies to all forms of sexual violation without consent;
- criminalising certain compelled sexual acts; and
- providing specific services to certain victims of sexual offences, including affording a victim of certain sexual offences the right to apply that the alleged perpetrator be tested for his or her HIV status and the right to receive this information.

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007:4-6) states the following:

**WHEREAS** there is a high incidence of sexual offences in the Republic which in turn has a particularly disadvantageous impact on vulnerable persons, the society and the economy;

**WHEREAS** women and children are particularly vulnerable to sexual offences, including ... prostitution ...;

**WHEREAS** the South African common law and statutory law fail to deal effectively and in a non-discriminatory manner with activities associated with the commission of sexual offences ...; and thereby which, in too many instances fails to provide adequate protection to the victims of sexual offences ...;

AND WHEREAS the Bill of Rights in the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), enshrines the rights of all people in the Republic, including the right to equality, the right to privacy, the right to dignity, the right to freedom and security of the person which incorporates the right to be free from all forms of violence from either public or private sources, and the rights of children to have their best interests considered to be of paramount importance;

3.4.5 Constitution of the Republic of South Africa (No. 108 of 1996)

South Africa’s signature legislation is the Bill of Rights in the Constitution of the Republic of South Africa (1996). Section 1 of the Constitution provides that the South African state is founded on the values of human dignity, the achievement of equality, as well as the advancement of human rights and freedoms, non-racialism and non-sexism.

Specific rights that protect every citizen of South Africa against any form of violence, as reflected in the Constitution of the Republic of South Africa (1996:1243-1247), are as follows:

- Section 7 (2) (p. 1243): “The state must respect, protect, promote and fulfil all the elements in the Bill of Rights.”

- Section 9 (1) (p. 1245): “Everyone is equal before the law and has the right to equal protection and benefit of the law.”

- Section 9 (3) (p. 1247): “The state may not unfairly discriminate, directly or indirectly, against anyone on any grounds, e.g. Race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.”
• Section 10 (p. 1247): “Everyone has inherent dignity and everyone has the right to have their dignity respected and protected.”

• Section 11 (p. 1247): “Everyone has the right to life.”

• Section 12 (p. 1247): “Everyone has the right to freedom and security of the person, which includes the right to be free from violence from either public or private sources. In addition, everyone has the right to bodily and psychological integrity, which includes the right to security and control over their own body.”

3.5 WHO GUIDELINES

The guidelines for medico-legal care for survivors of gender-based violence from the WHO (2003:57) describe the purpose of forensic specimens as follows:

The purpose of taking forensic evidence is to prove or exclude a physical connection between two individuals and objects or places. To take such evidence comprises a wide variety of substances or objects, the analysis of which often requires specialised scientific skills. This is because a close encounter of the assailant, victim and crime scene may result in an interchange of traces of evidence (Locard’s principle). Biological traces (such as hair, blood, semen and skin fragments) may be found on both the survivor and perpetrator; for instance, the survivor’s blood could get onto the perpetrator’s clothes. Fragments from the scene (such as mud or vegetation) may link a survivor and perpetrator to a particular location, or they may each have left traces of clothing or biological traces at the scene. On the basis of the facts that are available and information provided by the survivor and the investigators, the health worker must decide which specimens to collect from the individuals involved.

The guidelines of the WHO (2003:19) describe that, in most countries, local protocols, rules or laws govern the provision of medico-legal services to survivors of gender-based violence. The guidelines describe that it might include certification of the health worker, use of official documentation, an obligation to report any allegations to the appropriate authorities, procedures for the collection and handling of specimens, and access to a range of therapeutic interventions (for example, emergency contraception).
If nurses working with gender-based violence fail to comply with local regulations, they may compromise future investigations or court hearings. This is why it is essential that nurses working with gender-based violence have a good understanding of the local protocols, rules and laws that govern the field of gender-based violence.

The WHO (2013b:39) clinical and policy guidelines in the booklet *Responding to intimate partner violence and sexual violence against women* state that care for women experiencing gender-based violence should be integrated into an existing health service as much as possible rather than as a stand-alone service. The WHO (2013b:39) gives the following minimum requirements as described in Table 3.1.

**Table 3.1: Minimum requirements for a health sector response to violence against women**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and protocols</td>
<td>Develop and implement local policies and protocols defining roles and responsibilities, and procedures related to identification and management of survivors (with appropriate training and continual support).</td>
</tr>
<tr>
<td>Management support/finance</td>
<td>Management backing, often with financial support, is important, especially for the long-term sustainability of the integration of violence against women.</td>
</tr>
<tr>
<td>Comprehensive care</td>
<td>Ensure the provision of all aspects of medico-legal care either by providers/linked providers in health services, or through the support of NGOs, community-based organisations (CBOs) or community efforts, in a way that minimises the number of contacts required.</td>
</tr>
<tr>
<td>Links with CBOs/NGOs</td>
<td>Build relationships with local NGOs and CBOs. It should be noted that it is a state responsibility to ensure the provision of services, so this should not rely exclusively on NGOs and CBOs.</td>
</tr>
<tr>
<td>Inter-sectoral collaboration</td>
<td>Establish clear working protocols, including the referral pathway of survivors, between services offered by the same facility of by different sectors, and establish regular (monthly) meetings to ensure coordination.</td>
</tr>
<tr>
<td>Resource material</td>
<td>Ensure the availability of some resource material (posters, pocket cards and/or leaflets).</td>
</tr>
<tr>
<td>Surveillance and recording</td>
<td>Develop systems for maintaining records and conducting surveillance that are confidential and do not put women in any risk.</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Implement a system for monitoring and evaluation, based on local policy and procedures, including considerations related to safety.</td>
</tr>
<tr>
<td>Support for the carers</td>
<td>Provide support to those delivering care.</td>
</tr>
</tbody>
</table>

Source: WHO (2013b:39)
3.6 CARE FOLLOWING SEXUAL ASSAULT

The researcher attended a training course in 2013 that was presented by Dr A Lekoloana. He used the training manual that was written in 2011 by Lina Ploug and Alison Hultqvist, both of whom are trainers for the Swedish National Centre for Knowledge on Men’s Violence Against Women. The guide to care following sexual assault was discussed and the following priority procedures as shown in Table 3.2 have to be borne in mind when meeting the survivor of gender-based violence (Ploug & Hultqvist, 2011:10).

Table 3.2: Priority procedures to be kept in mind when meeting the survivor of gender-based violence

<table>
<thead>
<tr>
<th>Security</th>
<th>Make sure the survivor is not left alone. Arrange a room so that the survivor does not have to sit in the waiting room.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>Remember that it is the survivor who decides if an examination is to be done, and the extent of any examination, not the police or nurses working with gender-based violence.</td>
</tr>
<tr>
<td>Privacy</td>
<td>Meet with the survivor in private, without family or friends, to the greatest extent possible.</td>
</tr>
<tr>
<td>Information</td>
<td>Describe calmly but briefly what is going to be done. Use an interpreter if necessary; do not let family or friends interpret for the survivor.</td>
</tr>
<tr>
<td>Evidence collection</td>
<td>Do not offer food, drink or washing facilities until the examiner has decided what samples need to be collected as evidence. Evidence is collected regardless of whether a police report has been made.</td>
</tr>
<tr>
<td>Allow the survivor to recount events</td>
<td>Be prepared to support with specific questions.</td>
</tr>
<tr>
<td>Child survivors</td>
<td>A paediatrician must be in charge of the procedure. This is important for the follow-up.</td>
</tr>
<tr>
<td>Children at home</td>
<td>Are there children in the survivor’s home who could come to harm? Contact the social services if you have any questions.</td>
</tr>
<tr>
<td>The survivor’s need for protection</td>
<td>Carry out a risk analysis and consider the need for hospitalisation or a shelter.</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Make sure that a follow-up appointment is made and that the survivor receives contact information for psychological support.</td>
</tr>
<tr>
<td>Forensic medical report</td>
<td>Follow the instructions in the guide for a complete medical documentation. Give the survivor written and oral information about forensic medical reports. Obtain the survivor’s consent for the examination. Obtain the survivor’s consent for a forensic medical report.</td>
</tr>
</tbody>
</table>

Source: Ploug and Hultqvist (2011:10)
3.7 INSTRUCTIONS FOR EXAMINATION AND COLLECTION OF SAMPLES

Ploug and Hultqvist (2011:1) propose that blood and urine samples may be taken before or after examination of the survivor. Specific tubes are specified to take blood and urine samples. Specific cotton wool and slides are included in the Sexual Assault Evidence Collection Kit for the collection of samples. It is very important that all samples must be labelled as they are collected and must be ticked off on the checklist included in the Sexual Assault Evidence Collection Kit. Clinical samples must be sent off for immediate laboratory analysis and samples of evidence must be stored in a dry, locked location until they are requested by the police.

3.8 CONTENTS OF THE RAPE KIT

Ajema, Mukoma, Mugeynyi, Meme, Kotut and Mulwa (2012:17-18) developed a rape kit for utilisation when survivors of gender-based violence are examined at a health facility. The contents of the rape kit are described in Table 3.3.

Table 3.3: Contents of the rape kit

<table>
<thead>
<tr>
<th>Description of item</th>
<th>Quantity per kit</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powder-free gloves</td>
<td>1</td>
<td>To avoid contamination.</td>
</tr>
<tr>
<td>Sterile gloves</td>
<td>2</td>
<td>For sterile procedures such as collecting HVS (High Vaginal Swab).</td>
</tr>
<tr>
<td>Stick swabs</td>
<td>6</td>
<td>For taking the HVS and/or anal swabs.</td>
</tr>
<tr>
<td>Masking tape</td>
<td>1</td>
<td>For sealing the brown envelopes in which the specimens have been stored.</td>
</tr>
<tr>
<td>Brown envelopes for collecting samples</td>
<td>20</td>
<td>For proper storage of collected specimens.</td>
</tr>
<tr>
<td>Tape measure</td>
<td>1</td>
<td>To measure the physical injuries, if any, that are found on the survivor.</td>
</tr>
<tr>
<td>Needles and syringes</td>
<td>3</td>
<td>For the collection of blood samples.</td>
</tr>
<tr>
<td>Urine bottles</td>
<td>1</td>
<td>For the collection of urine samples.</td>
</tr>
<tr>
<td>Vercutainer tubes</td>
<td>1</td>
<td>For the collection of blood samples.</td>
</tr>
<tr>
<td>Speculum</td>
<td>1</td>
<td>For the collection of specimens from the vaginal cavity.</td>
</tr>
<tr>
<td>Labels</td>
<td>10</td>
<td>For labelling the brown envelopes with the details of the specimens stored inside.</td>
</tr>
<tr>
<td>Pregnancy testing kit</td>
<td>1</td>
<td>To test for pregnancy.</td>
</tr>
<tr>
<td>Seal lock bags</td>
<td>20</td>
<td>For proper storage of collected specimens.</td>
</tr>
<tr>
<td>Green towels</td>
<td>2</td>
<td>One for wiping hands during the sterile procedure. One for placing beneath the patient's buttocks.</td>
</tr>
</tbody>
</table>

Source: Ajema et al. (2012:17-18)
Rape kits must be available at the crisis centre, casualty department and community clinics to examine survivors of gender-based violence.

3.9 SUMMARY

In this chapter, the legal framework, which includes the Acts, policies and guidelines that nurses have to adhere to when working with gender-based violence, was discussed. The role of the nurse in the crisis clinic, community clinics and the casualty department and the Acts, policies and guidelines that have an influence on nurses working with gender-based violence were outlined. In Chapter 4, the findings of the study are discussed.
CHAPTER 4
FINDINGS OF THE STUDY AND LITERATURE CONTROL

4.1 INTRODUCTION

Chapter 3 was a discussion about the Acts, policies and guidelines applicable to nurses working with gender-based violence. The first objective of the study, namely, to explore and describe experiences of nurses working with gender-based violence in a semi-rural area in Tshwane, is addressed in this chapter.

In this chapter, the researcher discusses in detail the findings of the study obtained from the transcriptions of the focus groups and interviews, and field notes about the experiences of nurses working with gender-based violence in a semi-rural area in Tshwane. A description is provided of the findings from the focus groups and individual interviews. Illustrative quotations from the focus groups and interview transcriptions are included in the discussions. Findings from other studies related to this study are included to place this study within the context of what others have found in exploring the phenomenon of nurses’ experiences working with gender-based violence.

4.2 OPERATIONALISATION OF THE STUDY

Ethical clearance was obtained from the Medunsa Research Ethics Committee (see Annexure A) as well as from the Tshwane Metsweding Region Research Ethics Committee (see Annexure B). The CEO of the hospital and the area manager of the community clinics in the semi-rural area gave consent for the study to be done (see Annexures C and E).

Informed consent was obtained from each participant (see Annexure F) before the focus groups and individual interviews were conducted. Before the focus groups and individual interviews were conducted, the researcher met with the unit manager of the crisis centre and the nursing service manager of the hospital. The research was explained to them and consent was obtained. A pilot study was carried out with the first focus group; however, the data that were collected were so important and formed such an integral part of the findings that the data were included in the data analysis.
This study was done in 2011 and 2012, with data collection from the crisis centre and casualty department of the public hospital, and the four surrounding community clinics of the semi-rural area in Tshwane taking place between June 2011 and May 2012. The focus groups were conducted at the student learning centre at the public hospital in the semi-rural area in Tshwane and the individual interviews were conducted in a private room at the crisis centre. Before commencement of the focus groups and individual interviews, the researcher gave the participants the information leaflet (see Annexure F) and explained the background information of the study. The researcher and the facilitator of the focus groups answered questions to clear up any misunderstandings. The ethical principles as explained in Chapter 2 were adhered to before the participants signed the informed consent forms. The focus groups and individual interviews were conducted in English, a language with which the participants were familiar. The researcher and facilitator were satisfied that all participants were able to relate their experiences in English. It did occasionally happen that participants had difficulty in expressing themselves verbally, especially when they described painful situations. To make up for the loss of words, they used non-verbal communication and described the situation.

The questions that were asked in the focus groups and individual interviews were guided by the interview schedule (see Annexure G). The facilitator and the researcher started off with an open-ended explorative question, namely: *What are your experiences as a nurse working with gender-based violence?* Various probes were used in order to explore the participants’ responses to the above question. After the initial open-ended question, emancipatory-focused questions were asked according to the five sub-categories of the Wittmann-Price Theory of Emancipated Decision-Making, namely, *empowerment, flexible environment, personal knowledge, reflection and awareness of social norms*. Wittmann-Price (2004:437) also describes these sub-concepts as attributes of emancipation.

Focus groups and interviews were conducted until saturation was confirmed in consultation with the researcher’s supervisors and two independent coders. Consensus was reached between the researcher and coders about the themes, categories and sub-categories about the experiences of nurses working with gender-based violence in a semi-rural area in Tshwane.
4.3 DESCRIPTION OF THE BIOGRAPHICAL DATA

The participants were enrolled and registered nurses (Nursing Act, 2005) and had been working with gender-based violence for at least six months. Biographical information was obtained from all the participants before conducting the study (see Annexure G).

Table 4.1: Biographical data of the participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of participants</td>
<td>18</td>
</tr>
<tr>
<td>Gender</td>
<td>Female: 18</td>
</tr>
<tr>
<td>Average age</td>
<td>42 years</td>
</tr>
<tr>
<td>Category</td>
<td>Registered nurses: 10 Enrolled nurses: 8</td>
</tr>
<tr>
<td>Shortest period working with gender-based violence</td>
<td>6 months</td>
</tr>
<tr>
<td>Longest period working with gender-based violence</td>
<td>24 years</td>
</tr>
<tr>
<td>Average period working with gender-based violence</td>
<td>5 years</td>
</tr>
</tbody>
</table>

The total number of participants that adhered to the criteria was 18, with an average age of 42 years. Of those participants, ten were registered nurses and eight were enrolled nurses. The shortest period that they had worked with gender-based violence was six months and the longest period was 24 years. The average period that the participants had worked with gender-based violence was five years.

4.4 DISCUSSION OF THE FINDINGS

The findings of the study are discussed with reference to the central theme, themes, categories and sub-categories. Each theme, category and sub-category is discussed first. After this, verbatim quotes are included to confirm and authenticate the findings and a literature control is done to position the findings within the current body of knowledge.

Central theme:

The experiences of nurses working with gender-based violence were related to their inner self and their environment. Experiences related to the self of the nurse unfolded as a need for emancipation through an empowered self in an enabling environment by requiring specialised competencies.
A need for personal empowerment and knowledge, and an awareness of their personal feelings and experiences through a process of reflection, were evidenced in the emotional distress they experienced, as well as the influence and awareness of social norms that led to personal judgement when working with gender-based violence. Experiences related to the enabling environment of the nurses unfolded as a need for information, support, resources and flexibility in the environment.

The two main themes of the study related to nurses’ experiences of working with gender-based violence related to themselves and their environment, namely:

- **Theme one:** Experiences related to the self of the nurse when working with gender-based violence.

- **Theme two:** Nurses’ needs for an enabling environment when working with gender-based violence.
The themes, categories and sub-categories are summarised in Table 4.2.

### Table 4.2: Themes, categories and sub-categories identified

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4.4.1 Theme one: Experiences related to the self of the nurse when working with gender-based violence

The data for this item were rich with nurses sharing how their experiences of working with gender-based violence related to themselves. These experiences were related to their personal empowerment experiences, and their knowledge about and awareness of their personal feelings and experiences as a result of their reflection on certain situations that they dealt with. The data described how social norms influenced their knowledge and perceptions about gender-based violence.

4.4.1.1 Competencies required for empowerment of the nurse working with gender-based violence

In this study, competencies refer to the knowledge and skills nurses require to work with gender-based violence. Nurses are often the first persons in the community to encounter abused women; therefore, they need to have proper knowledge, training and experience to identify abuse and to treat the survivor properly. Nurses must also be able to understand how the abuser treats the abused woman and must understand the consequences that the violence will have on the survivor’s life and health (AbuTaleb, Dashti, Alasfour, El-Shazly & Kamel, 2012:84; Alsafl, Alhendal, Alhawaj, El-Shazly & Kamel, 2011:174; Häggblom et al., 2005:240). Guruge (2012:1) supports this statement by stating that nurses are the largest health care workforce globally and are more likely to interact more with women experiencing violence than other health care professionals. Guruge (2012:6) found in his study that nurses working with gender-based violence need adequate knowledge and skills to respond to the unique needs of survivors of gender-based violence. Sundborg, Saleh-Stat tin, Wändell and Törnvist (2012:1) emphasise the importance for nurses to be able to identify violence against women – they must know that it is a growing and multifaceted problem. Recent studies have shown that only a small percentage of women exposed to gender-based violence are identified by nurses; therefore, nurses need both knowledge and experience to identify women subjected to abuse (Sundborg et al., 2012:2; Flinck, Paavilainen & Astedt-Kurki, 2005:383).

Adams, Kellogg, Farst, Harper, Palusci, Frasier, Levitt, Shapiro, Moles and Starling (2016:82) stipulate that nurses must be able to recognise symptoms and signs of child abuse, and must be able to respond appropriately (see section 4.4.1.1 (e)).
In relating their experiences of working with gender-based violence in this study, nurses explained what they did in the work environment using examples of specific survivors of gender-based violence they treated. These competencies included **assessment** and **examination**, **physical** and **psychological interventions**, and **knowledge of the legal ethical framework**. Nurses perceived it as necessary to work with both **survivors** and **perpetrators**. **Survivors** included **adults** as well as **children**.

**(a) Assessment and examination**

There is no typical survivor of gender-based violence, and there is no typical reaction to the experiences of gender-based violence. Therefore, psychological effects vary considerably from person to person. Nurses working with gender-based violence have to recognise psychological symptoms from survivors and have to address them. Nurses also assist the doctor with the examination of survivors of gender-based violence. One of the participants described it as follows:

*She was seven years old and I was with the doctor and that child was telling her story when she was raped.*

Nurses working with gender-based violence have to fill in various forms when they take the history of the survivor and when they help the doctor with the examination. They also have to document all the findings. They must thoroughly document the patient’s description of the abuse and the injuries that are present. It must also be documented what information was given to the survivor and what referrals were made. They take samples and evidence from the survivor of gender-based violence and take blood samples from the perpetrator who is brought in by the police. One participant described it as follows:

*And you also need to take evidence. And you must collect evidence for the investigation. It's like I started in 2004. I'm been doing these cases …*
Nurses working with gender-based violence must be aware that all documentation that was completed in connection with the examination of the survivor of gender-based violence may be requested by the judicial system as supporting evidence. These documentation records are primarily used for documentation about the diagnoses that were made and the treatment that the survivor received, but in judicial matters they constitute a basis for supporting evidence in court. Therefore, records should be concise, limited to the incident in question and only medical observations and assessments should be documented. The participants described it as follows:

*Because the court will want to, if you go to court, you are going to be asked whatever you have written down.*

*So that is why they must be proper trained and they must be professionally mature to give expert evidence in court.*

(b) Physical and psychological interventions

**Physical interventions** are mainly attended to in the casualty department. One of the participants described it as follows:

*The domestic violence maybe if they are injured and they need stitches we will do it.*

Another participant said:

*In casualty we see assault …*

Survivors who have experienced gender-based violence may suffer from a range of physical injuries, genital and non-genital. Nurses working with gender-based violence have to assess and manage these injuries.
Nurses working in casualty also have to treat and manage severe physical injuries caused by gender-based violence. One participant said the following:

For instance here, we have this one lady; she came in with burns, burns on her face and on her chest. She was accompanied by her friend and she said her boyfriend was going to kill her. And what happened he came with petrol and he set her alight and this was most painful. Because with assault it is something else.

The participant working with this woman had a great deal of empathy towards the survivor and she admitted that she even tried to put herself in the survivor’s position. As a result of this, the nurse was thinking how men could be so cruel. She voiced the following:

I was thinking of the cruelty of men, how can one set another one alight? What if it was me: You know, I thought of her as if it was me. I put myself in her position. If like, you see how my skin is like, and once you are burned the skin colour changes and for me to get your colour complexion back it will never happens. It will definitely never happen.

When survivors of gender-based violence report to the specific hospital’s casualty department, they are directed to the crisis centre, where there is more privacy and where they can get more individual attention and consultation. This means that physical injuries are not managed at the casualty department unless the physical trauma is of such an extent and nature that the survivor is first attended to at the casualty department before being sent to the crisis centre. The assistance of a doctor is also available in the casualty department to help fill in the assessment forms and to attend to the physical injuries of the survivors.

All the follow-ups after the incident happen in the crisis centre. This is supported by the following quotes from participants:

Rape cases they arrive at reception immediately they are directed to the crisis centre.
In casualty, the casualty doctors, they see the patients and then maybe suture and give medication and then if she’s got a police form they just fill it in, and that’s it. So normally we don’t do follow up, they are focusing more on the external wounds.

Sometimes when nurses take the history from survivors, they have to use special instruments to make certain diagnoses, especially injuries that cannot be seen with the naked eye. One participant gave a very vivid description of how and when to use a colposcope:

A colposcope is an instrument that you put directly on the private part and you are able to see all injuries even those that are not visible to the naked eye and it was a child that was being abused, rectal penetration of a male child, we find that he’s got this thing, we call it a tyre rim, the rim cannot go anywhere.

Ray and McEneaney (2014:47) give the following description of how to use a colposcope: “the ano-genital examination can be enhanced through the use of a colposcope and toluidine dye to elucidate small lacerations.” The above quote can be linked with the section where nurses work with child survivors of gender-based violence. One of the participants attended a 10-day course on gender-based violence and made the following comment:

You see the injuries inside, you see them the perineal, and you will see it is torn, torn, torn, and that person never had a child before, and now she is raped … So I went for training when they come, I can take the specimen for DNA test. So maybe they can match the perpetrator.

Out of this comment, it can be assumed that it is very important for the nurses working with gender-based violence to see the perpetrator arrested. The following quote supports this statement:

… and you go for training and when you come back you are on fire. You just want these people to be locked up, you know, you just want these people to be locked up.
Psychological intervention is very important when a nurse works with survivors of gender-based violence. Psychological intervention is related to the survivor’s emotions and one participant described it as follows: “You are dealing with person’s emotions and feelings.” Sometimes, it can be difficult for the nurses to comfort a child who is a survivor of gender-based violence: “… we couldn’t manage to calm the child down. The child was crying.”

Psychological interventions also have to do with the mind of the survivor and this is where nurses working with gender-based violence help comfort the survivor and where they communicate with the survivor to gain trust. One participant described how she related with the survivor of gender-based violence:

    So I’m put myself, you know, how she felt, how she trusted me as a stranger.

    First of all, I shouldn’t be judgemental because if I become judgemental she wouldn’t tell me everything.

Sometimes it can be difficult for nurses working with gender-based violence, as they have to put themselves in the shoes of the survivors to get the impact of the situation and to gain trust from the survivor. One participant described it as follows:

    You counsel them, they just accept, to be HIV positive is trauma, and now being raped, it’s trauma, OK we try to give these trauma counselling. We help you to accept and to cope with the incident. It’s difficult for them to accept, so we arrange for them, to say after two weeks, to see a psychologist. It’s a must for them.
(c) Knowledge of the legal ethical framework

Nurses are expected to perform a variety of roles in their professional capacity whenever they work with gender-based violence. There are certain roles and functions that nurses must adhere to and it is expected of them to conform to certain standards of the profession and to adhere to certain professional behaviour. The Nursing Act (2005) states that:

\[
\text{nursing is a regulated profession comprising a body of scientific knowledge and skills practiced by persons referred to in section 30 of the Act and registered in terms of section 31 of the Act. The Act, the regulations, rules and codes made in terms of the Act provide the legal and ethical framework for the practice of nursing.}
\]

The Act further states that “the practice of nursing is a dynamic process that provides and maintains the care of individuals, groups and communities that are faced with actual or potential health problems.”

Other Acts that have an influence on nurses working with gender-based violence are the following:

(a) Domestic Violence Act (No. 116 of 1998);
(b) Criminal Law (Sexual Offences and Related Matters) Amendment Act (No. 32 of 2007);
(c) Children’s Act (No. 38 of 2005);
(d) Children’s Amendment Act (No. 41 of 2007);
(e) Constitution of the Republic of South Africa (No. 108 of 1996); and
One of the participants described the legislation that they had to adhere to as follows:

_We deal with the Children’s Act and the Criminal Offence Act. We deal with domestic violence in according to the Domestic Violence Act._

_A child will be governing by the Constitutional Act, will be governing by the Children’s Act, and will be governing by the Criminal Procedures Act. We make sure that all those Acts are incorporated._

Nurses working with survivors of gender-based violence must be able to meet the legal needs of the client. Häggblom et al. (2005:240) describe the importance of the correct documentation that must be filled in by nurses working with abused women and emphasise that this is of utmost importance if the abused woman reaches the stage of involving the criminal justice system in her case.

The nurses in the medico-legal clinic also have to collect specimens for forensic investigation. For this, they have to be trained as a forensic nurse; however, only one of the nurses had done a 10-day course in gender-based violence and she had to give training to all the other nurses who had not been on the course. The participants described it as follows:

_... you give evidence like you thought you are doing justice to this person._

_And you also need to take evidence. And you must collect evidence for the investigation. It’s like I started in 2004. I'm been doing these cases._

The participants described that, as a nurse, it is important to be very careful what one says in court and that one must be an expert witness in gender-based violence to do so. They described that the lawyers are there for the perpetrators and that they will try to make the nurse angry in order to win their case. The following quotes support this:

_Especially you know lawyers are paid by the perpetrator, they are been for them, so they will make you angry, you know, just to degrade you, just to look for a small thing._
So as far as you write information that you are able to explain, information that is critical, information that you want to judge by. That is information that is necessary and stick to what you say, instead of giving big information and think you impress the court.

... because court doesn't want opinions they want facts, they want scientific evidence. You are there as an expert nurse to provide scientific evidence ...

According to the guidelines of the WHO (2003:19), the codes of medical ethics are based on the principles of doing “good” and not “doing harm”. Nurses working with gender-based violence must use their professional skills in an ethical manner and must observe the law of the community. The WHO (2003:19) explains that adherence to these codes of conduct is particularly relevant when dealing with survivors of interpersonal violence who may suffer from abuse from a person in a position of power. A guideline for medico-legal care for survivors of gender-based violence was described in Chapter 3.

Nurses working with gender-based violence also have to deal with the court. Here, they must be careful not to give too much information but to concentrate on facts. Nurses fear the court because they have to deal with lawyers who represent the perpetrator and the work of the lawyer is to make sure that the perpetrator is not found guilty. Because of this responsibility, they have to make sure that they write down the correct observations when they examine the survivor. They must also stick to their facts because the lawyers will cross-examine them.

To deal with this makes them very nervous and also very angry towards the perpetrator. Some of the comments made by participants were:

And especially if you go to court and you must give evidence. You just say what you see at the time not the reason why?

If you go to court, you are going to be asked whatever you have written down. And you know court doesn’t want things, they want facts, scientific evidence if you say you didn’t see that the man raping the child. So you separate your mind from the raping. You concentrate on the wound and tell the court, according to your expert opinion that this wound was infiltrated by this kind of thing, and also the court is very sensitive about keeping evidence.
One of the participants described how humiliating it was for her to go to court, the feeling that the lawyers just want to degrade them:

*Especially you know lawyers are paid by the perpetrator, they are been for them, so they will make you angry, you know, just to degrade you, just to look for a small thing. You didn’t say that you said this. Is it a "yes" or a "no", there are cases that you can’t say yes or no.*

*And if you are going with that attitude you are going to make the police angry, because court doesn’t want opinions they want facts, they want scientific evidence. You are there as an expert nurse to provide scientific evidence and I have learned as a person that it’s not a once-off thing.*

**(d) Working with both survivors and perpetrators**

Nurses working with gender-based violence must attend to the survivor of gender-based violence as well as the perpetrator of gender-based violence. Sometimes it happens that the survivor and the perpetrator will be at the crisis centre at the same time. Nurses experience ethical dilemmas when working with gender-based violence and it is very confusing for them, especially when the survivor and the perpetrator are telling a different story. When nurses attend to the perpetrator, they experience feelings of anger and fear. The perpetrator and the survivor are attended to in different rooms. It often happens that the same nurse attends to both the perpetrator and the survivor.

The participants described the following experiences:

*And sometimes they (the police) bring the perpetrator with and you must face him; you must take some blood from him. And sometimes you just want to take the pink needle to draw blood. Just to punish him.*

*And sometimes the victim is still there and next thing is they see each other and the victim will say what now, because he said I mustn’t say anything to anybody.*
One of the dilemmas nurses have to deal with is that sometimes they work with the survivor of gender-based violence as well as the perpetrator who raped her. The nurses working with gender-based violence have to document everything they see and hear without being biased. This dilemma was actually a problem for the nurses and they confessed that sometimes they could not help to be biased, as one of the participants described it in the following quote: “The problem is that you, if you start to zoom into this programme you are going to be biased.” These dilemmas caused feelings of confusion for the nurses and they had the dilemma that they could not say that any of the clients were wrong. The participants described the following:

And the perpetrator said I didn’t rape her, she agreed, she is just telling you a story, and then the other side we was interviewing the victim, she was crying and said no sister!

You have to accept what he (the perpetrator) says because I’m not, I can’t say you wrong. I can’t even tell the perpetrator that, you see, so just have to accept. It’s so confusing.

Nurses working with gender-based violence are often concerned about what happened to the survivor and they know it will take a long time for her to forget what had happen to her. One nurse was really concerned when she told about the rape that a survivor went through. The following quote is evidence to her concern:

… and I was thinking the pain, the pain in the private part. She will also thing about a man raped her. Ja, so it takes a long time for her to forget.

Field note: The participant was really upset and she even sounded devastated, as if she did not know how to describe the situation. All the participants ‘hmmm’ in response to acknowledge that they felt the same. This concern of the nurses working with gender-based violence can be linked with social norms where nurses are aware that certain social and cultural norms let survivors and perpetrators behave in a certain way.
(e) Working with children

Nurses working with gender-based violence are often the first contact of a child subjected to abuse or neglect and may therefore be the first to recognise the signs and symptoms of abuse. It is the nurse’s responsibility to do a comprehensive assessment and to take the appropriate steps to report and document the findings. Reporting suspected child abuse can be very stressful for the nurse, but it is important to be non-judgemental and to focus on the safety of the child as it is the number one concern (Chihak, 2009:S213).

Child sexual abuse is a complex matter and the perpetrators are often relatives or family friends; therefore, all cases of sexual abuse must be referred for investigation and the children must be referred to social workers (Abrahams & Mathews, 2008:494; Booyse, Brown, Collison, Diedericks, Ginger, Hatherill, Hendricks, Loleka, Karp, Pieters, Slabbert & Van As, 2007:150). However, this can be linked to the support services where the nurses working with gender-based violence said that they have a shortage of support services.

Nurses often have to work with children who have been subjected to gender-based violence and therefore they have to be knowledgeable about identifying, reporting and documenting suspected child abuse. They have a significant role to play in the early intervention and identification of child abuse. Nurses working with child abuse have an important role of sharing information with the inter-disciplinary team members. Nurses working with gender-based violence should be competent to act accordingly when they suspect that a child has been subjected to gender-based violence. It is very important that the survivors of gender-based violence are cared for and that the examination is carried out correctly.

Adams et al. (2016:82) stipulate that nurses must be able to recognise symptoms and signs of child abuse and must be able to respond appropriately. Essabar et al. (2015: 5-6) did a study and a report on 311 gender-based violence cases, and found that the evaluation of children requires special skills and techniques in the history taking, forensic interviewing and examination of the child that has been subjected to abuse.
Essabar et al. (2015:5-6) further state that nurses working with gender-based violence need to address specific issues related to consent and reporting of child sexual abuse, as well as that support and counselling towards the survivor and those who care for the child are very important.

Nurses working with children who have been subjected to gender-based violence have to assess and evaluate the child, and their attitude towards the child is very important. A child subjected to gender-based violence is unique in the way that the nurses can start caring for that particular child and the nurses’ experience of thinking a great deal about the child. This section can also be linked to where the nurses working with gender-based violence experience a blurring of boundaries, because it is sometimes difficult for them to differentiate between their different roles and they will experience the pain from a child as if it is their own. The following participant quotes illustrate this experience:

*Me, you know I was feeling if that child was my own. I’m still thinking about that child every day. So every day when I woke up I think of that child which is experiencing that thing.*

*When you looked at that child you will feel that pain as if it is your child.*

*You know, you feel you, you know you are a woman. This one can also be your child. How will you feel?*

*Anger, as if I can kill the mother because she is not taking care of her child.*

Some of the cases can be very traumatic for the nurses, especially if children are involved. The witnessing of a child’s injuries has an emotional impact on the nurses and they can feel it in a sudden, intense way. One participant verbalised that she could not even look at the child, especially when she witnessed the physical state of the survivor.
The following quotes describe the horror of some of the cases that the participants faced:

*Sometimes we see things that is traumatising. Like for example a child come’s in let say she is a minor, she’s seven years old and then she is sexually assaulted.*

*Because also the dress she was wearing it was full of blood, full of blood, you see, so I couldn’t even look at the child, she was busy with the doctor.*

One of the participants described how some of the cases where children are involved can be very traumatising for themselves and for the children, and she described how they will just care for the child and comfort her:

*But in such a case, I mean you just comforting the child.*

### 4.4.1.2 Nurses’ knowledge about and awareness of their personal feelings and experiences as a result of reflection

In relating their experiences about working with gender-based violence, nurses told stories about their personal experiences with violence in their relationships and communities, and related their emotional distress when working with survivors of gender-based violence. Goldblatt (2009:1651) states that nurses’ personal and professional knowledge and their values and life experiences increase nurses’ perplexity regarding survivors of abuse and the appropriate professional way that they must care for them.

The focus groups were debriefing sessions for some of the participants and after the sessions, the participants expressed that it was good for them to speak about their feelings. The focus group sessions gave the participants the opportunity to reflect on their current working situation. Sumner (2010:E20) describes reflexivity as a process of honest self-examination in relation to one’s own biases and assumptions. According to Penney and Warelow (1999:263), reflection is behaviour and can be described as “reflection in action – stepping out of one self – freeze framing the moment to understand it better.” Johns (1999:241) states that it is an action where one stops and thinks about what one is doing. Wittmann-Price (2004:441) describes it further and states that action may be taken after true reflection has been done.
The field notes reflected a relaxed atmosphere after the focus groups had ended. The participants were offered the consultation of a psychologist after the focus groups if they were in need of it; however, the participants were very surprised and said that the session in itself was a debriefing session and that it was good for them to talk. When the recordings had stopped, some of the participants told the researcher stories about their own personal experiences of gender-based violence and its effects on their own lives.

(a) Emotional distress experienced by nurses when working with gender-based violence

Nurses experience emotional distress when working with survivors of gender-based violence. The emotions that the participants experienced were sadness, trauma, fear, compassion, powerless feelings, anger and ambivalence. This was similar to the findings of a study done by Flinck et al. (2005:389), where they acknowledge that it is a difficult and demanding task for nurses to help abused women because they have to face their own attitudes, fears, helplessness and insecurity. Emotional distress can also be linked with blurred boundaries and vicarious traumatisation.

In this study, nurses who work with gender-based violence voiced a general disgust towards perpetrators and to all males. They often felt paranoid about their own safety and the safety of their children. When nurses working with gender-based violence observe physical injuries and the emotional pain caused by the violence, and when these nurses listen to the stories of the violence, they can experience emotional distress that can be similar to the survivor’s feelings (Van der Wath et al., 2013:2245).

• Sadness

Nurses are also witness to the emotional suffering of survivors and have to deal with these emotions. It affects them so much that they also become emotional and cry with the survivor. The following statements were made by the participants:

… and then the tears were inside my eyes …

It is so hurtful.
... and then they became so emotional.

Sometimes, nurses working with gender-based violence have a feeling of sadness towards the survivor, but at the same time, have a feeling of anger towards the perpetrator. One of the participants verbalised:

I can say, sad. I was feeling sad, especially, for a patient and for the next of kin, and I was feeling angry because he got away with murder, he didn't even have the decency to give the details of the next of kin, because he was afraid that he would be arrested if he comes forward.

- Trauma

The trauma that nurses witness has such an emotional impact on them that it may have an effect on their families, which is sometimes very painful and traumatising for them. They can even start to feel that they are incapable of dealing with these cases, especially after giving evidence in court.

Nurses working with gender-based violence can experience vicarious trauma. This is a cumulative effect of being in contact with and helping survivors of violence over time. This reflects in participants’ strong emotional and behavioural responses, for example, over-protectiveness, fear, anxiety, paranoia, inability to cope, anger, controlling and distrust. This is confirmed by Figley (1995:1), who states that there is a cost to caring and that professionals who listen to their clients’ stories of fear, pain and suffering may feel similar fear, pain and suffering because they care. Nurses working with gender-based violence are at high risk for developing symptoms of vicarious trauma due to their frequent and often daily exposure to survivors of sexual assault (Beck, 2011:3; Gates & Gillespie, 2008:244). The participants described their experiences as follows:

You know when you get home you are so emotional that you are not even able to think clearly.

You know it was so painful, it was so traumatising.

... that is also very traumatising to you. Imagine to yourself, if you have been hunt in court, and then also you start thinking that you are incapable or what.
• Fear

Nurses working with gender-based violence often have disrupted safety needs. They become over-protective of their children and worry about them more than the average person. Participants mentioned various situations that had happened to them where they became over-protective:

... and when you go home you will think about your child also like for example, you get home, you get home, you are off duty let’s say you knock off at one o’clock and maybe arrive home past three you start panicking where is my child even if they say she went to the shops, it is there.

... like if you, you are just driving home and you see a young girl walking home and it is past seven and it is dark. You become so scared, how can she walk alone in such a case?

... and you become over-protective.

Witnessing the survivors' suffering has an emotional impact and leads to feelings of fear and anxiousness. The participants made the following statements:

... scared ...

*It depends on what you see, it makes you very anxious.*

Nurses working with gender-based violence become hyper-vigilant and sometimes have a decreased trust in men and question everything they say. Sometimes, they fear that the same things that happened to a survivor will also happen to them. A participant described it as follows:

... and as a result you become so hyper vigilant about everything.
• Compassion

Nurses working with gender-based violence experience compassion for the survivor, especially if it is a child, and they feel the pain with the child, which has a very emotional impact on them. The following experiences were voiced by the participants:

… like the pain of what was happening to that child of what was happening to that child.

With every case you are getting emotional.

You know, I thought of her as if it was me. I put myself in her position.

… and then you find when she comes everybody will say no when she speaks, so for the nurses it is so traumatic as well. You feel with them, it is so painful.

Nurses working with gender-based violence can have strong feelings of compassion towards the survivor and can recall the situation the survivor was in over and over in their minds. Because of this, they try to relate with the survivor but they also realise that they must be there for her. One participant described the following:

I’ve never been in an abusive relationship, so I’ve experience what she told me thinking about it over and over, thinking about how cruel men can be, you know. There was a time when I felt like crying but I told myself I must be strong for her.

• Powerless feelings

Nurses working with gender-based violence can have powerless feelings, which result in a sense of helplessness that can be linked to the nature and the severity of the violence and the abuse and can also be linked to vicarious traumatisation. The participants expressed the following feelings:

What help could I give?

… it was so painful, it was so traumatising.
These powerless feelings can also be linked with the theme of working with children. The nurses working with gender-based violence felt that they did not provide enough help for these abused children. The following quotes acknowledge these feelings:

... we get very traumatic cases, but you know for children, it’s even more painful.

No one … was able to calm the child … and then you asked yourself what did I do? What help did I provide?

Nurses experience emotional distress and feelings of powerlessness because they are not allowed to make diagnoses. They can see that a survivor is depressed but, if they say so in court, they will be asked if they are a psychiatrist. Sometimes, they feel inadequate and devastated because they feel they did not provide any help. Some of the quotes that describe the experiences of nurses working with gender-based violence follow:

You've seen depressed people but as nurses you are not allowed to diagnose it. You know even this incident made this child or the mother to be so depressed. And once you done that they will ask, are you, are you a psychiatrist?

So in the end of the day that child will come in and will go out and you asked yourself, you asked yourself what should I do to the child. What help could I give?

Yes, you know you feel so inadequate, you are a professional, the child has come in, and then you asked yourself what did I do, what help did I provide?

- **Anger and ambivalence**

Nurses working with gender-based violence experience anger and ambivalence towards certain survivors. Some of the nurses feel that the survivors are protecting the abusers and put themselves at risk through that. These feelings can cause the nurse to have a reduced sense of empathy and understanding towards survivors.
Nurses working with gender-based violence experience that the anger and ambivalence that they feel towards certain survivors are triggered by survivors’ perceived choice of **re-exposing** themselves to the abuse. The nurses working with gender-based violence described their experience as follows:

... after three months she comes again and being beaten by the same man.

I don’t get it, you can’t stay with someone who repeatedly abusing you.

The anger and ambivalence from the nurses working with gender-based violence towards the survivors are also triggered by the survivors’ perceived choice to **protect** the perpetrator. The disappointment of the nurses was voiced by one participant:

They are protecting the abuser.

Nurses working with gender-based violence experienced that the anger and ambivalence that they felt were triggered by the survivors’ perceived choice of **putting themselves at risk** of the violence and abuse. The following statements were voiced by the participants to describe their experiences:

... they chose to put themselves at risk, but I won’t tell that to the patient ... but on the other hand I see maybe she is not working...

... they will say I was at the shebeen, I was alone at three o’clock ... How can you, you go out at three?

I don’t say they must be raped, but even me, when I go out after seven, I feel that hour they won’t be safe.

... most of them is self-impose because a 19-year-old or a 15-year-old just going to a tavern around one and comes back around two to three a.m., being alone, being drunk.

A study by Kim and Motsei (2002:1246) found that nurses believe that women who are raped tend to put themselves at risk.
(b) Blurred boundaries led to personal life and workplace spill-over and difficulty in role differentiation

Nurses working with gender-based violence need to separate their professional and private lives from each other; however, this is very difficult due to the intense nature of their work environment and their work-related experiences as this has a ‘spill over’ into their private life. These influences shape and affect their private life and their personal choices. In some instances, this is transferred to and evident in other family members.

- Need to separate professional and private lives from each other

Recent studies have shown that it is impossible for nurses to separate their professional and personal lives from each other (Goldblatt, 2009:1646). The following quotes are evidence of the spill-over into the nurses’ private lives:

... all these things that these people are experiencing ... they affect you in such a way that they form part of you.

They ask you, ‘mommy, is there anything you can talk about without relating to domestic violence or rape?’ ... and you start to realise you are out of it.

I knock off and go home, and when I arrived at home, there’s my children, there’s my husband and then I’m still thinking about the work instead on focusing on them.

- Struggle to separate work and home from each other

According to McCann and Pearlman (1990:132), therapists that work with survivors may find that their cognitive schemas and their imagery system of memory may be altered or disrupted by long-term exposure to the traumatic experiences of survivors. This can also be applied to nurses’ experiences of working with survivors of gender-based violence. The nurses cannot forget survivors that they worked with and sometimes they will see somebody do something, like a teenager who is asking for a lift, and they will remember a similar situation where somebody was raped after hiking. These situations influence them in a certain way and they will be hyper-vigilant when they get home and see their own children.
Sometimes they cannot separate their working environment and their home environment and they will get very emotional when they get home. Goldblatt (2009:1648-1649) states that nurses experience an ongoing struggle to separate work and home from each other and that they struggle with its impact on their lives as women, wives and mothers. One of the participants described the situation as follows:

… when you get home you are so emotional that you are not even able to think clearly.

“You know, you feel you, you know you are a woman. This one can also be your child. How will you feel?

The personal ‘intimate relationship’ experiences of nurses working with gender-based violence may influence and affect their interaction with and attitudes towards certain survivors of gender-based violence; this can either increase or decrease a sense of empathy and understanding towards them. This can be linked with nurses’ personal experiences and their emotional distress when working with gender-based violence. Some of the participants voiced the following:

I think of myself like I was loving my husband, then even the mistake he was doing, I didn’t see it … so we women love too much and then try to always protect our partners.

… so my view is all men are looking for submissive, like women they can walk over.

• **Difficulty and inability to separate multiple roles in private and professional lives**

Sometimes, nurses working with gender-based violence have difficulty and an inability to separate their multiple roles in their private and professional lives. This especially comes forward when aspects of the survivor’s life mirror or resemble their personal life, for example, if they live in the same area.
Some of the remarks that were made by the participants as they experienced similar situations follow:

... anything like this can happen to you.

... that can happen to me and my daughters, because we are also three in the house.

And you will feel, if it was me because it can happen to anybody, anytime ... You put yourself in that situation.

4.4.1.3 The influence of social norms on nurses practice and perceptions about working with gender-based violence

Nurses working with gender-based violence need to be aware of social norms and must be aware that there are certain cultural norms that let survivors and perpetrators behave in a certain way, but there is a feeling that some clients re-expose themselves to the abuse. One of the participants described it as follows:

But sometimes it’s culture, you find that there is a culture that a woman should not say no to the husband, she must say be submissive to the husband always ...

The WHO (2009:4) describes in its report that “cultural and social norms are rules or expectations of behaviour within a specific cultural or social group.” A study by Petersen, Bhana and McKay (2005:1238) showed that sexual violence was used as a strategy by boys/men to put girls/women in their place if they become too assertive and independent.

The WHO (2012:4) states that researchers have increasingly recognised the importance of community and societal risk factors, such as traditional gender norms, unequal social, legal and economic status of women and the use of violence to resolve conflict in communities.
According to the WHO (2012:5), social norms and beliefs such as the following support violence against women:

- **A man has a right to assert power over a woman and is considered socially superior;**
- **A man has a right to physically discipline a woman for ‘incorrect’ behaviour;**
- **Physical violence is an acceptable way to resolve conflict in a relationship;**
- **Sexual intercourse is a man’s right in marriage;**
- **A woman should tolerate violence in order to keep her family together;**
- **There are times when a woman deserves to be beaten;**
- **Sexual activity – including rape – is a maker of masculinity; and**
- **Girls are responsible for controlling a man’s sexual urges.**

In this study, nurses explained their personal judgements when working with gender-based violence.

(a) **Personal judgement by nurses when working with gender-based violence**

There are times when nurses working with gender-based violence must be careful not to be judgemental towards survivors.

- **Careful not to be judgemental and difficulty in showing empathy towards teenagers**

Nurses working with gender-based violence must especially be careful not to be judgemental towards survivors when they work with teenagers who go out at night and are raped. The participants described that it is sometimes difficult for them to have empathy towards teenagers who have been abused, mainly because they felt that sometimes it is self-imposed and also because of the lies that they tell. They described it as follows:
… they will say I was at the shebeen, I was alone at three o’clock … How can you, you go out at three?

… most of them is self-impose because a 19-year-old or a 15-year-old just going to a tavern around one and comes back around two or three a.m., being alone, being drunk?

They are full of lies, full of stories. So that one I don’t, I don’t feel pity for them.

(b) Anger towards perpetrator

Nurses have been taught and trained to be compassionate and non-judgemental. This is applicable when they work with survivors of gender-based violence. Even if it is difficult for them, nurses working with gender-based violence must also apply this to the perpetrator. However, little is known about how nurses working with gender-based violence feel towards the perpetrator. In this study, feelings of anger were identified. In a study that was done by Fitzke (2009:12-13), the overall results of the study showed that the majority of nurses practise non-judgemental care, regardless of whether the client is a known perpetrator.

Sometimes, nurses need to deal with a survivor who is brought in by the perpetrator. Usually, this happens when there is inter-partner violence. The nurses explained how they have to be careful not to be judgemental when this happens, especially if it is the second or third time that the same survivor and perpetrator come to the crisis centre.

4.4.2 Theme two: Nurses’ needs for an enabling environment when working with gender-based violence

An enabling environment is necessary for nurses working with gender-based violence. Participants expressed the need for an environment that would provide them with the necessary information, support, resources and learning opportunities to help them to work with survivors and perpetrators of gender-based violence.
According to the rights of nurses as described by the SANC, under provisions of the Nursing Act of 2005 (SANC, n.d.), to enable the nurse working with gender-based violence to provide safe and adequate nursing, she has the right to a:

*safe working environment which is compatible with efficient patient care and which is equipped with at least the minimum physical, material and personnel requirements, proper orientation and goal-directed in-service education in respect of the modes and methods of treatment and relevant to her working situation and negotiation with the employer for such continuing professional education as may be directly or indirectly related to her responsibilities.*

The rights of nurses (SANC, n.d.) further include that there must be “a working environment which is free of threats, intimidation and/or interference” and that there must be "a medical support or referral system to handle emergency situations responsibly." The rights of nurses were described in Chapter 3.

### 4.4.2.1 A need for enhanced access to information in the environment

Nurses working with gender-based violence have to identify and acknowledge abuse towards women and children to help end the cycle of violence. This is confirmed by the Utah Department of Health guidelines (2008:7) which state that identifying and acknowledging the abuse may help to break the cycle of violence and increase the health and welfare of survivors.

#### (a) Identification

After identifying abuse, the nurse working with gender-based violence must be able to give counselling to survivors. To be able to give counselling, nurses need certain knowledge and skills. Identification of gender-based violence mainly happens in the casualty department and in the community clinics where a survivor will come for treatment of wounds. After the initial emergency treatment of wounds, survivors of gender-based violence are referred to the crisis centre for counselling and follow-ups. The participants explained it as follows:
... because since casualty is a trauma unit, we see most of it.

... at the clinic they do come, because the clinic is nearby ... like hospital is far from people ... so at clinic, clinic is next to them, they can walk to the clinic.

Nurses working in casualty and in the community clinics must have the knowledge to identify cases of gender-based violence when they attend to a client. Here, they also have the opportunity to intervene if they suspect gender-based violence. Casualty and community nurses can play a fundamental role in identifying gender-based violence. During this period following abuse, survivors are the most receptive to interventions. This statement is confirmed by Van der Wath et al. (2013:2242). One of the participants described it as follows:

So in casualty we see assault, we see specific cases, not all the cases.

Nurses also have to identify cases where they think the survivor is protecting the abuser, which can also be linked with nurses working with gender-based violence feeling that some of the abuse towards survivors is self-imposed. The nurses will identify that the survivor went through abuse when they take the history. One of the participants described it as follows:

So I think they just come there for medical help and they leave it there. They are protecting the abuser.

Usually when we take history and we asked, ask why do you still want to live with this person that beat her up like this and most of the time they will just say “no he was drunk” and they cover up ... after three months she comes again and being beaten by the same man ...

For nurses working with gender-based violence to be able to identify cases of abuse, they need proper training. Some of the participants described it as follows:

... you need proper training ...

... we don’t have the knowledge for specifics in the department ...

... we need to be trained of how to handle the situation.
The situation that the participant spoke about above is when they think somebody is abused and do not know how to describe and explain it to another person, for example the doctor. Häggblom et al. (2005:240) did a study that showed that only a fifth of the nurses who were part of the study had training related to working with abused women. Häggblom et al. (2005:240) found that nurses without this training did not know how to respond to abused women and therefore remained passive. Häggblom et al. (2005:240) further emphasise that their study showed an urgent need for training for nurses working with gender-based violence.

Nurses are in a unique position to identify gender-based violence, mainly because of the trust the survivors have in them. According to the WHO (2013b:1), “health professionals can provide assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care; or gathering forensic evidence, particularly in cases of sexual violence.”

Nurses working with gender-based violence need to take samples and evidence from survivors of gender-based violence as well as blood samples from perpetrators brought in by the police. A participant described it as follows:

\[ And \ you \ also \ need \ to \ take \ evidence. \ And \ you \ must \ collect \ evidence \ for \ the \ investigation. \ It's \ like \ I \ started \ in \ 2004. \ I'm \ been \ doing \ these \ cases \ ... \] 

(b) Documentation

Nurses working with gender-based violence must be aware that all documentation that is filled in during the examination of the survivor of gender-based violence may be requested by the judicial system as supporting evidence. These documentation records are primarily used for documentation about the diagnoses that were made and the treatment that the survivor received, but in judicial matters they constitute a basis for supporting evidence in court.
Therefore, records should be concise, limited to the incident in question and only medical observations and assessments should be documented (see Chapter 3 for how documentation must be filled in). The participants described it as follows:

Because the court will want to, if you go to court, you are going to be asked whatever you have written down.

So that is why they must be proper trained …

4.4.2.2 A need for support and resources in the environment

The participants in this study expressed a need for support from inter-disciplinary team members and from management to be empowered to work with survivors of gender-based violence. They also need the required resources to do referrals once they identify a woman or child who has been subjected to gender-based violence. At the community clinics, the nurses working with gender-based violence explained that they mainly refer to the crisis centre. Crisis centre staff receive referrals from the community clinics or the police, or survivors who walk in from where the nurse referred them to the social worker and the psychologist.

(a) Support

- Inter-disciplinary support

According to Daiski (2004:45), increased emphasis on inter-disciplinary teamwork will be very positive and the understanding of one another’s different roles will make it comfortable to work together and will improve patient care.
Nurses working with gender-based violence described a need for interdisciplinary support from police and lawyers when working with survivors and perpetrators. They need guidance from the police and lawyers on how to deal with gender-based violence. Nurses working with gender-based violence also have to deal with the court. Here, they must be careful not to give too much information but to concentrate on facts. Nurses fear the court because they have to deal with lawyers who represent the perpetrator and whose job is to make sure that the perpetrator is not found guilty. Because of this responsibility, they have to make sure that they write down the correct observations when they examine the survivor. They must also stick to their facts because the lawyers will cross-examine them.

Dealing with this makes them very nervous and also angry towards the perpetrator. Some of the comments made by participants were as follows:

And especially if you go to court and you must give evidence. You just say what you see at the time not the reason why?

If you go to court, you are going to be asked whatever you have written down. And you know court doesn’t want things, they want facts, scientific evidence if you say you didn’t see that the man raping the child. So you separate your mind from the raping. You concentrate on the wound and tell the court, according to your expert opinion that this wound was infiltrated by this kind of thing, and also the court is very sensitive about keeping evidence.

Nurses working with gender-based violence need training to be able to handle certain situations in court. They also need support from management and from their colleagues. One of the participants described how humiliating it was for her to go to court, the feeling that the lawyers just want to degrade them:

Especially you know lawyers are paid by the perpetrator, they are been for them, so they will make you angry, you know, just to degrade you, just to look for a small thing. You didn’t say that you said this. Is it a “yes” or a “no”, there are cases that you can’t say yes or no.
And if you are going with that attitude you are going to make the police angry, because court doesn’t want opinions they want facts, they want scientific evidence. You are there as an expert nurse to provide scientific evidence and I have learned as a person that it’s not a once off thing.

Nurses working with gender-based violence expressed a need for debriefing sessions with a psychologist after dealing with difficult cases. The participants felt that, if they received more support from psychologists and social workers, they would be able to cope better with difficult cases. The participants described it as follows:

Myself, I would like it, maybe to tell them again we should be taken for one on one session as woman, psychologist, because we are in the situation where we should try to talk to others that we should not take things personal, we should be more professional about those things.

Like maybe I’m working in casualty. I’m seeing more of these cases, I think we must organise. Maybe you see someone, maybe one-on-one, like the psychologist, counsellors or social worker. She asked us questions about this, How do you feel about this and then she helps us maybe. I would then be able to cope better.

- Managerial support

Nurses working with gender-based violence were of the opinion that the management of the hospital do not understand their needs and they stated that they really need support from decision-makers of the hospital. The following statements were made by participants:

And as a result they don’t stay, because of the volume of the work. And I don’t know, maybe it is the decision-makers that are not aware of needs, or sensitive to the needs of the community, because they sit in meetings and meetings and meetings. That you know we have a very scarce health source as for as social workers is concerns. You can imagine if we’ve got such a case and we’ve got many more in the hospital.

The hospital managers and stuff. They don’t care sometimes about nurses.
Nurses working with gender-based violence expressed the need for community resources and support. Some of the participants expressed the following needs:

You know that is a very difficult question to answer. You know we have a forensic forum. This is a forum that we’ve formed when we were taken over by the Gauteng Department and our forensic forum is a forum where everybody is involved like the police station, local authority and magistrate offices. But for now we see patients from the North West, North West is not far from us. But we cannot involve police stations that are not from us.

We need those services like halfway house because even if they go, if they come back where do they go?

… some I don’t know, they are just not aware that this is abuse. So I will make them more aware.

- **A need for enhanced learning opportunities**

Studies have shown that nurses working in primary health care are ill prepared to work with survivors of gender-based violence. Special attention should be paid to improving preparedness for these nurses and they need proper training (Flinck et al., 2005:389; Sundborg et al., 2012:1-2). Nurses expressed a need to be more knowledgeable about managing all aspects of gender-based violence and expressed a need for more education. This need is supported by the following statements:

… we don’t have the knowledge for specifics in the department.

We need to be trained on how to handle the situation …

… our clinics don’t have such education that you should …

… you must be trained and you must work under direct supervision under a trained person. You must be continually evaluated by your peers. And that is what is happening in medico-legal, you work here and you go for training, and then you work with a person that is in the field for a long time. And you go with that person to court before you yourself do it and see for yourself, and this is how you started to mature.
A study done by Häggblom et al. (2005:235) to assess nurses’ knowledge, training and practices regarding care of abused women found that strategies and related training should be implemented to help nurses deal with survivors of gender-based violence. As early as 1996, Orloff (1996:479) mentioned that nurses need training on gender-based violence so that they can effectively help survivors. In a study that was done by Vieira et al. in Brazil (2009:3-6), 9.5% of the participants were categorised as having very low general knowledge about gender-based violence, 34.8% had low knowledge, 34.45% had good knowledge and only 21.3% had high knowledge. As a result of the recent recognition of the status of gender-based violence, the authors felt that there was an urgent need to train health care professionals.

A study was done in India (Majumdar, 2004:354-364) among medical and nursing students to explore the knowledge and attitudes towards violence against women among fourth (final) year baccalaureate nursing students and fifth (final) year medical students from two educational institutions in India.

The findings were that only 38% of the participants believed that they had acquired classroom knowledge on women abuse through their respective educational programmes, whereas 43% thought they had practical skills to care for victims. The conclusion of the study was that health care students in India did not receive sufficient training, practical skills and classroom knowledge to effectively manage abuse against women.

Kim and Motsei (2002:1244) suggest training of nurses as a critical opportunity to address gender-based violence in the health sector. Christofides and Silo (2005:10) support this and state that training of nurses will improve quality of care. However, Christofides and Silo (2005:10) state that no protocols for screening of domestic violence exist in South Africa and that nurses need to recognise the signs and symptoms of domestic violence to be able to provide effective care and to refer to the appropriate provider where necessary.
Nurses must be knowledgeable about their responsibilities to be able to recognise, report and document suspected child abuse (Chihak, 2009:S211). Chihak (2009:S212) argues that education is essential for nurses working with gender-based violence to recognise signs and symptoms of child abuse and neglect. Chihak (2009:S212) further states that nurses must understand the laws of the state where they are employed, because legal requirements vary from state to state.

One of the participants attended a 10-day course on gender-based violence and she made the following comment:

> You see the injuries inside, you see them the perineal, and you will see it is torn, torn, torn, and that person never had a child before, and now she is raped … So I went for training when they come, I can take the specimen for DNA test. So maybe they can match the perpetrator.

Out of this comment, it can be assumed that it is very important for nurses working with gender-based violence to see the perpetrator arrested.

Nurses working with gender-based violence must be taught and trained how to manage survivors of gender-based violence. This includes the survivor of gender-based violence as well as the perpetrator of gender-based violence.

Survivors of gender-based violence have a right to be treated in a private place and with confidentiality. One of the participants described the crisis centre as follows:

> … the hospital management decided to start a unit where patients can be treated confidential and in a better private area.

Nurses working with gender-based violence need to be taught how to deal with ethical dilemmas that they will encounter. They need more guidelines and information on how to deal with these situations.
(b) Resources

- Referral system

Nurses working with gender-based violence not only do referrals, for example referring to the psychologist or social worker, but also get referrals from various sources. Nurses working with gender-based violence expressed the need to have a referral network to which they can refer survivors of gender-based violence. They specifically need more social workers in the field. They mentioned that there are not enough psychologists and social workers. The following quotes describe their feelings:

What we are sitting with is scarce resources, especially psychologist and social workers. You know the ones we have, you know we have scarce staff and haven’t got a social worker.

If there is adoption, they must go to court, to the magistrate. Other children, they must place to homes, they must also see patients, they must attend the meetings, and they are only one in the community. You know what we, I don’t know if it is a compromise position. But you still sit with 21 satellite clinics from North West. And eight of our own in Gauteng. So you can imagine the scope for the social worker. If they want to provide quality work, it is very difficult.

The nurses working with gender-based violence in the community clinics identified that they need external resources and a referral network to refer survivors. The nurses expressed the following:

The problem is we don’t have a social worker and we don’t have the knowledge for specifics in the department to refer the patients to the clinic.

According to Çavuş and Demir (2010:65), Kanter’s theory states “that power can be gained through the opportunities of access to the information and sources, and of support and learning and development.” Keane and Chapman (2008:6) found in their study that nurses had a lack of knowledge around the topic of child abuse when assessing paediatric patients. Kos and Shwayder (2006:311) acknowledge the fact that it can be extremely difficult to detect cases of child abuse.
Participants said the following on the subject of getting referrals:

*We get referrals from the community, from the police.*

*They also came as walk-ins.*

However, at the community clinics, there are problems with referrals, mainly because of the fact that they do not have the support system on board and they have to refer to the crisis centre. One of the participants described the following:

*We also don’t have a social worker that we can refer the child to, the social worker, we don’t have them.*

Out of this comment, the desperation about the lack of a support system can be heard. This can also be linked to where nurses work with abused children that have to be referred to a social worker.

The nurses described that sometimes they were alone in the crisis centre and had to deal with the survivors of gender-based violence even if they were alone. The nurses also sounded devastated that they had to deal with these cases on their own and that they had to make the decisions. As one participant explained:

*S sometimes other sisters will be off duty, then I’m alone, and then this rape comes and she is so traumatised, and it’s only me and after taken the history I’m just alone.*

After further questioning, the participant explained that this was not an ideal situation, because after she dealt with the survivor there was nobody that she could talk to and nowhere to go for debriefings, especially if it was a very bad case. One of the participants expressed her feelings for support as follows:

*I think maybe the psychologist. Maybe to talk to somebody …*

*… there is no one I can talk to after I saw the client.*
4.4.2.3 A need for flexibility in the environment

The environment should be a flexible, non-judgemental environment that supports freedom of choice. It must also be responsive to change that leads to personal benefits for individuals and therefore increases choices and enhances self-esteem and understanding (Wittman-Price, 2004:442). This flexible environment can be internal and external and must be intertwined with sources of power, obvious and obscure so that it can be used for positive outcomes, or negative oppressive outcomes depending on the intent (Wittman-Price and Bhattacharya, 2008:226).

One of the participants described the department and how isolated they are:

\[\text{I was thinking as she was talking, you know that the department we work in is isolated.}\]

\[\text{Like the Department of Health, they work in the community and the hospital. There was always been a traditional hospital and community and I don’t know, I think the bridge should be between services.}\]

4.5 SUMMARY

This chapter presented the findings of the study based on an exploration, and descriptions of the experiences of nurses working with gender-based violence were discussed. A literature control was applied throughout and has emphasised the trustworthiness of the findings.
CHAPTER 5
CONSTRUCTION OF CONCEPTUAL MEANING

5.1 INTRODUCTION

In Chapter 4, the findings and the literature control were discussed. Themes were identified and categorised. This chapter focuses on identifying the central statement, defining the main concepts and discussing the model.

5.2 SELECTION OF THE CENTRAL STATEMENT AND CENTRAL CONCEPTS

The central statement and concepts were derived from the findings and literature control of the study. The central theme of the findings was as follows:

The experiences of nurses working with gender-based violence were related to their inner self and their environment. Experiences related to the self of the nurse unfolded as a need for empowerment evidenced by requiring specialised competencies. A need for knowledge about and awareness of their personal feelings and experiences through a process of reflection was evidenced in the emotional distress and blurred boundaries they experienced. Social norms led to personal judgement when working with gender-based violence. Experiences related to the environment of the nurse unfolded as a need for information, support and resources.

From the findings, theoretical framework and literature control of the study, the central statement of the study emerged as:

*Emancipation through an empowered self of the nurse in an enabling environment.*

The main concepts have been highlighted in the statement as *emancipation, empowered self* and *enabling environment*.

The central statement and main concepts should be viewed against nurses’ experience of working with gender-based violence in the specific context of the semi-rural area where the study was conducted as described in Chapters 1, 2 and 4.

The central statement and concepts were identified and highlighted. Each of these are defined in the next section with reference to dictionary definitions and subject definitions (Chinn & Kramer, 2011:188-190; Walker & Avant, 2011:157).
5.3 CONCEPT DEFINITION

The central statement and concepts are defined with reference to dictionary definitions and subject definitions (Chinn & Kramer, 2011:188-190; Walker & Avant, 2011:157). The following bolded concepts are defined: emancipation through an empowered self of the nurse in an enabling environment. Thereafter, the attributes are identified and operational definitions are formulated.

5.3.1 Defining the concept ‘emancipation’

The concept ‘emancipation’ is defined with reference to the dictionary definition and subject definition.

5.3.1.1 Dictionary definition of the concept ‘emancipation’

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:299) defines ‘emancipation’ as “set free from restrictions” or “free from slavery.”

Merriam-Webster (2016b, s.v. ‘emancipate’) defines ‘emancipate’ as follows:

To free (someone) from someone else’s control or power. (Transitive verb) 1: To free from restraint, control, or the power of another; especially: to free from bondage. 2: To release from paternal care and responsibility and make sui juris. 3: To free from any controlling influence (as traditional morals or beliefs).

Merriam-Webster (2016b, s.v. ‘emancipation’) defines ‘emancipation’ as “to free someone from someone else’s control or power.”

5.3.1.2 Subject definition of the concept ‘emancipation’

Wittmann-Price (2004:438) states that nurse experts must recognise the need for a better understanding of emancipation, explaining that oppression is a negative phenomenon within the nursing profession. In order to clarify this, Wittmann-Price (2004:438) defines emancipation “as a process that promotes humanistic patient care and professional growth in the clinical realm of decision-making for women about health care issues.”
In a study conducted by Wittmann-Price in 2006, she took emancipation a step further, stating that emancipated decision-making is a theoretical concept and explaining that, by acknowledging the effect of oppression, a more positive state of being and a state of freedom in choice will be reached (Wittmann-Price, 2006:476).

Scarry (1999:424) stated as early as 1999 that oppressed nurses deliver oppressed care to their clients. To confirm this statement, research has been done and has shown that nurses are traditionally an oppressed group, as described by Paulo Freire (1972:60-73) and feminist theories (Seidman, 2008:201-221), and that they needed to be emancipated. Wittmann-Price (2004:438-440) states that, if the existence of oppression is recognised, it will help to create an emancipatory health care environment.

Mooney and Nolan (2006:241) describe ‘oppression’ as an imbalance of power and state that traditional approaches to nurse education may not have equipped nurses with the skills to function autonomously. Mooney and Nolan (2006:241) further state that nurses will only be autonomous when their decisions are based on clearly articulated nursing knowledge rather than on unquestioned ritualistic traditional practices. According to Mooney and Nolan (2006:242), nurses need to question and understand, and they must come to terms with their positions in order to be free to think on their own behalf as well as on behalf of their patients or clients. Sumner (2010:E22-E23) describes that nurses join the profession because they need to help others, but they are denying this need because of the fact that they are oppressed; therefore, in her study, she found that nurses have a need to be emancipated.

Wittmann-Price describes five sub-concepts of ‘emancipation’, namely, personal knowledge, empowerment, flexible environment, reflection and awareness of social norms (Wittmann-Price, 2006:377). The concepts, as antecedents of emancipation, have been included in the discussion of empowered self and enabling environment (refer to the dictionary and subject definitions of these concepts in sections 5.3.2 and 5.3.3).
Table 5.1: Essential and related criteria of the concept ‘emancipation’

<table>
<thead>
<tr>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
</table>
| Characteristics            | • Free from controlling influence  
|                            |  • Free from control or power  
|                            |  • Freedom of choice  
|                            |  • Recognised  |
| Antecedents                | • Awareness of oppression  
|                            |  • Knowledgeable doer  
|                            |  • Reflective practitioner  |
| Consequence of being emancipated | • Knowledge  
|                            |  • Understanding of the wider context of gender-based violence  
|                            |  • Being able to make emancipated decisions  
|                            |  • Being satisfied with decisions  |

5.3.1.3 Operational definition of ‘emancipation’

Emancipation of nurses working with gender-based violence leads to freedom from oppression. Emancipated nurses have freedom of choice, and are ‘knowledgeable doers’ and reflective practitioners who can take responsibility and understand the wider context of gender-based violence. They make emancipated decisions with which they are satisfied.

5.3.2 Defining the concept ‘empowered self’

‘Empowered self’ is defined based on dictionary and subject definitions.

5.3.2.1 Dictionary definition of the concept ‘empowered self’

According to the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:839), the ‘self’ is “a person’s essential being that distinguishes them from other people” or “a person’s particular nature or personality.” Dictionary.com (2016, s.v. ‘self’) defines ‘self’ as:

1. A person or thing referred to with respect to complete individuality: one’s own self. 2. A person’s nature, character, etc.: his better self. 3. Personal interest. 4. Philosophy. a. The ego; that which knows, remembers, desires, suffers, etc., as contrasted with that known, remembered, etc. b. The unifying principle, as a soul, underlying all subjective experience.
The Free Dictionary (Farlex, 2015, s.v. ‘self’) defines ‘self’ as follows:

1. *The total, essential, or particular being of a person; the individual.* 2. *The essential qualities distinguishing one person from another; individuality.* 3. *One’s consciousness of one’s own being or identity.* 4. *One’s own interests, welfare, or advantage: thinking of self alone.*

The Merriam-Webster dictionary (2016b, s.v. ‘self’) defines ‘self’ as:

*the person that someone normally or truly is, a particular part of your personality or character that is shown in a particular situation. The personality or a character that makes a person different from other people, the combination of emotions, thoughts, feelings, etc., that make a person different from others.*

The Oxford English Mini Dictionary (Liebeck & Pollard, 1997:470-471) describes the word ‘self’ as “an individual, a person’s special nature, person or thing as the object of reflexive action, one’s own advantage or interests”. It is also described as a combination form of or done by oneself or itself. The Concise Oxford Dictionary (Sykes,1976:1030) describes ‘self’ as a “person’s or thing’s own individuality or essence, a person or thing as an object of introspection or reflexive action.” It is also described by “expressing direct reflexive action”, on oneself or itself.

### 5.3.2.2 Subject definition of the concept ‘empowered self’

The empowered self is defined using the four internal or self-related concepts of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377), namely, empowerment, personal knowledge, reflection and awareness of social norms. In addition, concepts of psychological empowerment are included, as Rawat (2014:43-44) distinguishes between two types of empowerment, namely, eve empowerment, which is contextual in nature, and psychological empowerment, which is a motivational construct.

(a) Empowerment

The concept ‘empowerment’ is now defined based on dictionary and subject definitions.
The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:302) defines ‘empower’ as “give authority or power to and give strength and confidence to.” Merriam-Webster (2016b, s.v. ‘empower’) defines ‘empower’ as “to give power to (someone) and to give official authority or legal power to (someone).”

The Business Dictionary (WebFinance, 2016, s.v. ‘empowerment’) describes ‘empowerment’ as “a management practice of sharing information, rewards, and power with employees so that they can take initiative and make decisions to solve problems and improve service and performance.” The Business Dictionary (WebFinance, 2016, s.v. ‘empowerment’) also states that “empowerment is based on the idea that giving employees skills, resources, authority, opportunity, motivation, as well holding them responsible and accountable for outcomes of their actions, will contribute to their competence and satisfaction.”

Wittmann-Price (2004:441) describes empowerment as a positive process that promotes autonomy and independence. Wittmann-Price (2004:442) also describes empowerment as part of the emancipation process, but states that will ensure freedom of choice on its own. According to Chandler (1992:66), “empowerment has been defined as enabling individuals to feel effective so that they can successfully execute their jobs.” Chandler (1992:66) describes that there is an assumption by nurse managers that empowerment is achieved by delegating power to nurses. Kuokkanen and Leino-Kilpi (2000:237) make a unique statement and state that, “where there is power, there is also knowledge and power begets knowledge.”

Therefore, empowerment and knowledge are closely linked. Wittmann-Price (2006:379) states that knowledge is needed to make informed decisions. According to Kuokkanen and Leino-Kilpi (2000:237), empowerment can also be interpreted as professional knowledge when there is interaction and a relationship between a nurse and a client.

Schalk, Bijl, Halfens, Hollands and Cummings (2010:1) suggest that nurses should be empowered at all levels and state that empowerment is a process where leaders share power with others and therefore enable them to act. Ibrahim, Abo El-Magd and Sayed (2014:59) confirm this statement.
Alsafy et al. (2011:174) and AbuTaleb et al. (2012:84) state that nurses are frequently the first to encounter a battered woman and must therefore be equipped with the necessary knowledge, training and experience to identify that the woman has been abused and to manage the survivor effectively.

Avram and Priescu (2012:949) did a study with the aim to emphasise the impact of empowerment dimensions on workplace satisfaction, commitment, justice and workplace exhaustion. They agree with the definition of empowerment by Spreitzer (1996:484-485) and state that, through the process of empowerment, individuals will acquire special skills and knowledge as well as autonomy, which will give them the power to have influence over their own work (Avram & Priescu, 2012:949).

Alkahtani, Sulaiman, Shariff and Abu-Jarad (2011:1270-1273) explain that empowered employees will feel satisfied and motivated because they feel that the organisation trusts them; the employees will also feel efficient and energised to produce outcomes such as commitment, involvement, work productivity and performance at an individual and team level. Alkahtani et al. (2011:1271) discuss the concept empowerment and state that it centres on interventions that will strengthen employees’ self-efficacy and confidence when they accomplish task objectives. According to Alkahtani et al. (2011:1272), there is also a strong relationship between an empowered employee and job satisfaction: the more empowered employees feel, the happier they are and the more committed they are to the organisation. Özbebek and Kiliçarslan Toplu (2011:70) describe empowerment as an action that is taken by organisations to share power and decision-making.

Fulton (1997:529) states that there is evidence that nurses are an oppressed group and did a study to describe nurses’ view on the concept of empowerment. Fulton (1997:529) argues that the “definition of empowerment in nursing seems to be divided between management paradigms and concepts from critical social theory.” Fulton (1997:532) found that assertiveness links to personal power and that nurses want to be assertive rather than aggressive. Conger and Kanungo (1988:474) define empowerment as a “process of enhancing feelings of self-efficacy among organisational members through the identification of conditions that foster powerlessness and through their removal by both formal organisational practices and informal techniques of providing efficacy information.”
From the above discussion, it is clear that autonomy and independence are related concepts of empowerment. Therefore, they are discussed below.

- **Autonomy**

  Autonomy is (WebFinance, 2016, s.v. ‘autonomy’):

  A degree or level of freedom and discretion allowed to an employee over his or her job. As a general rule, jobs with high degree of autonomy engender a sense of responsibility and greater job satisfaction in the employee(s). Not every employee, however, prefers a job with high degree of responsibility.

  The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:57) defines ‘autonomy’ as “self-government” or “freedom of action.”

  Alkahtani et al. (2011:1270) explain that empowerment will increase employees’ autonomy and state that giving power to employees is sharing power with those who need it to perform their job functions. Ibrahim et al. (2014:59) state that autonomy plays an important part in nurses’ job satisfaction and retention, and they further define autonomy as “authority and accountability for one’s decision and activities.” Kowalik and Yoder (2010:260) refer to autonomy as nurses’ control over making clinical decisions independently.

- **Independence**

  Dictionary.com (2016, s.v. ‘independence’) describes ‘independence’ as “the state or quality of being independent” or “freedom from the control, influence, support, aid, or the like, of others.”

  The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:473) defines ‘independence’ as “the fact or state of being independent” and ‘independent’ as “free from the control or influence of others”, “(of a country) self-governing”, “having or earning enough money to support yourself” or “not connected with another; separate.”
Rawat (2014:43) explains that, if conditions favour empowerment and make a woman experience empowerment, it is termed psychological empowerment. Rawat (2014:45) defines the word as "to empower" and states that it means to authorise, delegate or give legal power to someone. According to Thomas and Velthouse (1990:667), psychological empowerment involves workers’ beliefs about the meaning of their work, their capability to do their job well, which is described as competence, as well as their sense of self-determination and their autonomy in influencing their work outcomes, which can be described as impact.

Based on these four cognitions of psychological empowerment that were hypothesised by Thomas and Velthouse (1990:667), Spreitzer (1995:1444) developed her psychological empowerment theory that was manifested in these four cognitions, namely, meaning, competence, self-determination and impact. The four cognitions of Spreitzer’s Psychological Empowerment Theory are described below:

- **Meaning**

According to Thomas and Velthouse (1990:667), meaning is the value of a work goal or purpose and is judged by one’s own ideals or standards. Spreitzer (1995:1443) describes it as a fit between the work role and beliefs, values and behaviours. According to Frankl (1984:111), it is one’s search for meaning; a primary force in one’s life. Frankl (1984:111) proclaims that it is unique and specific, can only be fulfilled by the person, and that an individual must be fully aware of his or her own responsibility.

- **Competence**

Spreitzer (1995:1443) and Thomas and Velthouse (1990:672) describe competence as one’s belief in one’s capability to perform activities with skills. Competence is analogous to agency beliefs, personal mastery or the effort-performance expectancy (Spreitzer, 1995:1443). According to Gist and Mitchell (1992:186-187), competence or self-efficacy is a belief that one has in one’s capability to perform work activities with skill and it is an important motivational construct that influences one’s choices, goals, emotional reactions, effort, coping and persistence.
• Self-determination

Self-determination is the perception that one has autonomy in performing job tasks and that one can choose how to behave in various job-related situations (Spreitzer, 1995:1443). Self-determination refers to perceived control over one’s own behaviour (Thomas & Velthouse, 1990:672).

According to the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:839), self-determination is the right or ability of a people to manage their own affairs.

• Impact

Spreitzer (1995:1443-1444) describes impact as the degree to which an individual can influence strategic, administrative or operating outcomes at work. Impact refers to a perceived control over one’s environment (Thomas & Velthouse, 1990:672).

(b) Personal knowledge

Below, personal knowledge is defined based on dictionary and subject definitions.

The Business Dictionary (WebFinance, 2016, s.v. ‘personal knowledge’) defines ‘personal knowledge’ as “cognizance of a circumstance or fact gained directly through first-hand experience or observation.” The Law Dictionary (n.d., s.v. ‘personal knowledge’) defines ‘personal knowledge’ as “possessed by any individual. Usually accumulated through observation or personal experiences.”

Other dictionaries consulted only give a definition of knowledge. These have a direct link to personal knowledge and are described below.

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:517) defines ‘knowledge’ as “information and awareness gained through experience or education” or “the state of knowing about something.” Merriam-Webster (2016b, s.v. ‘knowledge’) defines ‘knowledge’ as “information, understanding, or skill that you get from experience or education, awareness of something: the state of being aware of something.” Dictionary.com (2016, s.v. ‘knowledge) defines ‘knowledge’ as “acquaintance with facts, truths, or principles, as from study or investigation; general erudition.”
Personal knowledge is self-awareness and the ability to understand oneself. People are different and therefore personal knowledge will influence how people will react in certain situations (Polanyi in Wittmann-Price, 2004:441). Deci (1975:27) describes Polanyi’s definition of personal knowledge as the stimulus that is perceived by a person. Deci (1975:27) explains that all people have knowledge that is available only to themselves and that is derived from their own perceptions, emotions and behaviours. Deci (1975:27) further explains that this knowledge will provide important information for a person to take into account when making decisions.

Berragan (1998:210) states that personal knowledge influences everything one does because of the awareness of one’s own feelings. Wittmann-Price (2004:441) agrees with this and describes personal knowledge as the type of knowledge that has components of self-awareness. Wittmann-Price (2004:441) also states that it is the ability to understand one’s self. Porter-O’Grady (2003:106) describes knowledge as something that a person obtains and owns that creates an opportunity to be individually valued, regardless of the work environment where the knowledge is expressed.

Sweeney (1994:919) states that personal knowledge is the recognition of a new pattern through processing by an individual and that it may only be new to that specific individual or to all of humanity. Sweeney (1994:920) further states that, in personal knowledge, the comfort of subjectivity is upended and the knower seeks impersonal and universal knowledge. Sweeney (1994:920) further states that personal knowledge is measured by the perception of the individual. Sweeney (1994:920) describes antecedents as factors that must be present for personal knowledge to occur and states that the involvement of a human being who is sentient and rational is necessary. Sweeney (1994:920) describes attributes for personal knowledge as the passionate investment of energy by interpreting certain information through interaction with other humans and the environment, active comprehension, rational intuiting, appraisal and personal judgement. Sweeney (1994:920) also describes the consequences of personal knowledge and states that they occur after the presence of the phenomenon.
Sweeney (1994:920) describes that people who acquire personal knowledge feel energised by the new knowledge – they have convictions and intellectual satisfaction, they envision the application of the new knowledge, they gain a sense of responsibility, and they want to communicate and share the new knowledge.

Smith (1992:2) describes personal knowing as the most fundamental and primary way of knowing that is a process experienced by human beings; personal knowledge also recognises the inseparability of the knower from the known by the means of gaining knowledge. This is applicable for all types of knowledge gained.

Mantzoukas and Jasper (2008:321) indicate that personal knowledge is acquired in a conscious moment of encountering and interacting with specific patients and that the acquisition of this personal knowledge would be impossible without an individualistic and personal approach.

(c) Reflection

Below, reflection is discussed based on the dictionary and subject definitions.

According to the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:773), ‘reflection’ is “the process of reflecting”, “a reflected image”, “a sign of something’s true nature”, “something that brings discredit” or “serious thought.”

Merriam-Webster (2016b, s.v. ‘reflection’) defines ‘reflection’ as “an image that is seen in a mirror or on a shiny surface, something that shows effect, existence, or character of something else, something that causes people to disapprove of a person or thing.”

Dictionary.com (2016, s.v. ‘reflection’) defines ‘reflection’ as:

1. The act of reflecting, as in casting back a light or heat, mirroring, or giving back or showing an image; the state of being reflected in this way. 2. An image; representation; counterpart. 3. A fixing of the thoughts on something; careful consideration. 4. A thought occurring in consideration or meditation. 5. An unfavourable remark or observation. 6. The casting of some imputation or reproach.
Wittmann-Price (2006:378) describes reflection as a technique that requires critical thought either with oneself or in a group, and states that it is a self-analytical process to identify what one intends to achieve in a situation and the way one is behaving. The act of reflection requires all the information and knowledge that is available to one to make decisions. Penney and Warelow (1999:263) explain reflection as behaviour that is like stepping out of oneself and freeze-framing the moment to understand it better. Johns (1999:241) states that the true way to reflect is to stop and think about what one is doing.

Mantzoukas and Jasper (2008:324) describe different types of knowledge and state that reflexive knowledge is knowledge that will enable nurses to respond to future and unique situations based on their previous experience. According to Somerville and Keeling (2004:42), reflection is the examination of one’s personal thoughts and actions; therefore, it is a process through which nurses can better understand themselves in order to build their existing strengths and to take appropriate action for the future.

Somerville and Keeling (2004:42) describe two fundamental forms of reflection, namely, reflection-on-action and reflection-in-action. According to Somerville and Keeling (2004:42), reflection-on-action is the most common form of reflection and involves carefully re-running one’s mind on events that occurred in the past, with the aim to value one’s strengths and to develop different and more effective ways of acting in the future. Somerville and Keeling (2004:42) describe reflection-in-action as the hallmark of the more experienced professional and state that it is when one examines one’s own behaviour and that of others while one is in the situation.

(d) Awareness of social norms

Below, awareness of social norms is discussed based on the dictionary and subject definitions. The dictionaries do not include a definition of the combined terms awareness and social norms; therefore, it is necessary to define each term individually before defining them together as a concept.
According to the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:59), 
**awareness** is “the quality of being aware.” Dictionary.com (2016, s.v. ‘awareness’) 
defines **awareness** as “the state or condition of being aware; having knowledge; consciousness.” The Business Dictionary (WebFinance, 2016, s.v. ‘social norms’) 
defines **social norms** as a “pattern of behaviour in a particular group, community, or 
culture, accepted as normal and to which an individual is accepted to conform.” The 
online New Palgrave Dictionary of Economics (Durlauf & Blume, 2015, s.v. ‘social 
 norms’) defines **social norms** as “customary rules of behaviour that coordinate our 
interactions with others.”

Part of emancipation is being aware that knowledge development occurs in a social 
context and that it can influence individual perceptions (Berragan, 1998:212). Cody 
(2000:94) agrees with this statement and states that one must be aware that social 
norms can set standards and establish paradigms that are sometimes difficult to 
change. According to the WHO (2009:3-4), social norms are influential and can 
shape an individual’s behaviour, and there are certain rules and expectations of 
behaviour in specific cultural or social groups.

Wittmann-Price (2004:442) states that there must be awareness that social norms 
set standards and establish paradigms that are sometimes difficult to change and 
that emancipation involves knowledge development that occurs in a social context, 
and that this context has influence over information transfer and will thus influence 
individual perceptions. Wittmann-Price (2006:378) states that social norms refer to 
one’s awareness that the external environment promotes certain possible 
alternatives as more acceptable than others. Wittmann-Price (2006:378) further 
states that it originates as recognising that knowledge development occurs in a 
social context and that the social context will therefore be able to exert unequal 
power and influence over knowledge, thus influencing an individual’s perception. 
Wittmann-Price (2006:378) makes a valuable statement that the current decision-
making frameworks and research about health care have been developed within the 
social norms of the health care system. Wittmann-Price (2006:378) further states 
that the Wittmann-Price Theory of Emancipated Decision-Making assumes that 
social norms within the health care system can influence choices about health care 
issues.
Wittmann-Price and Bhattacharya did a study in 2008 where they re-explored the sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making. They found that social norms have the potential to be oppressive and state that an individual should include personal knowledge as a way of knowing because it has components of self-awareness (Wittmann-Price & Bhattacharya, 2008:227). Wittmann-Price, Fliszar and Bhattacharya (2011) did a third study in 2011 to test the Wittmann-Price Theory of Emancipated Decision-Making in health care. They state that it is essential to understand social norms as they evolve over time in health care as it is important to analyse how they will influence the effects of the decision-making process (Wittmann-Price et al., 2011:148).


Nurses who are empowered are more able to empower the patients they care for, which in turn has the potential to lead to better health outcomes (Laschinger et al., 2010:5).

Table 5.2 lists the identified attributes of the concept empowered self identified in the dictionary and subject definitions thereof.

**Table 5.2: Essential attributes of the concept ‘empowered self’**

<table>
<thead>
<tr>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
</table>
| Defining attributes of empowered self  | • Power to have influence over work  
• Personal knowledge, empowerment, reflection, awareness of social norms |
| Antecedents of empowered self           | • Personal knowledge  
• Empowerment  
  o Autonomy and independence  
  o Meaning  
  o Self-determination  
  o Competence  
  o Impact  
• Reflection  
• Awareness of social norms |
| Consequences/ outcomes of empowered self| • Freedom of choice  
• Successful job execution  
• Increased resilience  
• Job satisfaction  
• Improved health outcomes |
5.3.2.3 Operational definition of the concept ‘empowered self’

An empowered self of a nurse is one who has the power to influence her work through personal knowledge, empowerment, reflection and the awareness of social norms. An empowered self of the nurse enhances personal choice, satisfaction, resilience, and improved job executions and health outcomes.

5.3.3 Defining the concept ‘enabling environment’

Below, enabling environment is defined based on dictionary and subject definitions.

5.3.3.1 Dictionary definition of the concept ‘enabling environment’

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:303) defines enable as “provide with the ability or means to do something” or “make something possible.” Merriam-Webster (2016a, s.v. ‘enable’) defines enable as “to make (someone of something) able to do or to be something”, “to make (something) possible, practical, or easy” or “to cause (a feature or capability of a computer) to be active or available for use.” The Free Dictionary (Farlex, 2015, s.v. ‘enable’) defines enable as follows:

1. a. To supply with the means, knowledge, or opportunity (to do something); make able. b. To make feasible or possible. 2. To give legal power, capacity, or sanction. 3. To make operational; activate. 4. To behave in a manner that facilitates or supports (another’s abusive, addictive, or self-destructive behaviour).

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:310) defines environment as “the surroundings in which a person, animal, or plant lives or operates” or “the natural world.” Merriam-Webster (2016a, s.v. ‘environment’) defines environment as “the conditions that surround someone or something: the conditions and influences that affect the growth, health, progress, etc., of someone or something” or “the natural world.”
5.3.3.2 Subject definition of the concept ‘enabling environment’

According to Thindwa (in Brinkerhoff, 2004:3), a typical general definition for enabling environment is:

A set of interrelated conditions – such as legal, bureaucratic, fiscal, informational, political, and cultural – that impact on the capacity of ... development actors to engage in development processes in a sustained and effective manner. An enabling environment in the workplace.

The Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377; Wittmann-Price & Bhattacharya, 2008:226) has a flexible environment as its fifth sub-concept. Flexible environment refers to the external environment in the process of emancipation. Kanter’s Structural Empowerment Theory (Laschinger, Finegan, Shamian & Wilk, 2003:2; Lethbridge et al., 2011:637) also refers to the external environment and, if employees have access to the main concepts of Kanter’s Structural Empowerment Theory, namely, information, support, resources, and opportunities to learn and develop, they will be emancipated, which will influence employees’ attitudes and organisational effectiveness.

(a) Flexible environment

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:360) defines flexible as “able to bend easily without breaking” or “able to adapt to different circumstances.” Merriam-Webster (2016b, s.v. ‘flexible’) defines flexible as “capable of bending or being bent; easily changed; able to change or to do different things and willing to change or to try different things.”

The Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:310) defines environment as “the surroundings in which a person, animal, or plant lives or operates” or “the natural world.” The Business Dictionary (WebFinance, 2016, s.v. ‘environment’) defines environment as “the sum total of all surroundings of a living organism, including natural forces and other living things, which provide conditions for development and growth as well as of danger and damage.” Merriam-Webster (2016b, s.v. ‘environment’) defines environment as the “conditions that surround someone or something: the conditions and influences that affect the growth, health, progress, etc., of someone or something and the environment: the natural world.”
Wittmann-Price (2004:442) describes a flexible environment as a non-judgemental environment that supports freedom of choice and states that a flexible environment can be described as one that is responsive to change, leading to personal benefits for individuals. A flexible environment therefore increases choices and enhances self-esteem and understanding.

When the concept ‘environment’ is defined in the context of emancipation, Wittmann-Price and Bhattacharya (2008:226) explain that it can be internal and external and that it is intertwined with sources of power, obvious and obscure. It can be used for positive or emancipating outcomes, or negative or oppressive outcomes, depending on the intent. The person cannot be separated from the environment and the environment cannot be separated from the person. Wittmann-Price and Bhattacharya (2008:227) state that a flexible environment is needed for women who have to make decisions that are comfortable, and that the environment must also be resilient and responsive. Wittmann-Price and Bhattacharya (2008:227) describe nursing as a professional role that can foster a flexible environment. Stepanuk et al. (2013:2472) agree with the above statement and state that a flexible environment affords women with the opportunity to act on their choice without opposition.

Kanter’s Structural Empowerment Theory describes two systematic sources of power that exist in organisations, namely, formal power and informal power (Lethbridge et al., 2011:637). According to Lethbridge et al. (2011:637), formal power is evident where jobs allow discretion, flexibility, creativity and autonomy in decision-making within the organisation, while informal power develops from connections inside the organisation that will include sponsors, peers and subordinates.

Kanter (in Laschinger, Finegan, Shamian & Wilk, 2004:528) states that management should create conditions at work for work effectiveness. This must be done by ensuring that employees have access to the information, support and resources they need to accomplish work, and they must be provided with ongoing opportunities for development. According to Kanter (Laschinger et al., 2003:3), employees who have access to the above will be empowered, which will result in increased levels of organisational commitment and feelings of autonomy and self-efficacy.
The main concepts of Kanter’s Structural Empowerment Theory are information, support, resources, and opportunities to learn and develop. These concepts are discussed below.

**Information:** the knowledge and expertise that is required to do one’s job well (Lethbridge et al., 2011:637).

**Support:** regular feedback, guidance, advice and opinions from formal and informal networks (Lethbridge et al., 2011:637).

**Resources:** the supplies, equipment, money and time one needs to achieve organisational goals (Lethbridge et al., 2011:637)

**Opportunities to learn and develop:** this includes mobility, growth and advancement in the organisation, as well as opportunities to increase knowledge, skills and professional development (Laschinger et al., 2004:528).

According to Ning, Zhong, Libo and Qiujie (2009:2642), the outcome of the sub-concept of flexible environment of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377) and Kanter’s Structural Empowerment Theory (Laschinger et al., 2003:2; Lethbridge et al., 2011:637) is that enhancing empowerment for nurses in a supportive environment will allow them job satisfaction. After a prediction by the WHO regarding an imminent shortage of health care workers, Munyewende, Rispel and Chirwa did a study in 2014 where they linked staff shortages and job satisfaction with each other and found that managers in primary health care clinics in two South African provinces only had moderate levels of job satisfaction (Munyewende et al., 2014:9). Munyewende et al. (2014:9) found that low job satisfaction is one of the factors in leaving the workplace among South African nurses.

Laschinger et al. (2003:2) did a study where they tested Kanter’s Structural Empowerment Theory. According to them, Kanter argues that work environments which provide access to information, support, resources and opportunities to learn and develop are empowering and that this will influence employees’ attitudes and organisational effectiveness.
According to Kanter (Lethbridge et al., 2011:637), power is derived from formal and informal sources and is obtained through the positions that employees hold and the structural conditions within the organisation, not from the individual’s personality traits or socialisation processes. Kanter (Laschinger et al., 2004:528) conceptualises power as the “ability to mobilize resources to get things done” and describes that employees will be empowered when they have access to lines of information, support, resources and opportunities to learn and grow. According to Kanter (Laschinger et al., 2004:528), these lines of empowerment will derive from formal and informal systems within the organisation. Laschinger et al. (2003:3) state that there is considerable support for Kanter’s theory in the nursing profession and the researcher’s assumption was that the same would be true for nurses working with gender-based violence.

Table 5.3 lists the attributes of the concept ‘enabling environment’ identified in the dictionary and subject definitions thereof.

Table 5.3: Attributes of the concept ‘enabling environment’

<table>
<thead>
<tr>
<th>Essential criteria</th>
<th>Related criteria</th>
</tr>
</thead>
</table>
| Characteristics of enabling environment | Enable:  
- To make something possible  
- To supply with the means, knowledge, or opportunity to do something  
- To make operational, activate  
- To behave in a manner that facilitates or supports  
Environment:  
- Surroundings in which a person operates  
- The conditions that surround a person  
- The conditions and influences that affect a person’s growth, health and progress |
| Defining attributes of enabling environment | An environment where employees have:  
- Formal power: discretion, flexibility, creativity and autonomy in decision-making within the organisation  
- Informal power: connections inside the organisation that will include sponsors, peers and subordinates |
| Antecedents of enabling environment | Flexible environment  
- Information  
- Support  
- Resources  
- Opportunities for development |
| Consequences/outcomes of enabling environment | Job satisfaction  
- Organisational effectiveness |
5.3.3.3 Operational definition of the concept ‘enabling environment’

An enabling environment for nurses working with gender-based is one where nurses have formal and informal power. It is flexible and provides nurses with access to information, support, resources and opportunities for development. An enabling environment leads to job satisfaction and organisational effectiveness.

5.4 COMPREHENSIVE DEFINITION

From the definitions of the three central concepts, one comprehensive definition was compiled.

The comprehensive definition is: emancipated nurses working with gender-based violence make emancipated decisions with which they are satisfied. Emancipation is evidenced by an empowered self through personal knowledge, competence, reflection and the awareness of social norms.

Emancipated nurses work in enabling environments that are flexible and provide them with access to information, support, resources and flexibility. Emancipated nurses experience satisfaction, resilience and improved execution of their work, enhancing health outcomes for survivors.

5.5 CONCLUSION

In this chapter, the concept analysis was described. The main concepts were identified and described. Dictionary definitions, subject definitions and operational definitions were given. In the next chapter, the concept analysis assists with the construction of the emancipatory model and guideline development for nurses working with gender-based violence.
CHAPTER 6
CONSTRUCTION OF THE MODEL, CONTEXTUALISATION AND
GUIDELINES

6.1 INTRODUCTION

In this chapter, the focus is on describing the emancipatory model for nurses working with gender-based violence. Guidelines are described for the implementation of the model. The theoretical frameworks underlying the model are also described. The two objectives of the study addressed in this chapter are: to construct an emancipatory model for nurses working with gender-based violence, and to develop guidelines for the operationalisation of the model for nurses working with gender-based violence.

This study started off with a theoretical framework as described by Wittmann-Price. The researcher adhered to the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377) as a baseline while the focus groups, joint interview and individual interviews were conducted. However, with the development of the study and after the data analysis, it was discovered to be necessary to bring in other theories to support the study and the model construction. Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637) was brought in to support enabling environment and Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484) to help nurses understand themselves and to be emancipated. These theories were described in the concept analysis in Chapter 5.

The model was informed by the findings of the study that led to the concepts that informed the concept analysis. Synthesis of the concepts led to a comprehensive definition. The comprehensive definition is: emancipated nurses working with gender-based violence make emancipated decisions with which they are satisfied. Emancipation is evidenced by an empowered self through personal knowledge, competence, reflection and awareness of social norms.

Emancipated nurses work in enabling environments that are flexible and that provide nurses with access to information, support and resources. Emancipated nurses experience satisfaction, resilience and improved execution of their work, leading to enhanced outcomes for survivors of gender-based violence.
6.2 CONCEPT CLASSIFICATION

The elements of practice theory of Dickhoff et al. (1968:435) were applied to classify the identified concepts. The central concepts were: The **emancipated empowered self of the nurse in an enabling environment**. Dickoff et al. (1968: 415-435) ask six questions of the researcher regarding how these concepts will be identified and classified.

6.2.1 The agent

Who or what performs the activity?

In this study, it was found that management of the hospital will be the agent. They are responsible for providing the necessary information and resources for nurses working with gender-based violence. As the responsible entity, management have to fulfil certain expectations towards these nurses. They have to give them the necessary support and flexibility to enable them to become emancipated nurses.

6.2.2 The recipient

Who or what is the recipient of the activity?

In this study, it was found that nurses working with gender-based violence will be the primary recipients of the activity. Nurses working with gender-based violence experience and witness the effects of abuse on the survivor of gender-based violence who comes into the crisis centre, community clinics and casualty department. As a result of this, nurses experience certain emotions, such as sadness and powerless feelings, during their interaction with survivors of abuse; therefore, they need a support system to help them work through these emotions. Nurses working with gender-based violence also deal with the perpetrator who abused the survivor and who is responsible for certain emotions like fear and anger that result in nurses. The secondary recipients will be the survivors and perpetrators of gender-based violence – having an empowered nurse will mean that the survivor and the perpetrator will also be empowered.
6.2.3 The context

In what context is the activity performed?

The context is where the activities will take place, namely, the crisis centre, community clinics and casualty department in a semi-rural area in Tshwane.

6.2.4 The procedure

What is the procedure of the activity?

The procedure involves the action that will take place to emancipate nurses working with gender-based violence and to interact with survivors and perpetrators of gender-based violence. Nurses working with gender-based violence will reflect on their competence, personal knowledge and awareness of social norms in order to become emancipated nurses. An emancipatory model was constructed and guidelines were written on how to interpret the model. The purpose of this model is to emancipate nurses working with gender-based violence.

6.2.5 The dynamics

What is the energy source for the activity?

The semi-structured interview questionnaire that was used in the focus groups and individual interviews was used to construct the tentative model or framework. Nurses working with gender-based violence will be encouraged to build an interactive relationship with colleagues and management to create a support system to help them work with gender-based violence. They will be taught to hold debriefing sessions with each other and in groups, especially after a traumatic case.

6.2.6 The terminus

What is the guiding procedure and terminus?

The guiding procedure involves the processes that will be placed in the enabling environment by management, namely, support, resources, information and flexibility.
The terminus will be the emancipation of nurses working with gender-based violence. As an outcome, nurses working with gender-based violence will have satisfaction and resilience in their work environment.

They will have the competence to improve on the execution of their work performances and will be able to enhance the health outcomes of survivors. This means that nurses working with gender-based violence will be emancipated.

6.3 DESCRIPTION OF INTERRELATED STATEMENTS

The relationship statements were derived after conceptualisation and provided the basis for model construction.

In this emancipatory model for nurses working with gender-based violence, a relationship was found between the three theories, namely, the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:442), Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484) and Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637).

The empowered self is defined using the four internal or self-related concepts of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377), namely, empowerment, personal knowledge, reflection and awareness of social norms. The fifth concept of the Wittman-Price Theory of Emancipated Decision-Making (Wittman-Price, 2006:377), namely, an enabling environment, is incorporated with the concepts of Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637). Kanter (in Laschinger et al., 2004:528) states that management should create conditions at work for work effectiveness. This must be done by ensuring that employees have access to the information, support, resources and flexibility that they need to accomplish their work.

According to Kanter (Laschinger et al., 2003:3), employees who have access to the above will be empowered, which will result in increased levels of organisational commitment as well as feelings of autonomy and self-efficacy. The emancipation of nurses is influenced by Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484), which can be observed as satisfaction, resilience and improved execution of their work, enhancing health outcomes for survivors of gender-based violence.
According to Thomas and Velthouse (1990:667), psychological empowerment involves workers' beliefs about the meaning of their work, their capability to do their job well, which is described as competence, and their sense of self-determination and their autonomy in influencing their work outcomes, which can be described as impact. Based on these four cognitions of psychological empowerment that were hypothesised by Thomas and Velthouse (1990:667), Spreitzer (1995:1444) developed her psychological empowerment theory that is manifested in four cognitions, namely, meaning, competence, self-determination and impact.

6.4 CONSTRUCTION OF THE MODEL

Model construction was done using the following three phases of theory generation as described by Chinn and Kramer (2011:215-217):

Phase 1: Construction of conceptual meaning
Step 1: Concept selection
Step 2: Concept definition
Step 3: Concept classification

Phase 2: Construction and contextualisation of the model
Step 4: Description of relationship statements
Step 5: Description and evaluation of the model

Phase 3: Description of guidelines
Step 6: Description of guidelines for the operationalisation of the model

Barker (2003:276) and Silverman (2010:436) see a model as a representation of reality. Barker (2003:276) describes it further and states that the life model represents the interaction of forces that are found in the client's environment, which influence and are influenced by the client. The researcher agrees with this statement and, in this study, the researcher strives to represent the interaction of forces that influence nurses working with gender-based violence. The model was influenced by the theoretical framework of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:440, 2006:377), Kanter's Structural Empowerment Theory (Lethbridge et al., 2011:637) and Spreitzer's Psychological Empowerment Theory (Spreitzer, 1996:484).
Albert (in De Vos & Strydom, 2011:40) confirms this order by saying that a researcher must first postulate a theory and then construct a model from that theory.

The model serves as a framework to explain how nurses working with gender-based violence can be emancipated to work with survivors and perpetrators of gender-based violence. The model is titled ‘Emancipatory model for nurses working with gender-based violence’ (see Figure 6.1). The structure of this model includes a visual representation of the model and a short overview of the model. In this section, the guide for the structure of the model, as used by Chinn and Kramer (2011:195-196), is used to describe the model.

6.4.1 Overview of the model

The overview of the emancipatory model for nurses working with gender-based violence is based on the visual representation of the emancipatory model in Figure 6.1. The emancipatory model represents a constructive interaction between the self of the nurse and an enabling environment. An empowered self of the nurse is one that has the power to influence his or her work through personal knowledge, competence, reflection and the awareness of social norms. An enabling environment for nurses working with gender-based is one where nurses have formal and informal power. The environment is flexible and provides nurses with access to information, support and resources. The outcome of this interaction is the emancipation of nurses working with gender-based violence. Emancipated nurses experience satisfaction, resilience and improved execution of their work, enhancing health outcomes for survivors of gender-based violence.
Figure 6.1: Emancipatory model for nurses working with gender-based violence
6.4.2 Purpose of the model

The purpose of the emancipatory model for nurses working with gender-based violence is to emancipate them to be able to work with survivors and perpetrators of gender-based violence. Emancipated nurses will have satisfaction, resilience and improved execution of their work, enhancing health outcomes when working with survivors of gender-based violence. This emancipation may lead to a freedom of choice so that they can recognise oppressive forces.

6.4.3 Assumptions of the model

Chinn and Kramer (2011:178) describe assumptions as underlying givens that are presumed to be true. The presumed assumption of this study is that nurses are an oppressed group and therefore cannot make emancipated decisions. The assumption is that an emancipatory model for nurses working with gender-based violence will emancipate them.

The emancipatory model is based on the following assumptions:

- Reflection is the core of the emancipatory model and, through reflection, nurses working with gender-based violence will become aware of their social norms and their personal knowledge, which will help them to review and improve their competencies.

- Reflection will enhance the nurses’ personal knowledge and their professional maturity to work with survivors and perpetrators of gender-based violence. With reflection, they will learn how to handle the emotional distress which they experience when working with gender-based violence. They will learn how to cope with the sadness, trauma, fear, compassion, powerless feelings, anger and ambivalence that they experience.

- Reflection can be used as a tool to connect the nurses’ knowledge and experiences when they have blurred boundaries, where there is a spill-over between their professional and private lives and where they need to separate these from each other.
• Reflection will enhance self-learning and will improve the clinical skills that nurses need to work with gender-based violence, namely, the assessment and examination they have to do; the physical and psychological interventions they have to carry out; the knowledge they need for the legal ethical framework; and the competencies they need when working with survivors, perpetrators and children of gender-based violence.

• Reflection will help nurses working with gender-based violence to be aware of their social norms, and to be careful not to be judgemental when they experience difficulty in showing empathy towards teenagers and when they experience anger towards the perpetrator.

• Reflection is connected to the competence of the nurses, their personal knowledge and their awareness of social norms. If they adhere to these principles, it will reflect in their empowered selves and the outcome will be emancipated nurses who will experience satisfaction, resilience and improved execution of their work. It will also enhance health outcomes for survivors of gender-based violence.

• There is also an assumption that there is an inter-relationship and a connection between information, support, flexibility and resources, which results in an enabling environment for nurses working with gender-based violence.

• If nurses working with gender-based violence have more access to information, they will be able to identify a survivor of gender-based violence. Here, they need certain knowledge and skills to identify whether it is abuse or not when a survivor comes for treatment of wounds. They will also have the skills and knowledge to counsel these survivors.

• The court and judicial system will need information about the survivor. The assumption is that, if nurses working with gender-based violence have access to all the information they need, they will be able to fill in all the supporting documentation.
When nurses working with gender-based violence have the necessary support systems, such as inter-disciplinary support, they will be able to understand each other’s different roles and will be able to work together to improve care provided to survivors.

Nurses working with gender-based violence believe that management and the decision-makers of the hospital do not understand them. The assumption is there that, if the management of the hospital are made aware of the needs of nurses working with gender-based violence, they will have a better understanding of these nurses’ needs and will be able to give the necessary managerial support.

If there are enough learning opportunities for these nurses, they will learn strategies related to working with survivors and, if special attention is paid to improving their knowledge and skills, they will be prepared and trained to work with survivors of gender-based violence.

Nurses working with gender-based violence need resources to be able to do their work properly and, if a referral network consisting of psychologists and social workers can be established, they will be able to give the necessary care to survivors.

Wittman-Price (2004:442) sees a flexible environment as a non-judgemental environment that supports freedom of choice. This is also applicable to this study and the assumption is that, if the environment can be responsive to change, it will increase and enhance the self-esteem and understanding of nurses working with gender-based violence.

The researcher believes that, if the empowered self of the nurse functions within the boundaries of an enabling environment, the outcome will be that of an emancipated nurse who will experience satisfaction, resilience and improved execution of his or her work and will enhance health outcomes for survivors of gender-based violence.
6.4.4 Context of the model

The setting for contextualising the model is a semi-rural area in Tshwane. The context of the model is the crisis centre, community clinics and casualty department of the public hospital where nurses work with gender-based violence and where they interact with survivors of gender-based violence, perpetrators of gender-based violence, inter-disciplinary team members, colleagues and management.

Nurses working with gender-based violence function within the boundaries of the health services and the community. All of these function under the umbrella of a legal ethical framework, as violence against women and children forms part of South African legislation. In Chapter 3, a legal ethical framework was provided to explain the legal ethical framework and the Acts, policies and guidelines involved with it.

6.4.5 Structure of the model

According to Chinn and Kramer (2011:175), structuring and contextualising the emancipatory model involve systematic linkages between and among the concepts. In this study, the emancipatory model was constructed, giving form to the relationships among the concepts in the theory using visual shapes, colours, arrows and connecting lines.

6.4.5.1 Description of the colours used in the model

Marshall (2008:1) describes colours as meaning something on an emotional level and states that it is essential to learn what colours mean, especially what different colours mean to different cultures around the world. Vastani (2012:1) states that it is crucial to understand the essential things about colour if one wants it to have an impact on one’s design. Therefore, the researcher tried to choose colours to demonstrate what is meant by the structure of the model so that it can be understood by nurses working with gender-based violence when they look at the model.
(a) Empowered self – Blue

The colour blue indicates the sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making (2006:377), namely, reflection as the core of the empowered self, in relationship with competence, personal knowledge and awareness of social norms.

Blue was chosen because it is described as trustworthy and loyal; it also represents confidence, professionalism, trust, authority, power and loyalty (Black, 2013:2; Marshall, 2008:2; Vastani, 2012:1).

- **Reflection:** Wittmann-Price (2006:378) describes reflection as a technique that requires critical thought either with oneself or in a group. Johns (1999:241) states that reflection is a self-analytical process to identify what one intends to achieve in a situation and the way one is behaving.

Red is the colour of fire and blood, and is associated with energy, leadership, strength and power, as well as passion, desire and love (Black, 2013:2; Marshall, 2008:1; Vastani, 2012:3). Because it is emotionally an intense colour, it was chosen to represent reflection as it is the core of the emancipatory model.

Reflection forms the core of the empowered self. By reflecting (on social norms, personal knowledge and competence), the nurse will feel a sense of calmness that will reduce stress and prevent chaos. This will lead to extension of the nurse’s intuition and the nurse will feel more in control of the situation.

- **Competence:** Competence refers to the knowledge and skills that nurses require to work with gender-based violence. Nurses working with gender-based violence need no have proper knowledge, training and experience to identify abuse and to treat the survivor. They must also be able to understand how the abuser treats the abused woman and must understand the consequences that the violence will have on the survivor’s life and health (AbuTaleb et al., 2012:84; Alsafy et al., 2011:174). The competencies these nurses need include assessment and examination, physical and psychological interventions, and legal ethical knowledge.
- **Personal knowledge**: Personal knowledge is self-awareness and the ability to understand oneself. Because people are different, personal knowledge will influence how persons will react in certain situations (Polanyi, in Wittmann-Price, 2004:441).

- **Awareness of social norms**: Part of emancipation is also to recognise that knowledge development occurs in a social context, which can influence individual perceptions (Berragan, 1998:209).

(b) **Enabling environment – Yellow**

Yellow enhances practical thinking and works on the left side of the brain where decision-making takes place. Yellow represents knowledge, optimism, education, innovation and caution (Black, 2013:2; Marshall, 2008:2; Vastani, 2012:1). It helps one to focus, learn and communicate.

An enabling environment consists of the support, flexibility, competence and resources that will assist the nurse to make appropriate, non-judgemental decisions and think practically in the health care environment.

If the enabling environment is conducive for nurses when they work with gender-based violence, they will function optimally and will be emancipated. An enabling environment also consists of three of the concepts of Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637), and shows the need for information, support and resources. Flexibility is one of the sub-concepts of the Wittman-Price Theory of Emancipated Decision-Making (2006:377) that was added to form part of an enabling environment in this study.

- **Support**: In the context of this study, the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:934) defines support as “carry all or part of the weight of”, “give help, encouragement, or approval to” or “confirm or back up.” Dictionary.com (2016, s.v. ‘support’) defines it “as a group of people who meet regularly to support each other by discussing problems affecting them in common.” Merriam-Webster (2016b, s.v. ‘support’) defines support as “a group of people who have similar experiences and concerns and who meet in order to provide emotional help, advice, and encouragement for one another.”
Nurses working with gender-based violence need support from inter-disciplinary team members, management, colleagues, friends and family to be emancipated to work with survivors and perpetrators of gender-based violence.

- **Resources:** In the context of this study, the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:789) defines resources as “a stock or supply of materials or assets”, “something that can be used to help achieve an aim” or “personal qualities that help you to cope with difficult circumstances.” Dictionary.com (2016, s.v. ‘resource’) defines a resource as “a source of supply, support, or aid, especially one that can be readily drawn upon when needed.”

Nurses working with gender-based violence need specific identified resources to be able to work with survivors and perpetrators, which include the inter-disciplinary team members who are involved with abused women and children. They need to know the identified referral systems which are involved with gender-based violence.

- **Information:** In the context of this study, the Oxford Dictionary and Thesaurus (Waite & Hawker, 2009:479) defines information as “facts or details supplied to or learned by someone.” Dictionary.com (2016, s.v. ‘information’) defines information as “knowledge communicated or received concerning a particular fact or circumstance” or “knowledge gained through study, communication, research, or instruction.” Merriam-Webster (2016b, s.v. ‘information’) defines information as “knowledge that you get about someone or something.”

Nurses working with gender-based violence need to identify and acknowledge abuse against women and children. They need to know how to take samples and evidence from the survivor and how to take blood samples from the perpetrator who is brought in by the police. These nurses need to know how to fill in all documentation that is needed. These records should be concise, limited to the incident in question and only medical observations and assessments should be documented.
• **Flexibility**: Wittman-Price (2004:442) describes flexibility as a non-judgemental environment that supports freedom of choice and states that a flexible environment can be described as one that is responsive to change, leading to personal benefits for individuals; therefore, such an environment increases choices and enhances self-esteem and understanding.

Wittmann-Price and Bhattacharya (2008:226) state that flexibility can be internal and external, that it is intertwined with sources of power, obvious and obscure, and that it can be used for positive or emancipating outcomes, or negative or oppressive outcomes, depending on the intent.

*(c) Outcome: Emancipated nurse – Green*

The colour green is a natural colour and represents the unchanging environment and nature; it also represents self-awareness (Black, 2013:2; Marshall, 2008:2; Vastani, 2012:1). It shows a strong sense of good decision-making that is non-judgemental. It brings together the clarity and optimism of the colour yellow and the emotional insight of blue. Together, there will be growth and hope for nurses working with gender-based violence. The green emancipated nurse will further develop into a good listener and be able to put his or her own emotions and feelings in balance. The nurses can now love themselves unconditionally and be in control of their emotions while working with survivors.

The empowered selves of the nurses in this enabling environment need Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484) to help them understand themselves and to help them achieve their ultimate goal, namely, freedom from oppression. Working with gender-based violence is a challenge for nurses in that it is emotionally and physically draining to work with survivors and perpetrators on a daily basis. Nurses working with gender-based violence comfort and communicate with the survivors and gain their trust. Nurses working with gender-based violence need to have satisfaction and resilience, and must improve the execution of their work, enhancing health outcomes for survivors. With the emancipation of nurses working with gender-based violence, the goal of the Wittmann-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2004:438) will be in place, as described in Chapter 1.
(d) Health services – Light purple

Purple was chosen as the colour for health services (light purple) and the community (dark purple). This was done because the health services and the community cannot be separated from each other; there is a relationship between them and this is where all the activity happens. Purple represents royalty, power, education and elegance, but it also represents mourning and sensitivity (Marshall, 2008:2; Vastani, 2012:6).

Nurses who are working in the health services must enable themselves to deal with survivors in a situation without being judgemental. Purple gives one the sense of striving to be better than one’s current situation. It inspires nurses to love unconditionally and to be more sensitive and compassionate towards the survivors they are working with. Purple also enhances creativity and will allow the nurses to create their own coping mechanisms as well as techniques to assist the survivors of gender-based violence and make them feel more comfortable while working with them.

The health services and context where the research took place were the crisis centre, community clinics and the casualty department.

(e) Community – Dark purple

The purple colour has been also been chosen for the community as it is the national colour that is used every year in South Africa to indicate abuse towards women and children and to make the general public aware of gender-based violence. Purple also indicates power.

Community represents the context where the gender-based violence takes place before the survivors come to the crisis centre, community clinics or casualty department.

(f) Legal ethical framework – Light blue

Blue was chosen to represent the legal ethical framework because it is described to be trustworthy and loyal; it also represents confidence, professionalism, trust, authority, power and loyalty (Black, 2013:2; Marshall, 2008:2; Vastani, 2012:1).
From a psychology perspective, light blue represents reliability and responsibility. The colour gives inner security and confidence. The legal ethical framework forms the basis of the emancipatory model; this helps to emancipate the nurse by giving security and support through the community and the health services. The nurse working with gender-based violence can rely on the legal ethical framework to help her take control and make the right decisions in difficult circumstances. This will help her to gain confidence to reflect on the situations and, through that, improve and emancipate herself.

As described in Chapter 3, it is expected of nurses working with gender-based violence to fulfil certain roles and to adhere to certain Acts, policies and guidelines. Geyer (1998:28) states that nurses play an important role in the delivery of primary health care services in South Africa and that nurses should be emancipated to practise within legal and ethical boundaries.

The Nursing Act (2005) states that:

*Nursing is a regulated profession comprising a body of scientific knowledge and skills practiced by persons referred to in section 30 of the Act and registered in terms of section 31 of the Act. The Act, the regulations, rules an codes made in terms of the Act provide the legal and ethical framework for the practice of nursing.*

Other Acts that have an influence on nurses working with gender-based violence are the following:

(a) No. 108 of 1996: Constitution of the Republic of South Africa
(b) No. 116 of 1998: Domestic Violence Act
(c) No. 38 of 2005: Children’s Act
(d) No. 32 of 2007: Criminal Law (Sexual Offences and Related Matters) Amendment Act
(e) No. 41 of 2007: Children’s Amendment Act

Nurses working with gender-based violence are guided by the guidelines for medico-legal care for victims of sexual violence from the WHO (2003).
6.5 PROCESS OF THE MODEL

The process of the emancipatory model has six main components. The central part, which is the first component, contains reflection, competence, personal knowledge and awareness of social norms; this component indicates the empowered self of the nurse. The second circle is the also the second component, namely, information, support, resources and flexibility; this component indicates the enabling environment, which will lead to the third component, namely, the outcome of the emancipated nurse. Around these components are the health services, with the crisis centre, community clinics and casualty department; it is here that survivors and perpetrators of gender-based violence are treated and these health services represent the fourth component. The fifth component is the community where gender-based violence happens, and the sixth component is the legal ethical framework where all the Acts, policies and guidelines are formed.

Symbolic meanings of the structured model are presented as follows:

- The frame around the model represents the legal ethical framework. Nurses working with gender-based violence function under this legal ethical framework.
- The figure in the centre, namely, reflection, represents the core of the emancipatory model and represents where the emancipatory model starts.
- Around reflection are competence, personal knowledge and awareness of social norms. Bi-directional arrows between them indicate that there are influences that flow in both directions and cannot be separated from each other. These bi-directional arrows contribute to the dynamics of the whole process of the empowered self of the nurse.
- The blue arrow that goes from the centre towards the outcome, which is the emancipated nurse, is a unidirectional arrow and indicates the single direction of flow.
- The second circle contains the words information, support, resources and flexibility. They are connected to each other by bi-directional arrows which indicate the direction and flow. All of these have an influence on each other.
- The yellow arrow that goes from the second circle towards the outcome, which is the emancipated nurse, is a unidirectional arrow that indicates the single direction of flow.
• Dotted lines between the centre of the structure of the model and the second circle indicate that there is a strong relationship between these two areas which are divided by the dotted line.

• There are also dotted lines between the second circle and the health services, which include the crisis centre, community clinics and casualty department. Again, this is an indication of the strong relationship between these two areas.

• There are no definite lines indicated between the health services, community and legal ethical framework. This indicates that all of these are influenced by each other and cannot be separated.

6.6 GUIDELINES FOR OPERATIONALISATION OF THE MODEL

The emancipation of the nurse working with gender-based violence will be a positive process that promotes freedom of choice; therefore, staff development programmes should be incorporated. With the incorporation of these programmes, nurses working with gender-based violence will have the opportunity for development and will acquire the necessary skills and knowledge to work confidently with survivors and perpetrators.

Emancipation of nurses working with gender-based violence will lead to freedom from oppression. This will take place within the empowered self of the nurse in an enabling environment. Emancipated nurses make decisions that they are satisfied with, enabled by their empowered self that consists of four concepts, namely, competence, personal knowledge, reflection and awareness of social norms. The empowered self of the nurse will function within an enabling environment where nurses have formal and informal power with access to information, support, resources and flexibility. Self-empowered nurses in the context of working with gender-based violence will be psychologically empowered. An enabling environment is structurally empowered and flexible.
Kanter’s Structural Theory (Laschinger et al., 2003:2; Lethbridge et al., 2011:637) also refers to these concepts and states that, if employees have access to information, support and resources, they will be emancipated. In this study, flexibility, which is a sub-concept of the Wittman-Price Theory of Emancipated Decision-Making (Wittmann-Price, 2006:377), is brought in to form part of Kanter’s Structural Theory (Laschinger et al, 2003:2; 2011:637). Opportunities for development cannot be described separately in the model as they form part of all three theories which will emancipate nurses working with gender-based violence.

The following guidelines are intended to provide support and direction for nurses working with gender-based violence in the crisis centre, community clinics and casualty department of the public hospital in a semi-rural area in Tshwane. The crisis centre, community clinics and casualty department will be given the recommendations and the guidelines for the implementation of the emancipatory model. These guidelines can also be implemented in other settings where nurses come into contact with gender-based violence.

The emancipatory model for nurses working with gender-based violence is based on the selected concepts and themes that were derived from the study.

6.6.1 Aim of the guidelines

The aim of the guidelines is to create an enabling environment with information, support, resources and flexibility, where nurses working with gender-based violence are challenged to reflect on themselves through their competence and personal knowledge, and to be aware of social norms. Through this, they will be empowered and will become emancipated nurses. Emancipation of the nurse is the final concept and the outcome of the emancipatory process. Emancipation is about helping nurses working with gender-based violence to free themselves from oppression and from things they take for granted in their everyday lives.
6.6.2 Objective 1: Educational programmes

Educational programmes should be incorporated and compiled where nurses working with gender-based violence can learn adequate skills to work with survivors and perpetrators and where they can be taught how to respond to the unique needs of survivors.

6.6.2.1 Activity

- The learning environment is crucial. There should be optimal learning facilities for nurses working with gender-based violence where the action is part of the real world.
- The environment must be conducive to learning as well as professional development.
- Management will have to provide a clinical setting that should be planned and coordinated as necessary.
- The 10-day course to provide a learning opportunity that is currently available for nurses to attend must be expanded. It should form part of the curriculum and be incorporated in the basic training for nurses.

6.6.2.2 Outcome

- The environment that surrounds nurses working with gender-based violence should support and influence enablement and will therefore enhance emancipation.
- The environment will have an impact not only on the skills of nurses working with gender-based violence, but also on their cognitive processes, values and attitudes.

6.6.3 Objective 2: Debriefing sessions

Nurses working with gender-based violence experience blurred boundaries and a need to talk about their experiences was identified. Therefore, management and psychologists should hold debriefing sessions with nurses working with gender-based where they can express their feelings.
6.6.3.1 Activity

- The services of a psychologist must be implemented to help nurses working with gender-based violence to acquire the necessary skills to understand themselves and to help them acknowledge why they experience certain emotions when they work with survivors and perpetrators. Once they understand themselves, they will be able to act and work with more confidence.
- Counselling sessions through a psychologist should be available to nurses when they need it.

6.6.3.2 Outcome

- If nurses can talk about their feelings and how they feel when they work with gender-based violence, they will be able to reflect on their behaviour. The outcome will be emancipated nurses who can acknowledge their feelings and who will learn how to cope with them.

6.6.4 Objective 3: Workshops and training sessions

Practical workshops should be held where nurses can gain practical experience of how to fill in the necessary forms that they use in practice.

6.6.4.1 Activity

- In these workshops and training sessions, nurses need to do roleplay, especially sessions where they can simulate situations that happen to them in court. They need to learn how to gain confidence to stand up in court and where they have to represent cases in connection with survivors and perpetrators of gender-based violence.
- Nurses should be taught the necessary skills to counsel survivors as a psychologist is not always available.
- Sessions must be held with nurses where an experienced educator can help them to understand the process of reflection and how they can make it applicable to themselves.
• Workshops have to be held with human resource management where nurses can be made aware of different cultures, the diversity of cultures and how different cultures respond in different situations. In these workshops, the nurses have to be made aware of social norms and be given tools to deal with these norms so that they can understand different cultures and be non-judgemental towards survivors.

• Lawyers and the police have to be involved with the training of these nurses to make them aware of procedures in court and to provide them with skills regarding what is expected of them when they attend court cases.

• Formal training should be given on the Acts and policies that they deal with so that nurses working with gender-based violence can understand the importance of these Acts and policies as well as how to interpret them.

6.6.4.2 Outcome

• The outcome will be competent nurses who will function with competency and personal knowledge, and will be aware of social norms.

• These competent nurses will know how to fill in forms and will have the necessary knowledge to stand up in court.

• Nurses working with gender-based violence will not be judgemental towards survivors as they will have the necessary knowledge to know how to deal with it.

6.6.5 Objective 4: Support

Nurses working with gender-based violence need support from management and their colleagues.

6.6.5.1 Activity

• Support must be provided to the nurses from the hospital’s management. Regular guidance and advice should also be provided.

• The necessary equipment should be supplied to nurses working with gender-based violence so that they can achieve their organisational goals.

• Management should provide the necessary information to the nurses.
6.6.5.2 Outcome

- If nurses working with gender-based violence know that management are there to support them, they will gain confidence to call management if they experience problems or uncertainties.
- The nurses will have the necessary equipment to care for survivors and will be able to deal with perpetrators.
- The nurses will have the necessary information to provide good care and will have the skills to know how to support survivors of gender-based violence.

The guidelines were developed to provide information and guidance for nurses working with gender-based violence. The recommendation for the guidelines is that management should consider implementing the guidelines according to their individual needs. Management should ensure a positive learning environment. Colleagues and support groups should be identified for implementation of the guidelines. Management should also bear in mind that implementation of the guidelines is an ongoing process and the emancipatory model should be taught by unit managers to their staff to help emancipate them when working with gender-based violence.

With the above guidelines in place, the outcome will be that nurses working with gender-based violence will be emancipated. They will have satisfaction, resilience and an improved execution of their work, enhancing health outcomes for survivors of gender-based violence.
6.7 EVALUATION OF THE MODEL

The study was conducted under the supervision of two experts in model construction and qualitative research. After finalising the model, it was presented to experts with doctoral degrees in nursing science and extensive experience in qualitative research and theory generation, and PhD students. This was to make the evaluation of the model meaningful and comprehensive. The evaluation document (see Annexure J) was used for feedback. The model was also evaluated according to the criteria for theory generation as described by Chinn and Kramer (2011:196-205), to answer the following questions:

- How clear is the model?
- How simple is the model?
- How general is the model?
- How accessible is the model?
- How important is the model?

6.7.1 Clarity of the model

Clarity refers to how well the theory can be understood and shows how consistently the ideas are conceptualised (Chinn & Kramer, 2011:198). The concepts used to construct and described the model for ‘The emancipatory model for nurses working with gender-based violence’ were derived from themes that emerged from focus groups and individual interviews that were conducted.

The evaluators stated that the meanings of the model were clear. The evaluators confirmed the model’s semantic consistency and stated that the model was simple, clear and self-explanatory, and that the concepts consistently provided a structural map. One of the evaluators said that the model was easy to follow and simplistically beautiful, and that the concepts and their relationships were understood and clear.

6.7.2 Simplicity of the model

Simplicity means that the number of elements in the model should be minimal (Chinn & Kramer, 2011:201).
The majority of evaluators stated that the number of elements was minimal, that the relationships were simple and that the relational components were appropriately limited. One of the evaluators said that the elements were not minimal, but she thought they were all essential and important, that the description provided made things clear and that the colours bound the concepts very well together to clarify the relationships. Another evaluator said that the minimalistic nature of the model was of great value and said that it was visually a great replication of the structure and process of the model development, as well as that the visual replication was easy to understand.

6.7.3 Generality of the model

Generality refers to the model's breadth of scope and purpose to be applied to a broad array of situations (Chinn & Kramer, 2011:202).

The evaluators were of the opinion that the model could be applied to anyone working with gender-based violence, that it could be useful throughout the management of both survivors and perpetrators, and that it should be applied continuously.

The evaluators were also of the opinion that the model could be applied to general and specific specialities and in different situations. They said that the model was not limited to certain situation because of the fact that gender-based violence can occur in different situations at any given time. One of the evaluators said that the model was open to be used in a wide range of contexts and that the model showed potential to be adapted, tested and possibly be developed for greater application.

6.7.4 Accessibility of the model

Accessibility describes how accessible the model is, to what extent the empiric indicators can be identified for the concepts described, as well as to what extent the purpose of the model can be attained (Chinn & Kramer, 2011:203).
The evaluators stated that the purpose of the model could be attained. One of the evaluators said that the model was aligned to the desired purpose and fitting for the research goals, and that the concepts were grounded in empirically identifiable phenomena.

6.7.5 Importance of the model

In describing the importance of the model, its clinical significance and practical values are described with reference to nurses working with gender-based violence (Chinn & Kramer, 2011:205).

The evaluators stated that it is important for nurses to understand that working with the context of gender-based violence is important, as they are the first line of entry to assist survivors of gender-based violence and to have knowledge about it. One of the evaluators stated that she thought that she had experienced most of the aspects of this model through the years in her career as essential for emancipation. On the question ‘Does the model create understanding that is important for nursing?’, one of the evaluators said: “Yes, it does, an emancipated nurse is crucial given the context we are residing in, where violence has become the norm of the day.”

The evaluators stated that the model had practical value and that student nurses and nurses could be taught about this model in order to be aware of social norms, have personal knowledge and be competent in dealing with survivors and perpetrators of violence. The evaluators stated that the model was of significant importance for nursing research and one of the evaluators suggested that more research could be done to see how this model can be added to the curriculum.

The evaluators agreed that the model could be very valuable for nursing education if applied correctly and that student nurses and nurses could be taught about this model in order to be aware of social norms, have personal knowledge, and be competent in dealing with survivors and perpetrators of violence. One of the evaluators stated that inter-professional education could be encouraged in order to cultivate collaborative practice for providing victims, survivors and perpetrators with holistic care. Another evaluator said that the model could be included in curricula of nursing education programmes to provide an enabling environment of acquiring knowledge, skills and a way to move forward to the outcome of emancipated nurses.
Another evaluator said that the beauty of the model lay in its ability to be practically applied in multiple situations and to contribute to a positive change in the caring experiences of professional nurses. This evaluator also said that it was of great importance that the current model must be further tested, refined and adjusted to use in practice. The evaluator also said that the self-empowerment of the professional nurse to care in a rather difficult caring context would add greatly to the practical experiences of engagement, as well as greater patient outcomes and satisfaction.

6.8 SUMMARY

This chapter dealt with the construction of an emancipatory model to emancipate nurses working with gender-based violence. Guidelines for the operationalisation of the emancipatory model were described. In the next chapter, an overview of the study, the conclusions drawn from the study, the recommendations for nurses working with gender-based violence, as well as the limitations of the study are described.
7.1 INTRODUCTION

In the previous chapter, the researcher dealt with the structure and the description of a model to emancipate nurses working with gender-based violence. Guidelines for the operation of the model were also discussed.

In this chapter, the limitations, recommendations and conclusions derived from the findings of this study on the experiences of nurses working with gender-based violence are discussed. The conclusions, which are based on the purpose, research questions and findings of the study, are presented first. Next, the limitations of the research are highlighted. The chapter concludes with recommendations on the utilisation of the emancipatory model in the crisis centre, community clinics and casualty department at the public hospital in a semi-rural area in Tshwane.

7.2 OVERVIEW OF THE STUDY

The purpose of the study was to construct an emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane and to develop guidelines for implementation of the model. The objectives of the study were:

1) To explore and describe experiences of nurses working with gender-based violence in a semi-rural area in Tshwane.

2) To construct an emancipatory model for nurses working with gender-based violence.

3) To develop guidelines for the operationalisation of the emancipatory model for nurses working with gender-based violence.

4) To evaluate the model for nurses working with gender-based violence and revise it if indicated.
This study followed a qualitative approach with a descriptive, explorative, contextual design (Babbie & Mouton, 2001:272; Burns & Grove, 2009:25; Polit & Beck, 2012:727; Struwig & Stead, 2001:12). The study was conducted in a semi-rural area in Tshwane and included the crisis centre and casualty department of the public hospital, as well as the surrounding community clinics. The focus groups and the joint interview were held at the student learning centre at the public hospital, while the individual interviews were held at the crisis centre of the public hospital.

The participants were enrolled and registered nurses who had been working with gender-based violence for at least six months. The researcher made use of a skilled facilitator who was trained in qualitative methods to help guide the focus groups so that maximum information could be gained from the participants. Open-ended questions, followed by probing questions, were used during the focus groups, joint interview and individual interviews. Data analysis was done after the data had been collected. The data were interpreted and conclusions were drawn which reflected the experiences of nurses working with gender-based violence (Babbbie, 2010:117).

Tesch’s coding guidelines (as described in Creswell, 2009:186-190) were used in the study. The data were prepared for analysis by the verbatim transcription of the audio and video recordings of the focus groups, joint interview and individual interviews. The researcher as well as two independent coders analysed the data and reached consensus about the categories and sub-categories identified in the data (Creswell, 2009:191). A literature control was done after the findings of the study were described, in order to make comparisons with existing findings in the literature (Creswell, 2009:27-28). Trustworthiness of the data was assured and ethical considerations were respected (Lincoln & Guba, 1985: 301-331).

The research questions were based on the five sub-concepts of the Wittmann-Price Theory of Emancipated Decision-Making, and the focus groups, joint interview and individual interviews were started off with an open question, namely: What are your experiences of nurses working with gender-based violence?
Two themes emerged from the data. Three categories emerged from the first theme and three from the second theme. The findings were discussed according to the two themes that emerged from the data, namely:

**Theme one:** Experiences related to the self of the nurse when working with gender-based violence.

**Theme two:** Experiences related to the environment of the nurse when working with gender-based violence.

The recommendations described are based on the experiences of nurses working with gender-based violence. This study acknowledges and confirms that nurses working with gender-based violence need to be emancipated.

### 7.3 LIMITATIONS

The findings in this study should be interpreted with certain limitations kept in mind.

The interview schedule (see Annexure G) was guided by the five sub-categories of the Wittmann-Price Theory of Emancipated Decision-Making, namely, **empowerment, flexible environment, personal knowledge, reflection and awareness of social norms** (Wittmann-Price, 2004:442). Spreitzer’s Psychological Empowerment Theory (Spreitzer, 1996:484) and Kanter’s Structural Empowerment Theory (Lethbridge et al., 2011:637) were included after the interviews to broaden the theoretical basis of the study. It is possible that, if all three theories had been included in the interview guide, richer data could have been obtained.

### 7.4 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made. The major recommendations from the study include *experiences related to the self of the nurse when working with gender-based violence* and *nurses’ needs for an enabling environment when working with gender-based violence.*
7.4.1 Experiences related to the self of the nurse when working with gender-based violence

Recommendations related to the personal empowerment of nurses, nurses’ knowledge and awareness of their personal feelings and experiences, and the influence of social norms on nurses’ practices and perceptions when working with gender-based violence are discussed below.

7.4.1.1 Competencies required for empowerment of nurses working with gender-based violence

- Staff development programmes should be integrated to help nurses working with gender-based violence with knowledge in decision-making and to promote an organisational climate of emancipation of these nurses.

- As nurses working with gender-based violence are often the first persons to encounter survivors of gender-based violence, they have to be taught and trained to treat survivors properly. These nurses need to be taught adequate skills to know how to respond to the unique needs of survivors of gender-based violence.

- Nurses working with gender-based violence need to be taught how to do assessment and examination of survivors and how to do physical and psychological interventions, and must have legal and ethical knowledge on how to deal with survivors of gender-based violence.

- Nurses working with gender-based violence frequently have to work with children who have been subjected to gender-based violence; therefore, they have to be knowledgeable about identifying, reporting and documenting suspected child abuse.

- Nurses working with gender-based violence need to be taught how to deal with perpetrators of gender-based violence.

- Sometimes, nurses working with gender-based violence experience difficulty in separating their personal life from their professional life. They need to be taught skills to handle these situations.
7.4.1.2 Nurses’ knowledge about and awareness of their personal feelings and experiences as a result of reflection

- In relating their experiences about working with gender-based violence in the focus groups, nurses told stories about their own personal lives and experiences, and related their emotional distress when working with survivors of gender-based violence. After these groups, they described the focus groups as the first time ever that somebody listened to them and tried to understand what they went through. The recommendation is that more debriefing sessions be held with nurses working with gender-based violence so that they can reflect on their emotions, especially after a traumatic case.

- Nurses working with gender-based violence experience emotions such as sadness, trauma, fear, compassion, powerless feelings, and anger or ambivalence. Nurses working with gender-based violence need to acknowledge these emotions and need to be taught reflecting skills so that they can cope with these emotions.

7.4.1.3 The influence of social norms on nurses’ practices and perceptions working with gender-based violence

- Nurses working with gender-based violence deal with different cultures and need to be aware that cultural norms let survivors and perpetrators behave in certain ways. They need to be taught about the different cultures in the areas where they work.

- Nurses working with gender-based violence need to be taught social skills in the areas where they work so that they can be careful not to be judgemental and biased towards a survivor, especially when they think that the survivor brought the abuse upon herself. Even if it is difficult, nurses working with gender-based violence also need to be taught not to be judgemental towards perpetrators, especially when there is inter-partner violence and the survivor is brought in by the perpetrator.
7.4.2 Nurses’ needs for an enabling environment when working with gender-based violence

Recommendations related to the needs of nurses working with gender-based violence for enhanced access to information, support and resources, and enhanced learning opportunities are discussed below.

7.4.2.1 A need for enhanced access to information in the environment

- An enabling environment is necessary for nurses working with gender-based violence where they have to identify and acknowledge abuse towards women and children.

- Nurses working with gender-based violence need to be given information on how to identify abuse and how to treat and counsel women and children who have been subjected to gender-based violence.

- Nurses working with gender-based violence need information on how to understand the cycle of violence and how to help end it.

7.4.2.2 A need for support and resources in the environment

- Nurse management should provide support to nurses working with gender-based violence.

- Counselling and debriefing guidelines should be developed and implemented.

- Psychological and emotional support should be an integral part of support for nurses working with gender-based violence in the form of the availability of a psychologist for debriefing and counselling when the need arises.

- The quality of care towards survivors of gender-based violence will improve if nurses undergo training in how to deal with gender-based violence to enhance the understanding of working with women and children who have been subjected to gender-based violence, and to promote the effective management of survivors and perpetrators of gender-based violence.
• All nurses working with gender-based violence should receive ongoing in-service training to help them with coping skills.

• Nurses working with gender-based violence require training from lawyers and the legal department to help them understand the legislation that they deal with and to help nurses to be confident when they attend court cases.

• This model could be considered by the educational and clinical department of the hospital and the community clinics to teach nurses working with gender-based violence how to emancipate themselves.

7.4.2.3 A need for flexibility in the environment

• Nurse management should provide a flexible environment that is non-judgemental and that will support freedom of choice.

• The environment should be responsive to change that can lead to personal benefits for nurses working with gender-based violence. It should increase choices and enhance self-esteem and understanding.

• The flexibility of the environment should be internal as well as external; it will be intertwined with sources of power, obvious and obscure, so that it can be used for positive and emancipating outcomes.

7.5 SIGNIFICANCE OF THIS RESEARCH CONTRIBUTION

The significance of the study was based on the originality of the contribution and the ability to address a relevant area for nurses which has not been addressed before. With this study, the researcher wants to make a difference in the lives of nurses working with gender-based violence.

The researcher strived with this research study:

• To contribute to new knowledge. Unit managers will have a better knowledge of how nurses experience working with gender-based violence.
• To make the study applicable for future research and education.
7.6 CONCLUSION

Conclusions of the study were described according to what was found and developed in the whole study. The research objectives have been achieved. The experiences of nurses working with gender-based violence have been explored and it has been shown that nurses need to be emancipated when working with survivors and perpetrators of gender-based violence.

It is hoped that this study will contribute to the understanding of experiences of nurses working with gender-based violence and that its findings and recommendations can serve as a basis for future research in this field.
REFERENCES


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ANNEXURE A: MEDUNSA RESEARCH & ETHICS COMMITTEE CLEARANCE CERTIFICATE

UNIVERSITY OF LIMPOPO
Medunsa Campus

MEDUNSA RESEARCH & ETHICS COMMITTEE
CLEARANCE CERTIFICATE

MEETING: 08/2010
PROJECT NUMBER: MREC/H/195/2010: PG

PROJECT:
Title: The construction of an emancipatory model for nurses working with gender-based violence in

Researcher: Mrs EM Joubert
Supervisor: Prof EJ van Aswegen
Co-supervisor: Ms Y Havenga
Department: Nursing Science
School: Health Care Sciences
Degree: PhD (Nursing Science)

DECISION OF THE COMMITTEE:
MREC approved the project.

DATE: 05 October 2010

PROF SAKOGBUNABO
CHAIRPERSON MREC

Note:

i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.

ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

African Excellence – Global Leadership
ANNEXURE B: TSHWANE METSWEDING REGION RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

Meeting: 02/2011
PROJECT NUMBER: TMREC 2011/03
PROJECT:
Title: A MODEL FOR NURSES WORKING WITH GENDER-BASED VIOLENCE IN...
Researcher: E.M. Jonker
Supervisor: Prof Ed van Aswegen
Co-Supervisor: Ms Y. Havenga
Department: Nursing Science (MEDU/NSA)
Degree: PhD

DECISION OF THE COMMITTEE
Approved
Date: 16th February 2011

Chairperson Tshwane Metswedging Research Ethics Committee
Tshwane Metswedging Region

Director: District Health Services Support
Tshwane Metswedging Region

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedure as approved by the committee.
ALL CORRESPONDANCE TO INCLUDE PROTOCOL NUMBER

The Fields Building, 427 Hilda Street, Hatfield, 0028, Pretoria

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ANNEXURE C: PERMISSION FROM CEO OF PUBLIC HOSPITAL

Declaration of intent from the clinic manager or hospital CEO

I give preliminary permission to [Name of researcher] to do his or her research on [Research topic] in [Name of clinic or hospital].

[Name of clinic or hospital]

I know that the final approval will be from the [Hospital Name] Research Ethics Committee and that this is only to indicate that the clinic/hospital is willing to assist.

Other comments or conditions prescribed by the clinic or CHC manager or hospital CEO:

[Signature]
Clinic Manager/CHC Manager/CEO

[Date]
7010 - 11 - 23
ANNEXURE D: LETTER TO CHAIRPERSON OF THE RESEARCH ASSESSMENT COMMITTEE

P.O. Box 53009
Wierdapark
0149
20 October 2010

Chairperson of the research assessment committee

Re: Conducting a research study in

I hereby request to conduct a research study at Hospital and in the community of . I'm a PhD student at the University of Limpopo (Medunsa Campus).

My research topic is to construct a model for nurses working with gender-based violence in .

The Medunsa Research & Ethics Committee approved the project.

Project number: MREC/H/195/2010: PG

Yours faithfully

[Signature]

E.M. Joubert
Student number: 201015312
Mobile: 082 564 4493
E-mail address: elsabe@iconnection.co.za
Mrs M.E. Manne

Re: Conducting a research study in [removed]

I hereby request to conduct a research study at the Community Clinics in [removed]. The clinics that will be involved will be [removed] Clinic; [removed] Clinic; [removed] Clinic and [removed] Clinic. I’m a PhD student at the University of Limpopo (Medunsa Campus).

My research topic is to construct a model for nurses working with gender-based violence in [removed].

The Medunsa Research & Ethics Committee approved the project.

Project number: MREC/H/195/2010: PG

The approved the project.

Project number:

Yours faithfully

E.M. Joubert
Student number: 201015312
Mobile: 082 564 4493
E-mail address: elsabe@iconnection.co.za
Dear Colleague

THE CONSTRUCTION OF A MODEL FOR NURSES WORKING WITH GENDER-BASED VIOLENCE IN [REMOVED]

I am a PhD student at the Department of Nursing Science at the University of Limpopo (Medunsa Campus). You are hereby invited to participate in my research study. The purpose of this study is to construct a model for nurses working with gender-based violence in [REMOVED].

This letter is to help you to decide if you would like to participate. Before you agree to participate in this study you should fully understand the magnitude of this research study. If you are not completely satisfied of what is expected from you, you may agree not to take part in this study.

Based on your experiences as a nurse practitioner working with victims of gender-based violence, participation can be as follow:

By invitation to attend a workshop and a focus group which will be held at the University of Limpopo (Medunsa campus). The workshop will equip you with interviewing and communication skills. During the afternoon a focus group will be held with 6 to 8 people. The focus group will be recorded by means of a video and an audio-recording and notes will also be taken. An assistant facilitator will help with the focus group. The duration of the focus group will be between 1 to 2 hours.

or

You will be interviewed by me during a time that suits you in your work environment. There are no right or wrong answers, but you are requested to be as honest as possible. The interview will be for about 45 minutes, limited to an hour and will be conducted in a private room. The interview will be recorded by means of an audio-recording and notes will also be taken.

The study protocol was submitted to the Medunsa Research Ethics Committee of the University of Limpopo (Medunsa Campus). The committee has granted written approval.

Your participation in this study is voluntary and you can refuse to participate or stop at any time without stating any reason. Your withdrawal will involve no penalty or loss of benefits.
The benefit to you will be the enhancement of your interviewing and communication skills through the workshop and as well have the opportunity to share your experiences with colleagues. No harm is foreseen, however if you require further assistance you will be referred to a psychologist.

Data will be reported in a Thesis, scientific journals and conferences. These reports will not include any information that identifies you as a participant in this study, as all information or data is anonymous. All information during the course of this study is strictly confidential.

If you have any questions during this study, please do not hesitate to approach me.

I sincerely appreciate your help.

Yours truly,

E.M. Joubert

Mobile: 082 564 4493
Work: 011 777 2246

**Statement by the Researcher**

I provided written information regarding this Study.

I agree to answer any future questions concerning the Study as best as I am able.

I will adhere to the approved protocol.

…………………………
…………………………
…………………………
…………………………

Name of Researcher Signature Date Place
ANNEXURE G: INTERVIEW SCHEDULE FOR NURSES WORKING WITH GENDER-BASED VIOLENCE

Interview Schedule for nurses

A. BIOGRAPHICAL DATA

Please tick the appropriate block.

<table>
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<th>Professional qualifications</th>
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<td>Enrolled Nurse</td>
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<td>General Nursing</td>
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<td>Community Nurse</td>
<td></td>
</tr>
<tr>
<td>Forensic Nursing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post-Basic Clinical Qualification</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Theatre</td>
<td></td>
</tr>
<tr>
<td>Intensive Care</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

B. WORK-RELATED EXPERIENCES

1. Number of years working in the crisis clinic, casualty department or community clinic with survivors of gender-based violence.

_____ years

2. List forensic specific education that you have.

___________________________________________________________________

___________________________________________________________________
3. In which area are you currently working? For example: Casualty Department.

________________________________________________________________________

4. In which areas have you been working before? List all the relevant areas.

________________________________________________________________________

C. INTERVIEW SCHEDULE FOCUS GROUPS AND INDIVIDUAL INTERVIEWS

EXPERIENCE AS A NURSE WORKING WITH GENDER RELATED VIOLENCE

1. Open ended explorative question

What are your experiences as a nurse working with gender-based violence?

Various probes will be used in order to explore the responses to the above question, e.g.

- “You spoke about…please tell me more about that”.
- “I wonder what you mean by …?”

2. Questions exploring the Wittmann-Price subconcepts

2.1 Empowerment

2.1.1 What knowledge and skills do you think need to work with gender-based violence in your hospital/community?

2.1.2 To what extent do you think you have these knowledge and skills?

Probing questions

- How does this affect your experiences?

2.1.3 What resources do you need when dealing with gender related violence?

Probing questions

2.1.3.1 Which of these do you have in place?

2.1.3.2 Which of this need to be put in place?

2.1.3.3 Who is responsible for making these resources available?
2.2 Flexible Environment

2.2.1 Tell me about how you as a nurse make decisions when working with survivors of gender-based violence.

Probing questions

- How are decisions taken in the crisis clinic, casualty department or community clinic?
- What do you base your clinical decisions on?
- What happens when other members of the inter-disciplinary team differ from you?
- How are you included in decision-making by the manager / management of the service?
- Why do you think this is the case?

2.2.2 How did you come to work with gender-based violence?

Probing question

- Did you have a choice to work in this environment? Please explain

2.3 Personal knowledge

What are your personal norms related to being a women and a nurse?

2.3.1 Describe your thoughts and feelings related to gender-based violence.

Probing questions

- Thoughts and feelings towards survivors of gender-based violence.
- Thoughts and feelings related to perpetrators of gender-based violence.

2.3.2 How does your own life-story influence your experience of working with gender-based violence?

2.3.3 How do you cope with working with survivors of gender-based violence?

2.3.4 What challenges you personally when working with gender-based violence?

2.3.5 What strengths do you have that assists you to cope with your work?
2.3.6 How does working with gender-based violence influence your other relationships?

2.4 Reflection

2.4.1 After dealing with survivors and perpetrators of gender-based violence, (e.g. after day’s work) what do you do with the experiences of that day / encounter?

2.4.2 Looking back at how you deal with gender-based violence, what would you want to changed or do differently?

2.4.3 If you could give advice to other nurses who work with gender-based violence, what would you tell them?

2.5 Social Norms

2.5.1 What are the norms of the community you work in related to the role of women and nurses?

2.5.2 What are the norms of the institution you work for related to the role of women and nurses?

2.5.3 How do these norms influence the decisions you make as a nurse working with gender-based violence?

Probing question

- Why do you think that is the case?
TO: Prof E. van Aswegen
HOD: Department Nursing Sciences

FROM: Prof L. Hay
Chairperson: HDC

DATE: 02 September 2016

SUBJECT: PhD (Nursing Sciences) – E.M. Joubert: 201015312

PGC at their meeting held on Thursday, 18 August 2016 APPROVED the title “An emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane”.

Yours sincerely,

[Signature]
Prof L. Hay
Chairperson: PGC

Cc: Ms A.S. Malope
Ms S. Mogale
ANNEXURE I: EVALUATION OF THE EMANCIPATORY MODEL FOR NURSES WORKING WITH GENDER-BASED VIOLENCE

EVALUATION OF THE EMANCIPATORY MODEL FOR NURSES WORKING WITH GENDER-BASED VIOLENCE

Please evaluate this model according to the following criteria set out below.

<table>
<thead>
<tr>
<th>CLARITY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semantic clarity</td>
<td>How clear are the meanings in this model?</td>
</tr>
<tr>
<td>Semantic consistency</td>
<td>How consistent is the purpose of the model, in relation to the other components of the model?</td>
</tr>
<tr>
<td>Structural clarity</td>
<td>How self-explanatory is the diagram representing the model?</td>
</tr>
<tr>
<td>Structural consistency</td>
<td>Do the concepts consistently provide a structural map?</td>
</tr>
<tr>
<td>SIMPLICITY</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Simplicity of structural components</td>
<td>Is the number of elements and concepts minimal?</td>
</tr>
<tr>
<td>Simplicity of relationships within the model</td>
<td>Are the relational components limited appropriately?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERALITY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope of experiences in the model</td>
<td>To whom/what does the model apply?</td>
</tr>
<tr>
<td>When does it apply?</td>
<td></td>
</tr>
<tr>
<td>Does the purpose apply to general or specific specialities?</td>
<td></td>
</tr>
<tr>
<td>Width of scope</td>
<td>Can the model be applied to different situations?</td>
</tr>
<tr>
<td><strong>Range of the scope of the phenomenon</strong></td>
<td>Can the model only be applied to limited situations? Please explain.</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**ACCESSIBILITY**

<table>
<thead>
<tr>
<th>Concepts grounded in empirically identified phenomena</th>
<th>Can the purpose of the model be attained?</th>
</tr>
</thead>
</table>

**IMPORTANCE**

<table>
<thead>
<tr>
<th>Importance for nursing practice</th>
<th>Please explain what you as a nurse think about this model?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the model create understanding that is important for nursing?</td>
</tr>
<tr>
<td></td>
<td>Does this model have practical value? If yes in what way?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research</th>
<th>How important is the model in nursing research?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>How important is the model for nursing education?</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Does the model add value to nursing education?</td>
</tr>
<tr>
<td></td>
<td>Does the model add practical value to research in nursing?</td>
</tr>
</tbody>
</table>
ANNEXURE J: LETTER FROM LANGUAGE EDITOR

I, SE Louw, hereby declare that the dissertation by E.M. Joubert titled *An emancipatory model for nurses working with gender-based violence in a semi-rural area in Tshwane*, with the exception of verbatim quotes, has been professionally language edited by me.

For any further information, my contact details may be obtained through Mrs Joubert.

*SE Louw*  
Susanna Elizabeth Louw  
2017-01-09  
Date