HEALTH CARE FOR INTIMATE PARTNER VIOLENCE:

CURRENT STANDARD OF CARE AND DEVELOPMENT OF PROTOCOL MANAGEMENT

by

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Declaration

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

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Signature

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Name in full

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Date

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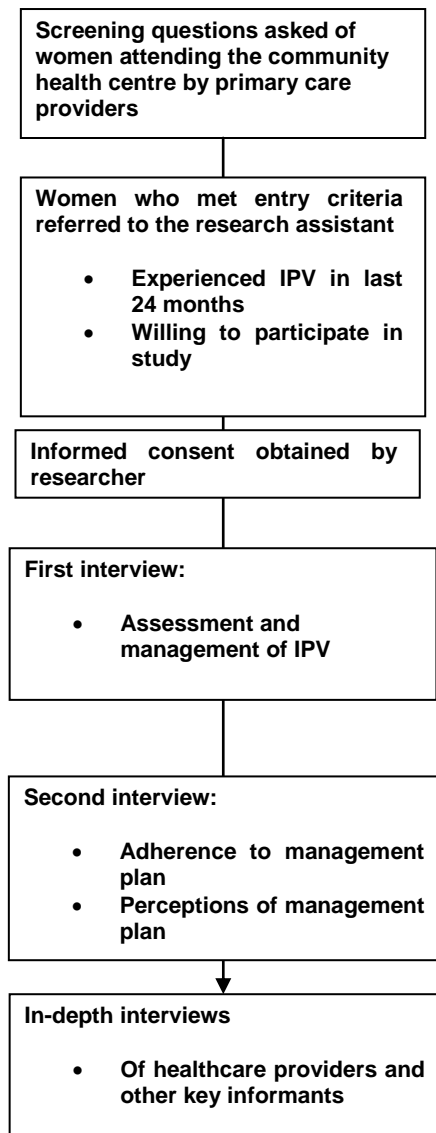
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ABSTRACT

The World Health Organisation recognises intimate partner violence (IPV) to be of major consequence to women's mental and physical health, yet in South Africa it remains a neglected area of care. Within a professional action research framework, this study implemented a previously recommended South African protocol for the screening and holistic management of IPV in women in order to test its feasibility and to adapt it for use in the primary health care (PHC) sector of the Western Cape. It also aimed to identify the current nature of care offered to female survivors of IPV. Thirdly, it aimed to learn from the process of training and supporting (nurse) researchers who were new to the action research paradigm and methodology.

Successfully implementing and evaluating a complex health intervention in the current PHC scenario required a flexible methodology which could enable real engagement with, and a creative response to, the issues as they emerged. Guided by the British Medical Research Council's framework for development and evaluation of randomised controlled trials for complex health interventions (Medical Research Council, 2000, p.3), this study was positioned within the modelling phase. Professional action research used a co-operative inquiry group process as the overarching method with the usual cycles of action, observation, reflection and planning. Altogether five co-researchers were involved in implementing the protocol and were members of the inquiry group. A number of techniques were used to observe and reflect on experience, including participant interviews, key informant interviews, focus groups with health care providers at each site, quantitative data from the medical records and protocol, field notes and academic literature. The research design worked as follows:

```
┌─────────────────────────────────┐
│ Screening questions asked of    │
│ women attending the community   │
│ health centre by primary care   │
│ providers                       │
└─────────────────────────────────┘
              │
┌─────────────────────────────────┐
│ Women who met entry criteria    │
│ referred to the research assistant │
│                                 │
│   • Experienced IPV in last     │
│     24 months                   │
│   • Willing to participate in   │
│     study                       │
└─────────────────────────────────┘
              │
┌─────────────────────────────────┐
│ Informed consent obtained by    │
│ researcher                      │
└─────────────────────────────────┘
              │
┌─────────────────────────────────┐
│ First interview:                │
│                                 │
│   • Assessment and              │
│     management of IPV           │
└─────────────────────────────────┘
              │
┌─────────────────────────────────┐
│ Second interview:               │
│                                 │
│   • Adherence to management     │
│     plan                        │
│   • Perceptions of management   │
│     plan                        │
└─────────────────────────────────┘
              │
┌─────────────────────────────────┐
│ In-depth interviews             │
│                                 │
│   • Of healthcare providers and │
│     other key informants        │
└─────────────────────────────────┘
```

At two urban and three rural community health centres, 168 women were provided with an IPV intervention, and 75% returned for follow up a month later. Over the previous 24 months, prior to the intervention above, only 9.6% of the sample had been identified as IPV, although this did not guarantee effective assistance. The reasons for encounter (RFE) and diagnoses provided during these 24 months suggested cues that could be used to better recognise IPV. For example cough, which is usually the commonest RFE in primary care, was preceded by headache, psychiatric medication, sleep disturbance and dizziness. These are all cues for mental difficulties and clearly suggest that IPV should be asked about whenever a mental problem is likely. Fatigue, anxiety, depression and other psychological symptoms also occurred in the top twenty RFEs, strengthening the case.

Of the 9.6% who had been identified, scanty documentation in their medical records revealed inadequate management mostly in the form of referral. Seventy percent had been referred to

the inundated social workers, and 30% for psychological care that is in equally short supply. Only 30% had been referred to the NPO sector which offers assistance with obtaining a Protection Order, counselling, legal advice and shelters.

Better fitting the chronic illness framework, IPV is not a 'quick-fix' problem. The bio-psycho-social-forensic intervention took 60 – 90 minutes per client, which is too long for a PHC system aiming for an average of seven minutes per consultation. Clinics were under-staffed, referral pathways were under-resourced and morale amongst personnel was low. Health care providers were generally uncooperative about asking one screening question of all female patients over 18, making recruitment difficult. Intervention was experienced as extremely beneficial by 63% of participants and as helpful by an additional 13%, amounting to 76% overall who thus found it beneficial. At all stages women wanted recognition and ongoing support from health care providers, without pressure for a specific course of action. A key finding was thus the need for a person to be with the patient in a caring way (emotional labour) and not just to work through a series of tasks. The impact of the intervention was also measured by the extent to which IPV survivors had implemented intended action plans by one month later.

Currently IPV is largely unrecognised by primary care providers and in the few cases that are diagnosed the standard of care is fragmented, poorly coordinated, lacking in continuity and missing important aspects. The results of the study indicate that the levels of IPV in South African society are unacceptably high and require urgent attention from health systems regarding the roll-out of appropriate care. This study employed innovative professional action research techniques to test the feasibility of an intervention for female IPV survivors in the PHC sector and to modify it for use. A comprehensive yet practical model for IPV care is presented in Chapter Nine. A one page flowchart for the identification and management of IPV is provided which can be used by any health care provider. This links to an adaptation of current chronic care health policy for the Western Cape to suit the needs of IPV survivors. The role of communities is emphasised in the need for a comprehensive social response to IPV. Professional action research techniques developed within the project could link well with a participatory action research involvement with surrounding communities.

At a methodological level, we found firstly that in action research the reliability and validity of the study may be definitively influenced by the co-researchers ability/capacity to honestly engage with both action and reflection, and to account for each in a rigorous way.
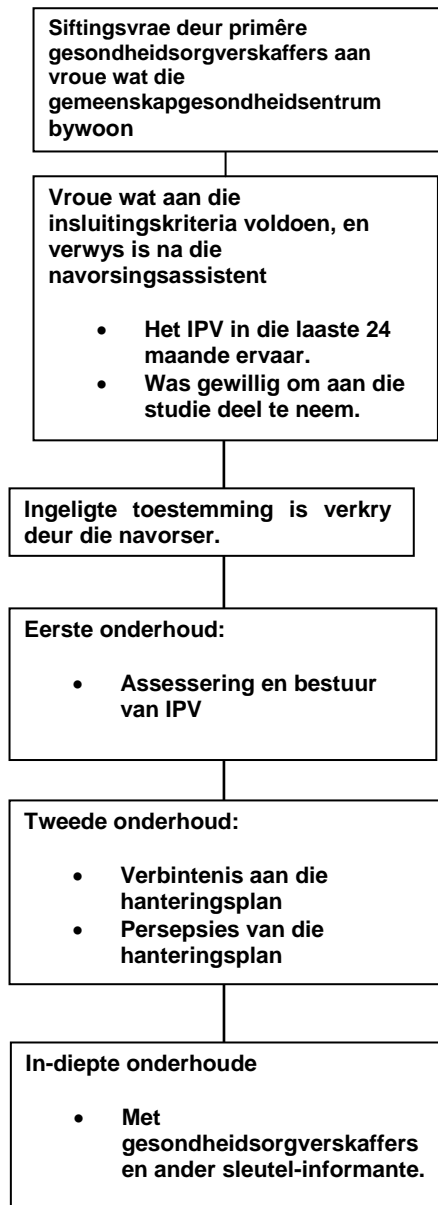
This requires a different stance from that of the stereotypical independent observer of classic science, and an openness to personal transformation which may be experienced as akin to psychotherapy or spiritual journeys. Therefore it is vital to do in-depth preparatory training to open the trainees' minds to inhabit the inquiry as autonomous equals and also to sift potential candidates.

The thesis recommends that University Ethics Committees should develop an application procedure that accommodates action research processes by focusing on the research principles to be followed while allowing flexibility for the evolution of project details in accordance with this process. Similarly, interdisciplinary doctorates could be encouraged if an interdisciplinary ethics application procedure is developed to offer an intelligent compromise between divergent faculty guidelines. Finally, core synergies between feminism, action research and complexity theory are outlined as they form the meta-methodological matrix of the work.

ABSTRAK

Die Wêreld Gesondheidsorganisasie erken dat geweldpleging in intieme verhoudings ("intimate partner violence", of IPV) 'n groot impak het op vroue se geestes- en fisiese gesondheid, terwyl dit 'n verwaarloosde area van sorg in Suid-Afrika is. Binne 'n professionele aksie-navorsingsraamwerk, implementeer hierdie studie 'n voorheen aanbevole Suid-Afrikaanse protokol vir die sifting en holistiese hantering van IPV by vroue om die uitvoerbaarheid daarvan te toets en om dit aan te pas vir gebruik in die primêre gesondheidsorgsektor (PGS) van die Wes-Kaap. Die projek poog ook om die huidige aard van sorg wat aan vroulike oorlewendes van IPV beskikbaar is, te identifiseer. Derdens het dit ook ten doel om te leer van die proses van opleiding en ondersteuning van (verpleeg-) navorsers vir wie die aksie-navorsingsparadigma en methodologie nuut was.

Suksesvolle implementering en evaluering van 'n komplekse gesondheidsintervensie in die huidige PGS scenario vereis 'n buigsame methodologie wat betrokkenheid met, en 'n kreatiewe respons tot, kwessies soos wat dit ontwikkel, moontlik maak. Gelei deur die Britse Mediese Navorsingsraad se raamwerk vir die ontwikkeling en evaluering van ewekansige gekontroleerde proewe vir komplekse gesondheidsintervensies (Mediese Navorsingsraad, 2000, bl.3), was hierdie studie binne die modelleringsfase geposisioneer. Professionele aksie-navorsing het 'n gekoördineerde ondersoekgroep as die oorkoepelende metode - met die normale siklusse van aksie, waarneming, reflektering en beplanning - gebruik. Altesaam vyf mede-navorsers wat lede van die ondersoekgroep was, was betrokke in die implementering van die protokol. 'n Aantal tegnieke is gebruik om waar te neem en te reflekteer op ervarings, insluitend deelnemersonderhoude, sleutel-informant onderhoude, fokusgroepe met gesondheidsorgverskaffers by elke fasiliteit, kwantitatiewe data van die mediese verslae en protokol, veldnotas en akademiese literatuur. Die navorsingsontwerp het as volg gewerk.

```
┌────────────────────────────────────┐
│ Siftingsvrae deur primêre          │
│ gesondheidsorgverskaffers aan      │
│ vroue wat die                      │
│ gemeenskapgesondheidsentrum        │
│ bywoon                             │
└────────────────────────────────────┘
┌────────────────────────────────────┐
│ Vroue wat aan die                  │
│ insluitingskriteria voldoen, en    │
│ verwys is na die                   │
│ navorsingsassistent                │
│                                    │
│   • Het IPV in die laaste 24       │
│     maande ervaar.                 │
│   • Was gewillig om aan die        │
│     studie deel te neem.           │
└────────────────────────────────────┘
┌────────────────────────────────────┐
│ Ingeligte toestemming is verkry    │
│ deur die navorser.                 │
└────────────────────────────────────┘
┌────────────────────────────────────┐
│ Eerste onderhoud:                  │
│                                    │
│   • Assessering en bestuur         │
│     van IPV                        │
└────────────────────────────────────┘
┌────────────────────────────────────┐
│ Tweede onderhoud:                  │
│                                    │
│   • Verbintenis aan die            │
│     hanteringsplan                 │
│   • Persepsies van die             │
│     hanteringsplan                 │
└────────────────────────────────────┘
┌────────────────────────────────────┐
│ In-diepte onderhoude               │
│                                    │
│   • Met                            │
│     gesondheidsorgverskaffers      │
│     en ander sleutel-informante.   │
└────────────────────────────────────┘
```

By twee stedelike en drie landelike gemeenskapsgesondheidsorgsentrums, is 168 vroue voorsien van 'n IPV-intervensie, en 75% het teruggekom vir 'n opvolgsessie 'n maand later. In die voorafgaande 24 maande, voor die bogenoemde intervensie, was slegs 9.6% van die steekproef as IPV gevalle geïdentifiseer, alhoewel dit nie effektiewe bystand gewaarborg het nie. Die redes vir besoek aan die gemeenskapsgesondheidsorgsentrums ("reasons for encounter", of RFE) en diagnoses wat gemaak is tydens hierdie 24 maande, het tekens voorgestel wat gebruik kon word om IPV meer effektief te herken. So byvoorbeeld kan hoes, wat gewoonlik die mees algemene RFE in primêre sorg is, voorafgegaan word deur hoofpyn, psigiatriese medikasie, slaapsteurnisse en duiseligheid. Hierdie is alles tekens vir geestesongesteldhede en dui duidelik daarop dat daar oor IPV uitgevra moet word wanneer die teenwoordigheid van 'n geestesprobleem 'n waarskynlikheid is. Moegheid, angs,

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depressie en ander sielkundige simptome was van die twintig RFE's wat die meeste voorgekom het, en dit versterk hierdie oortuiging.

Vir die 9.6% wat identifiseer is, was daar min dokumentasie in hulle mediese lêers. Dit dui moontlik op onvoldoende hantering, hoofsaaklik in die vorm van verwysings. Sewentig persent is verwys na alreeds oorlaaide maatskaplike werkers, en 30% vir sielkundige sorg wat ewe skaars is. Slegs 30% is verwys na die NPO sektor wat ondersteuning bied met die verkryging van 'n beskermingsbevel, berading, regsadvies en skuilings.

IPV pas beter in die kroniese siekte-raamwerk en is nie 'n probleem met 'n vinnige oplossing nie. Die bio-psigo-sosiale-forensiese intervensie het 60 – 90 minute per kliënt geneem, wat te lank is vir 'n PGS-sisteem wat mik vir 'n konsultasie van gemiddeld sewe minute. Klinieke het te min personeel, verwysingsraamwerke het 'n tekort aan hulpbronne en die moraal van personeel is laag. Gesondheidsorgverskaffers was oor die algemeen onsamewerkend met die vra van een siftingsvraag aan alle vroulike pasiënte ouer as 18 jaar, wat werwing bemoeilik het. Intervensie is as besonder voordelig deur 63% van die deelnemers, en as behulpsaam deur 'n addisionele 13% ervaar, wat dus beteken dat 76% in totaal dit voordelig gevind het. Op alle stadia wou vroue wat IPV ervaar het, erkenning en deurlopende ondersteuning van gesondheidsorgverskaffers hê, sonder druk vir spesifieke aksies. 'n Sleutel bevinding was dus die behoefte van die pasiënt om by 'n persoon te wees wat omgee (emosionele ondersteuning) en nie net deur 'n reeks take te werk nie. Die impak van die intervensie is ook gemeet aan die mate waartoe IPV-oorlewendes 'n beplande aksieplan implementeer het, soos een maand later geëvalueer.

Tans word IPV grootliks nie erken deur primêre sorgverskaffers nie, en in die enkele gevalle waar dit wel gediagnoseer is, is die standaard van sorg gefragmenteer, swak gekoördineer, daar is 'n gebrek aan deurlopendheid en belangrike aspekte word oorgesien. Die resultate van die studie dui daarop dat die vlakke van IPV in die Suid Afrikaanse samelewing onaanvaarbaar hoog is en vereis dringende aandag van gesondheidsisteme met betrekking tot die verskaffing van toepaslike sorg. Hierdie studie het innoverende professionele aksie-navorsingstegnieke in werking gestel om die uitvoerbaarheid van 'n intervensie vir vroulike IPV oorlewendes in die PGS sektor te toets en om dit aan te pas vir gebruik. 'n Omvattende, dog praktiese model vir IPV-sorg is in Hoofstuk 9 voorgestel. 'n Enkel blad vloeidiagragm vir die identifisering en hantering van IPV wat deur enige gesondheidsorgverskaffer gebruik kan word, is voorsien. Dit hou ook verband met die aanpassing van huidige kroniese sorg

gesondheidsbeleid vir die Wes-Kaap om by die behoefte van IPV oorlewendes aan te pas. Die rol van gemeenskappe is beklemtoon in die behoefte vir 'n omvattende sosiale reaksie tot IPV. Professionele aksie-navorsingstegnieke wat binne die projek ontwikkel is, kan goed aansluit by 'n deelnemende aksie-navorsingsbetrokkenheid met omliggende gemeenskappe.

Op 'n metodologiese vlak, is eerstens gevind dat in aksie-navorsing kan die betroubaarheid en geldigheid van die studie definitief beïnvloed word deur die mede-avorsers se vermoë / kapasiteit tot eerlike verbintenis tot beide aksie en reflektering, en om deeglike rekenskap te gee. Dit vereis 'n ander standpunt as dié van die stereotipiese onafhanklike waarnemer van klassieke wetenskap, en 'n openlikheid tot persoonlike verandering wat ervaar kan word as verwant aan psigoterapie of geestelike reise. Daarom is dit noodsaaklik om in-diepte voorbereidingsopleiding te doen om die leerders se gedagtes oop te maak en om hulle die ondersoeke te laat benader as outonome gelykes en om potensiële kandidate uit te wys.

Die tesis beveel aan dat die Universiteit se Etiese Komitees 'n aansoekprosedure behoort te ontwikkel wat aksie-navorsingsprosesse akkommodeer deur te fokus op navorsingsbeginsels wat gevolg moet word terwyl buigbaarheid toegelaat word vir die ontstaan van projekbesonderhede in ooreenstemming met die proses. Verder moet interdissiplinêre doktorale projekte aangemoedig word indien 'n interdissiplinêre etiek-aansoekprosedure ontwikkel is om 'n intelligente kompromie tussen uiteenlopende fakulteitsriglyne te bied. Laastens, kern samewerking tussen feminisme, aksie-navorsing en kompleksiteit teorie word uiteengesit soos wat dit die meta-metodologiese matriks van die werk gevorm het.

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CHAPTER ONE
INTRODUCTION

1.1 Scope and aims of thesis

Most South African social contexts are characterised by oppression of women. At a fundamental level, disrespect for the feminine seems validated by cultural norms and values which prioritise males over females in multiple ways. This translates into the quality of people's relationships and their self-expectations. Unsurprisingly therefore, in South Africa, intimate partner violence (IPV) statistics are among the highest in the world (Jewkes, Penn-Kekana, Levin, Ratsaka & Schreiber, 2001b; Mathews et al., 2004). Despite progressive legislation and a progressive constitution, IPV is still regarded as culturally acceptable, and thus, in many contexts, is normalised (Parenzee, Artz & Moult, 2001). The challenge of this study has been to systematically address the problem of providing adequately comprehensive care for survivors of IPV, within the contemporary primary health care sector in the Western Cape, South Africa.

1.1.1 Background

IPV is no longer a family or community secret. The World Health Organisation recognises it as being of major consequence to women's mental and physical health (Krug, Dahlberg, Zwi & Lozano, 2002). Despite this recognition, an analysis of the health sector response to IPV reveals that most health professionals in South Africa tend to hide from the problem (Jacobs, Steenkamp & Marais, 1998, pp.2-3). The neglected, under-documented and under-reported nature of IPV, as well as the perception that it is only a 'family affair' or a 'justice issue' and therefore does not require a comprehensive health intervention, is an international phenomenon. This study turns the spotlight on the Western Cape and thus confines itself mostly to the particularities of the South African context.

The women's movement, worldwide, brought the issue of violence against women to public attention. Its feminist vision is widely understood as key to comprehending the phenomenon of gender-based violence (Hoff, 1992, p.18). Originally, *"... 'feminist research' was defined as a focus on women, in research carried out by women who were feminist, for other women ..."* (Stanley & Wise, 1990, p.21). Feminist research was expressly political in its commitment to changing women's lives and its critique exposed male-dominated disciplines and research behaviours (Spender, 1981). It also drew on over-generalised categories such as 'women'

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without unpacking embedded assumptions (Stanley & Wise, 1990, p.21). In fact this tendency to reify categories lurks as a key danger in my discussion of 'nurse(s)' and 'nursing' in this thesis. Writing it as a nurse, I felt impaled on the paradox that nurses are at one and the same time a multiplicity of individual possibilities and a monolithic category. At the risk of reductionism the latter is used more frequently for ease of reference, but the paradox remains.

Ideally, insights from mental health nursing and anthropology play an integrating role in health sciences because both use a holistic perspective that understands individuals in relation to their socio-cultural context. Hoff (1992, p.19) points to how nursing and anthropology further complement each other by staying open to diverse ways of understanding related meanings of phenomena such as violence against women. This thesis shows how the use of a feminist perspective lends crucial depth in its deconstruction of key silences and absences in the IPV field.

The experience of 'women' is complex because women do not share a single material reality. Since the 1980s the category 'women' in academic feminist writing has been critiqued for reflecting the experiences of white, middle-class, First World, heterosexual women, yet treating these as universals (Stanley & Wise, 1983). In South Africa, our multi-racial context and feminist awareness within 'the struggle' produced diversity and a postmodern experience of local feminist voices.

Feminist work on IPV which started in the late 1970s, took time to be recognised within international standards for health. Since 1997 the World Health Organisation has been prioritising gender based violence as a major public health problem (Garcia-Moreno, 2001; Garcia-Moreno, 2002; Krug et al., 2002; World Health Organization, 1997; World Health Organization, 2005). In the latest World Health Report, IPV is showcased as a top priority (2008, p.47).

1.1.2 Underlying methodological issues

The ethical imperative of feminist social science research requires constructive engagement with the critical social problems such research claims to address. Action research is ideal for this since both feminism and action research aim to enhance the human condition through the creation of a more just and caring world and both show commitment to dedicated integration of knowledge and action in inquiry as a practice of living.

In early feminist thinking, there was a tendency to dichotomise feminist qualitative and 'male' quantitative methods (Yllö, 1988). Action research offers an eclectic mix of methods to transcend / bridge the traditional divide between quantitative and qualitative. Action research, with its emancipatory-critical approach, also enables and enlivens all quadrants of the action research cycle while interpretive-hermeneutic and empirical-analytical techniques can only function within specific sections of it. For this study, an action research approach was opted for.

1.2 The study in a nutshell

In SA the primary health care system has been in the grip of a major transition for the last fifteen years, and many more changes are intended to ensue as the 2010 Heath Care Plan is deployed. This was the context within which the research was conducted and as such it impacted powerfully on the data collection and research experience.

The study tested the feasibility of using a published screening and management protocol for IPV (Martin & Jacobs, 2003) between August 2006 and June 2007. The protocol was based on research conducted by a Cape Town group, *The Consortium on Violence Against Women* (Martin & Jacobs, 2003, pp.19-29; see 5.6.2). Professional action research techniques were used in this project to test the protocol and adapt it for use in the primary care context. Cooperative-inquiry group meetings, in-depth interviews, focus groups, fieldnotes, and quantitative data were triangulated to furnish the data for the three findings / discussion chapters, each of which links to a specific research goal:

1. **To identify the current nature of care offered to survivors of IPV in the primary health care sector of the Western Cape.**

2. **To determine the feasibility of implementing a published South African protocol for screening and management of IPV within local primary healthcare settings and to modify it for use.**

3. **To learn from the process of training and supporting researchers who are new to the action research paradigm and methodology.**

Although initially the focus appeared to be on piloting a particular model for the screening and management of IPV (Martin & Jacobs, 2003), the data collection experience adjusted the emphasis significantly. The resistance encountered from most health care providers towards IPV, even if only asking one screening question of every female over eighteen years old, became a key area of focus alongside issues related to perfecting a 'model'. My calculation of

the sample size had seemed realistic given the prevalence of IPV in South Africa, and the number of women over eighteen seen at the community health centres each day. But I had clearly underestimated the stigma surrounding IPV work, not anticipating the health care providers' resistance mentioned above. In the final analysis, a sample of 168 women instead of the 300 I had anticipated, was recruited. This shifted the emphasis of the study rather dramatically. Instead of a sizeable sample of women affected by IPV, there was a large cohort of nurses and doctors who were reluctant to ask their female clients, "How are things going in your relationship?", and then, if appropriate, refer them to the co-researcher on site. This resistance thus became a major focus and key area of fascination in the study.

1.3 Idiosyncrasies of this thesis

1.3.1 D Phil in Social Science Research Methods

As an interdisciplinary option, this doctorate appealed to me because it offered an opportunity to synchronise parallel components of my working life, namely (mental health / psychiatric) nursing and the pursuit of postgraduate social science degrees. Thus, although employed by the Division of Nursing in the Faculty of Health Sciences, I registered for a D Phil in Social Science Research Methods in the Faculty of Arts and Social Sciences. Also, I felt that my understanding of the research field was far too limited, and thus found the emphasis on methodology in this degree appetizing. Had I been aware of the extent of the challenge I was undertaking, I would never have proceeded. I shall detail some examples as they speak to the underlying enormity of succeeding with an interdisciplinary doctorate.

- At a practical level, in terms of getting the project going, it was almost impossible to access university funding that is available to Health Sciences faculty members. Doing an interdisciplinary degree, working in one faculty while doing a doctorate through another, means that the other receives the substantial subsidy in its entirety. Therefore a lot of opportunities that are open to other members of the Health Sciences Faculty were closed to me, and it took a great deal of personal time and effort, and commitment and support of others, to get the study off the ground.

- At an academic level, anthropology and family medicine belong to discrete academic paradigms. The former is more orientated to theoretical argument and philosophy and the latter to practical application and policy. This led to exciting discussions, which left me time and again with testing intellectual and practical challenges. Essentially, within the Faculty of Health Sciences, doctoral theses s follow criteria for a peer-reviewed article within medical publishing, so theses sequate to an expansion thereof.

By contrast, in the Faculty of Arts and Social Science, theory moves to central place and a complex engagement must be sustained and integrated throughout the work.

- Disparity between my supervisors' initial expectations of the findings and discussion chapters was salutary. In health sciences, findings are always presented neutrally. The discussion chapter, which follows, will pick up the literature debates on relevant issues. Anthropology, on the other hand, is at one level defined by its fusion of findings with discussion. Fortunately, flexibility prevailed and it was decided to combine the findings and discussion for each of the three research goals in three separate chapters instead. This issue indicates how challenging it can be to straddle two disconnected disciplines that are located within quite different paradigms.

- It also required a far more extensive surveillance of the literature spanning action research, research methodologies, IPV, anthropology, psychoanalysis and nursing-related literature.

1.3.2 Use of first person

In keeping with the tradition of writing with / from a feminist perspective, I situate myself in the research by use of the personal pronoun rather than 'the researcher'. I am a mental health nurse and academic with an interest in this topic because I have experienced and overcome IPV-related issues in my own life. This motivated and fuelled my passion to provide a practical system for comprehensive care for IPV that is feasible for our current PHC system. The positivist (empirical-analytic) paradigm rejects 'I' and 'me' / subjectivity, in pursuit of the illusion of objectivity. Here I choose to reclaim authorial authority which is consistent with being reflexive because the initial 'I' is also a changing 'I' which takes an argument and discusses various experiences.

1.3.3 'Our' study versus this study

The doctoral process, from conception to completion lasted six years. However a unique strength of the project was the action research methodology we employed, and this spanned 14 months. Note though that we only met for six co-operative inquiry group meetings during that time. For the rest, the work is the product if my intensive effort guided by my supervisors.

Nevertheless, while I played a pivotal intellectual role in the whole process, the value of the ancillary contribution of the action research team's input leaves me always thinking of the work as 'our' study, and consequently refer to 'we' at times in reference to the research team

and our group learning. As discussed above, at other times, I speak in the first person about my personal thoughts and integration of ideas.

1.4 Definitions

1.4.1 Intimate Partner Violence: A pattern of aggressive and coercive behaviours used against a woman that involves the following:

- *"Her intimate partner in a current or former dating, married, or cohabiting relationship*
- *The repeated use of multiple abusive strategies that tend to increase in severity and frequency over time*
- *A mixture of psychological attacks, physical violence and other controlling behaviours that create fear and compliance and inflict harm*
- *Patterned behaviours aimed at controlling her and making her obey the abuser*
- *Her increasing isolation and entrapment*

A woman may experience abuse in many forms including physical, emotional and psychological, verbal, environmental, social, financial, sexual, religious and/or spiritual, or ritual abuse" (Cherniak, Grant, Mason, Moore & Pellizzari, 2005, p.368).

The working definition of intimate partner violence used in this thesis refers to words or behaviour that violate the full humanity of the other. Thus it felt fitting that the forms of abuse identified by the protocol included sexual, verbal and financial abuse in addition to physical.

1.4.2 Blurred boundaries

One of our participants was a farm worker who had been sexually violated by the farmer over the past ten years. The abuse began when she was thirteen, and continued until she was twenty-three. The farmer would make sure that she worked alone on the section nearest to the house, while his wife was at school, teaching. The rule on these farms was that workers might not cross from one section to another, so she was unable to access protection from her co-workers. For some years, he had her work alone in his son's house. In these ways, he ensured his access to her and would insist that she comply with his sexual demands. The last physical interaction they had was when he assaulted her in October 2006. She charged him with assault and he responded by ordering her off his farm.

Although she was never a consenting partner she nevertheless endured ten years of sexual intercourse with him. When discussing this case with our research team, parallels with many of the abused women I had interviewed struck me. They described sex lives devoid of eroticism, intimacy or tenderness. They were often ordered to comply with penetration following a vicious verbally and/or physically abusive encounter. Generally, foreplay did not seem to feature much. They too were trapped, controlled and violated although their sexual partners were men they might, at some point, have chosen. I have included this farm worker as a valid participant of our study because of these shared features and because she was able to benefit significantly from the help we offered her.

The point is therefore that the term 'intimate partner' is already, in the South African context, impacted on by the gender and racial inequalities that intersect, as indicated by this case. It was therefore necessary to include this case of IPV that was strictly speaking far from 'intimate partner' in the sense usually understood, namely as a relationship between consenting adults.

1.4.3 Intimate femicide: *"The killing of a female person by an intimate partner (i.e. her current or ex-husband or boyfriend, same sex partner or a rejected would-be lover)"* (Mathews et al. 2004, p.1)

1.4.4 Health care providers: The latest politically correct terminology collapses nurses and doctors into the category 'health care providers'. Since this is the current term in the primary health care (PHC) sector, it is used in the thesis to refer to either or both doctors and nurses. Considering that the PHC sector is to be nurse-driven by 2010, the majority of health care providers are nurses.

1.4.5 IPV survivors: IPV survivors is a term I feel more comfortable using than battered or abused women for those affected by IPV. Although some literature refers to victims, I believe IPV victims are those who suffered intimate femicide.

1.4.6 A note on the use of racial terminology: The use of colour/racial terminology is not intended to legitimise nor to justify the continued use of a racial classification system, nor to imply essentialist notions of genetic or cultural difference. Under the apartheid government all South Africans were classified according to skin colour and this has created a legacy of marked disparities in all aspects of life, including health. The terms in

this thesis are used to acknowledge this impact and track progress in redressing past inequality based on colour (Cooper et al., 2004). The term 'black' refers to indigenous African people who mostly speak indigenous African languages. 'White' refers to English- and Afrikaans-speaking South Africans and others who are of European descent. The descent and heritage of 'coloured' people is diverse, including indigenous Khoisan, slaves brought to the Cape Colony from Malaysia and Indonesia and the progeny of intermarriage between whites and people of colour (van der Walt, 1998, p. vi). In this thesis, the term 'coloured' is used in preference to the more internationally acceptable 'mixed origin' because 'coloured' is a key term in South African vernacular.

1.5 Research design

Field sites	2 urban and 3 rural community health centres
IPV survivors	168 at 1st interview (protocol intervention) and 126 at follow-up interview
Interviewers/ researchers	Three co-researchers, including myself, conducted all 1st interviews. Five follow-up researchers, myself included, conducted the follow-up interviews although two researchers only did about ten each.
Key informant interviews	Sixteen
Focus groups	One urban and four rural – two in each rural site whereas our urban focus group combined health care providers from both sites.

1.6 Outline of the thesis

Chapter Two frames the meta-methodological aspects of the study in terms of the synergy between feminism, action research and complexity theory. The three dominant paradigms in social science research methodology are explored and critiqued from a feminist perspective. Since a variety of research techniques within a professional action research framework were used, the priorities and values underpinning these methodological choices are exposed and elaborated upon.

Chapter Three continues the feminist critique in its historical overview of IPV literature since its inception in the late 1970s. It outlines the importance of IPV as a health and human rights issue both locally and internationally. Multiple issues related to the provision of IPV services by health care providers are explored. Methodological concerns are also raised.

Chapter Four presents and discusses various theories that shed light on the organisational and professional issues pertinent to the recognition and management of IPV. It examines multiple oppressions that permeate nursing environments, as these appear to restrict nurses' capacity to provide appropriate, constructive responses to patients experiencing IPV. We see how nurses' potential has been funnelled into very restrictive modes of professional expression counterproductive for IPV care, which requires constructive involvement in individual and family care. Mechanistic managerial styles within PHC are critiqued. Psychoanalytic understandings of organisational defences against anxiety in nursing provide an illuminating discussion with regard to potential terrain for effective IPV care.

Chapter Five tracks the development of the research proposal, features thereof and the ensuing study. It also describes the different methods used to investigate the study objectives and links these to their ethical implications.

Chapter Six presents and discusses the findings related to the first objective, which was to identify the standard of care for IPV in study sites. Both quantitative data and qualitative case studies are utilised to illustrate relevant issues.

Chapter Seven presents and discusses the findings related to the second objective. What did our implementation of the protocol in five rural and urban research sites reveal about the capacity of the health system, and surrounding resources, to deal with this issue? How feasible was it to implement the protocol for IPV and how useful did the patients find the intervention?

Chapter Eight presents and discusses the findings related to what we learnt about training and supporting researchers who were new to the action research paradigm. It is structured in accordance with our research journey in order to trace what was learnt from designing and developing the study and from selecting and preparing the research team. An analysis of quality criteria and a reflection on my methodological journey provide a critique of the process.

Chapter Nine speaks to the study's conclusions and recommendations regarding health policy issues in terms of the way forward for IPV care at three levels within the primary health care sector of South Africa. Recommendations and methodological conclusions regarding the training and support of action researchers are also presented.

CHAPTER TWO

THE POINT IS TO CHANGE THE WORLD, NOT ONLY TO STUDY IT

"Action research and feminism are mutually implicated because action research involves collaboration among all the legitimate stakeholders, the valuation of all knowledge, and the enhancement of fairness, justice, healthfulness and sustainability – all values that underlie feminism" (Greenwood, 2004, p.158).

2.1 Introduction

Contemporary social and health sciences research is dominated by three methodological paradigms: empirical-analytic ("quantitative"), interpretive-hermeneutic ("qualitative") and emancipatory-critical ("action research"). Each is rooted in correlating meta-theories, namely positivism, phenomenology, and critical theory. Note that the term "methodological paradigm" integrates both actual techniques and methods used by social science researchers with underlying principles and assumptions regarding their use (Babbie & Mouton, 2001, p.49). A key theme in social science debate has been the evaluation of one paradigm by the criteria of another to find it wanting. This chapter argues that action research offers multiple possibilities for transcending this simplistic opposition, by working eclectically across this divide within the living system of an action research process.

At a meta-methodological level this project was born out of my deeply feminist values, which breed an activism for social justice within me. The investment of five years of the prime of my life has been sustained by my commitment to doing research that will be useful and valuable for families affected by IPV. It is my observation that narrow professional interests and personal gain tend to dominate social science and health research, at the expense of constructive engagement with the critical social problems it claims to address. Greenwood's assertion that social scientists seem unperturbed by *"profiting from a passive role in the face of injustices that … [they] documented without confronting them politically"* (Greenwood, 2004, p. 179) reinforces my perception. Therefore, I make no apologies for my activism.

Greenwood (2004, p.158) argues that feminism's examination of a universal 'gradient of inequality' not only provided core critiques of methodological and epistemological humanistic and social science research conventions. Also, feminists have been active in social

service agencies, non-profit organisations and courts creating transformative policy and practices such as the Domestic Violence Act of 1998 (see Chapter Three). Stating unequivocally that action research owes its recent resurgence to the feminist movement directly, Greenwood urges action researchers to commit to their combined intellectual and moral obligations, which are in wholehearted support of feminist voices and endeavours. Speaking from his perspective of significant expertise in the anthropological study of contemporary universities, he sketches a grim depiction of the marginalisation of feminist, ethnic and action research studies in academic and corporate environments (Greenwood, 2004). In agreement with this chapter's argument around the value of forming living systems of networks within our working environment to enhance our practice, he urges us to form supportive alliances as action researchers, feminists, and others dedicated to social change and democratisation. In the United States and Europe, the so-called post-feminist phase since the early-1990s has seen social movements die down and a swing to the right.

"At this point, there is no peace movement, no major women's movement, and no democracy movement, but there is massive inequality, decreasing unionism, and decreasing social support. Unless we can learn to count on each other, we have no allies at all" (Greenwood, 2004, p.166).

Like action research, feminism is not simply a perspective (way of seeing) or an epistemology (way of knowing), it is also an ontology (way of being in the world). "*Succinctly, the point is to change the world, not only to study it"* (Stanley, 1990, p.15). In essence, feminist scholarship, like action research, is a political movement for structural, social and personal transformation. Disturbingly though, feminist theories and practices are unfamiliar to many action researchers despite the fact that feminist scholarship centres on the value of transformational action (Maguire, 2001). Yet action research and feminism could be powerfully united in a struggle to dissolve interwoven systems of oppression: *"Feminism ... is resistance to invisibility and silencing"* (Faith, 1994, p.37).

Maguire (2001, p.62) discusses how the metaphor of voice is common to both feminist and action research. The consciousness-raising groups cardinal to the feminist activism of the 1960s and 1970s opened up spaces to talk, listen, affirm, reflect and analyse personal stories. Action research also works with this potentially empowering strategy. The connection between acquiring a voice and the appreciation of knowledge as socially constructed in the context of human relations is central to feminist-grounded action research. A post-modern use

of feminist-grounded action research works to reveal and disturb silencing mechanisms. Within modernist and traditional thinking, one is positioned at discrete points in a system of dichotomies such as feminist or non-feminist, activist or scholar, straight or gay, male or female, white, black or other, powerful or powerless. A post-modern feminist approach enables us to imagine ourselves at the intersection of multiple identities, all of which influence one another. Combined, these form our continually changing experience and interactions (Brydon-Miller, 2004).

It is important to consider the congruence between the action research process and feminist values. If one interprets the values of action research as being about respect for peoples' voices, and honouring their experience and learning, this links closely with my ethical values as a feminist (mental health / psychiatric) nurse. My initial understanding of the study was of a feminist engagement with IPV as it impacts on the lived experience of female participants. Obviously, a key aspect of IPV is abusive power relations. A key feminist influence on action research in this project has been the restructuring of traditional power dynamics to accord with an action research process. As the project evolved, the emphases shifted (see Chapter Eight) and the issues of the lived experience of the health care providers moved to centre stage for analysis. The findings revealed that there is a tendency to some abuse in the relationship between the health service and its workers. Flattening the hierarchy of our professional action research team enabled the modelling, within the very fabric of the research project, of a different, inherently respectful way of relating to one another as individual co-researchers rather than as nurses and doctors.

Having laid down the foundation of feminist worldview and its synergies with action research, let us turn to the argument and content of this chapter, which explores the theoretical underpinnings and implications of the methodological approaches adopted in this study, and motivates our methodological choices.

Care was taken to ensure that the research study complied with, if not exceeded, two ethics protocols, that of the International Research Network on Violence Against Women as recommended in 1999 to the World Health Organisation, and that of Stellenbosch University Ethics Committee for Human Research as of 2009. Indeed, exploring the ethical issue of what benchmark of care should be provided to a control group of IPV survivors in any future randomised controlled trail, led to the formulation of the first research goal of identifying the current standard of IPV care within the PHC system. Despite ethics being at the forefront of

researchers' minds, the nature of the real-world situations that the research encountered, threw up intensely challenging ethical questions. Section 2.2. addresses the need for these ethical considerations to be acknowledged at the outset, which are then specifically picked up again in Chapter Five. In an attempt to see how others might have grappled with questions of research ethics, I briefly review the literature thereon, and find a call to action in feminist ethics.

In section 2.3 we move from paradigm, to methodological techniques, in unpacking and motivating the methodological choices made for this thesis, which places itself in the emancipatory-critical paradigm. The historical background to action research is given, tracing it back to Kurt Lewin and the Tavistock Institute, before it emerged as participatory action research in Paolo Freire's work. The epistemological shifts represented by the emancipatory-critical paradigm are explored. The fact that recognising power relations and effecting socio-political change is central to action research is underlined as the motivation for selecting it as this thesis' methodological paradigm. Professional action research is characterised, and the reasoning for our adoption of it as the methodology for this thesis is given. The co-operative inquiry group method is described and critiqued. Our research team formed such a co-operative inquiry group, and this method was adopted as central to our research process. The emancipatory-critical paradigm of our study for professional action research, allows for a range of approaches and practices. The quantitative and qualitative research techniques used for the three research goals are explicated.

The co-operative inquiry group of action research is an example of an open and living system, in the sense that complexity theory uses these terms. Action research, feminism and complexity theory are interconnected through the idea that relational processes are open to transformation, and this change can be leveraged for empowerment. Section 2.4 thus explores complexity theory, by which is meant an approach which seeks to cater for the full complexity, interconnectivity and interrelatedness of phenomena, organisations and systems (rather than mathematical complexity theory). A note of caution is sounded that complexity theory should not be used to generate abstractions and formulae about 'how complex systems work', devoid of context. This thesis acknowledges that its own process of research and reflection attempts to make sense of complex relations and systems, and in so doing simplifies the full complexity of reality into a picture which is less than the totality.

After the diversion into complexity theory, in sections 2.5 and 2.6 I return to the other two main meta-methodological paradigms. Our study inherits the interpretive-hermeneutic (qualitative) paradigm, which stems from anthropology and underpins much feminist research. Inherent is an acknowledgement of work as context dependent and a recognition of the validity of subjective meaning, as interpreted by researcher. This research project used qualitative techniques and methods of interpretation drawn from the interpretive-hermeneutical paradigm, which proved fruitful for observing and reflecting on researchers' and respondents' experiences. However, the involvement of the co-researchers in our co-operative inquiry group takes us beyond the interpretive-hermeneutic realm, to allow for collective ongoing evolvement of the research process and our own professional practices.

Modelled on the epistemology and practices of the physical sciences, at the heart of the empirical-analytical paradigm is the belief that one needs to aim for (and can achieve) quantitative data gained by wholly objective means within strictly controlled laboratory-type conditions, because this is inherently more valid than data obtained from more subjective interpretation of experiences. A critique is offered of this belief, with particular reference to examples from the IPV literature. Notwithstanding this critique, the social sciences researcher should not throw the baby of quantitative techniques out with the empirical-analytical bathwater, and this study made fruitful use of statistical and quantitative tools and methods. Within the empirical-analytical approach of the British Medical Research Council's steps for evaluating complex health interventions, this study fits within the modelling stage, and therefore is in a position to offer some conclusions about the value how to intervene in our health care system in terms of improving IPV care. In this approach such a model intervention can subsequently be evaluated for efficacy clinical trial.

2.2 Ethical considerations

The subject of this work, IPV, is imbued with delicate ethical dimensions that are of methodological relevance for feminist work. Therefore, I am foregrounding an ethical discussion here at a meta-level, to open up the issues from the start. I set out how the research was designed to satisfy two sets of research ethics guidelines; illustrate how real-life dilemmas confronted us with deeper ethical questions than just technical adherence to ethical research guidelines; briefly review literature on feminist ethics which provide some guiding principles; and find an incomplete resolution.

2.2.1 Taking account of ethical considerations in designing the research project

As a matter of fact, the first research goal of this study was originally formulated to address an ethical concern. Professor Mash and I were thinking of a randomised controlled trial and needed to understand what care should be provided for the control group. We agreed that if we identified the current standard of care available within the PHC system, this could provide a baseline to be offered to the control group.

My starting point of ethical exploration was the ethical considerations and research solutions recommended to the World Health Organisation by the International Research Network on Violence against Women (IRNVAW, 1999). The *safety of respondents and the research team* was paramount and infused all project decisions. The physical safety of participants and researchers from retaliatory violence by the abuser was a concern that was addressed as follows:

Interviews were conducted in a private setting within the community health centre. The participant was free to reschedule the interview to a time that was more safe or convenient for her.

Researchers were trained to change the subject of discussion if an interview was interrupted by anyone.

All research team members received *specialised training and on-going support*. The International Research Network on Violence Against Women's recommendation to the World Health Organisation urged that training should include opportunities for research staff to come to terms with their own experiences of abuse. It emphasised that even where a researcher had not personally experienced violence, listening to stories of violence and abuse could be draining and disruptive, perhaps more so for those who had prior experience of victimisation. Members of the Network had found that unless this reality was directly confronted, research projects tended to experience high rates of attrition among staff.

As it transpired, the Faculty of Arts and Social Sciences at the University of Stellenbosch passed the research proposal without any additional ethical specifications. By contrast, the Faculty of Health Sciences' Human Research Committee interrogated the ethical issues of the protocol for approval according to the university's research policy involving human participants (Stellenbosch University Ethics Committee for Human Research, 2009, p. 5). Their key principles follow in italics. Thereafter I detail how our study addressed each point:

"Be relevant to the needs and interests of the community in which the research is conducted."
Chapter Three shows how PHC for IPV sorely neglects addressing communities' needs. Our study was designed to evaluate changes that could be made in health care policy formation to provide appropriately for IPV-related community needs.

"Have a valid scientific methodology."
An empirical-analytical mindset dominates the Faculty of Health Sciences at Stellenbosch University, which consequently has a rather cautious approach to action research. Because their criteria are strictly empirical, triangulation with statistical methods in two research goals provided the necessary compromise.

"Ensure research participants are well informed on the purpose of the research and how the research results will be disseminated and have consented to participate, where applicable."
In our study, informed consent was attended to as soon as the participant was in the privacy of the co-researcher's office. The informed consent form was translated and back-translated into Xhosa and Afrikaans (Appendices B, C, and D)

"Ensure research participants' rights to privacy and confidentiality are protected."
Confidentiality was protected to ensure both participants' safety and data quality as follows:

i.   All researchers were trained about the importance of maintaining confidentiality and all data was kept confidential.
ii. Unique codes were used to distinguish questionnaires.
iii. Interview and assessment material was kept in a locked file away from research sites. Access was restricted to members of the research team.
iv. Photographs, taken for forensic documentation purposes only, were agreed to as part of the informed consent process.

"Ensure the fair selection of research participants."
During training health care practitioners at each site were requested to ask one question of every female patient over eighteen. Patients then consenting to participate were referred to the co-researcher present on site from Monday to Friday, and some weekends during each data collection period.

"Be preceded by a thorough risk benefit analysis."
As Chapter Three shows, the IPV literature is calling for work of this kind.

"Thorough care must be taken that research in communities is effectively coordinated."
Our research was coordinated as effectively as possible, within the PHC sector.

Given that this study had functioned within the framework provided by these two sets of guidelines – those of IRNVAW and those of the Stellenbosch University Ethics Committee for Human Research – until recently I was confident about the ethical standards of the research. But as the study was hugely interventionist and traumatic, I have been forced to unravel deeper ethical issues by reflecting on the power we had and how responsibly we used it. One example will serve as illustration.

2.2.2 Haunted by the limits of research ethics

And so I find myself reflecting on a participant about whom I still worry and whom I feel the study failed. I interviewed this woman at Site B, and her description of the abuse she endured has haunted me ever since. Her husband, a Cape gangster, was imprisoned at the time, but due for release four months later. She described a history of being locked in a room for days on end to prevent anyone from seeing her. She couldn't have friends or family to visit. She slept on the carpet and he would smash her head against the brass bed repeatedly and verbally abuse her with words she found too upsetting to name. She admitted believing that it was her fault. He broke her ribs while she was in the room. She ran away to a shelter, but she discovered she was pregnant. He came and took her out, threatened to use force. He also beat her and forced her to take drugs: heroine, crack and cocaine, even while pregnant with his sons, both of whom are disabled. This woman became drug free after he was sent to jail for attacking her with a hammer to the head. At the time of the interview, he had been in jail for seven years. She explained that six months of his sentence had been for attacking her and 22 years for stealing cars. Significantly also, he used to "doctor" her himself, so she has no medical documentation to testify to abuse. During this time she fled his abuse with a Taiwanese man but was so socially isolated that she felt herself to be a "prisoner" and became so homesick that she returned to the husband.

A forensic psychologist and domestic violence legal research specialist advised that the only course of action possible for this woman and her children would be to move her to another city. I engaged with my colleague, the social worker at Site B and we explored the possibility of moving her and her children to another city, which she was very keen to do in advance of her husband's release. The social worker took responsibility for facilitating this, but it was still in process when the data collection period for that site was completed, and I remain concerned about this participant's and her children's well-being and states of mind. So at the time of my moving on from the site, her future safety was still not resolved. I did call her a number of times to provide support and assess progress and when we last spoke she was

confident that it was "all systems go" for her move, and she was about to sell her furniture. My supervisor reminded me to stay focused on attending to the extensive work of the research goals, and not to become embroiled in the lives of participants, as stated in the ethical provisos of our approved project. I obeyed at the time, but now wonder whether I can claim to have achieved sufficient ethical standards as a feminist action researcher. What does this really mean?

2.2.3 A brief look at feminist ethics literature

In an attempt to see how others have grappled with ethical issues in research, one turns to the literature on research ethics. I discovered that action research literature on ethics is rather thin, and interestingly, is primarily feminist work.

In common with the mainstream, feminist ethicists interrogate the nature, consequences, and motives of action; identify and apply moral principles relevant to decision-making; and define the moral good. Feminist ethics further require individuals to be proactive in their creation of just social structures that ensure people are given attention and just care. Reviewing the literature, Brabeck and Ting (2000, p.18) identified themes for a feminist ethics of psychological practice.

The first theme centres on Gilligan's (1982) breakthrough around the ethic of care being a moral orientation. The ethical theme of concern and care for others requires the ethical feminist researcher to be mindful of participants' wellbeing at all times. Emphasising women's experiences, rather than simply abstract principles, feminist ethics prioritises knowledge that is acquired through lived experience. The second theme is an ethic of justice, which demands attention to the power hierarchies and dynamics specific to the research context. The crucial ethical choice is to recognise these issues and their potential effects and to challenge the inequities. Thirdly, feminist ethics require us to critique all discriminatory and stereotypical distortions, analysing knowledge construction from a gendered, socio-cultural perspective. Finally, feminist ethics demand action aimed at achieving social justice, since the fundamental aim of feminist ethics is to improve the human condition by creating a more caring and just world for all (Shartrand & Brabeck, 2004, pp.143-145).

It is clear that toeing the formally required ethical research line does not protect one from being faced with seemingly unmanageable real-life ethical challenges, particularly in human research. I contend that our research was conducted in such a way as to satisfy as far as

possible the precepts of feminist ethics outlined above. The challenge in research is clearly that ethical norms blur at times because researching humans is very difficult. Whatever the successes, research inevitably will fail some participants. Nevertheless, Chapter Seven shows how helpful most of the participants found the intervention. Therefore, in congruence with the feminist ethical principle of taking action to improve the human condition, contemporary IPV discourse should recognise the value of working creatively in such challenging terrain. It is crucial to think as laterally as possible around the formation of living sub-systems within larger systems such as health care, justice, the non-formal sector, and so forth; to work constructively with families blighted by IPV.

2.3 Choice of action research methodology in this study

2.3.1 The emancipatory-critical (action research) paradigm

Action research was designed to integrate theory, practice and research. Predating Freire's participatory action research paradigm, which is commonly understood as the original and dominant model, action research was in fact created as a method of inquiry by Kurt Lewin in social psychology in the late 1940s. A range of approaches, definitions and uses has since proliferated. Lewin's quest was to fuse theory and practice in an entirely new paradigm for research and practice, namely action research (Holter & Schwartz-Barcott, 1993, p.298). Simultaneously, an independent formulation of action research was occurring at the Tavistock Institute in London, soon after Lewin developed his ideas in the United States of America (USA). Arguably therefore, Lewin and the Tavistock Institute were the initiating forces behind the development of professional action research, which is predicated on the understanding that professionals should be integrally involved in research since they have important insights to contribute from within their work context:

"If social scientists are to let go of their control of the research process and engage with 'insiders' as full co-researchers ... they have ... struck a blow at the epistemological assumptions of orthodox science. Our whole world-view ... and the framework of our intellectual strivings are fundamentally based on separation of subject and object. If we are to take seriously the proposal that social scientists work with insiders as 'co-researchers' we must recognise this as a shift in the nature of our knowing" (Reason, 1994, p.1262).

Thus the justification for positioning action research as a distinct methodology is to be found in the epistemological rather than methodological realm. Mouton identifies four aspects,

which set action research apart from conventional research methodologies (Babbie & Mouton, 2001, pp.61-62).

The first relates to the relations of power in the research process. In essence, action research transforms participation into shared ownership of the research enterprise. This epistemological standpoint therefore contravenes the detached observation, which is a foundation of structuralism, empiricism and logical positivism.

Secondly, action research probes whose political interests individual research projects satisfy. Thus the action research perspective offers an understanding of how epistemology and ideology, power and knowledge, are intertwined. Action research's evidently political stance and its consequently "ideological-ethical orientation" (McTaggart, 1994, p.330) is rooted in critical theory. The latter emphasises the political role of scientific knowledge production, including the social power to define what knowledge is valid.

Critical theory's emphasis on the 'dialectics' of theory and practice feeds into the third reason why action research is seen as a distinct research methodology for productive work.

This links with the fourth aspect, which denotes an epistemological shift in action research's prioritisation of the significance of experiential knowing in the form of thinking, feeling and acting.

In relation to the second point above, the theory in Chapter Four puts a spotlight on the links between power and resistance as mapped out by Foucault and as lived by feminists. Some key points are relevant at the level of meta-method. As Faith (1994, p.42) points out, words like 'sisterhood', 'movement', 'feminist', 'radical', reveal an activist commitment to destabilising patriarchal power relations, despite inherent divisions. The feminist movement accentuates significant features of power relations. Feminism exposes how hierarchies are built on divisions founded on categories of difference. This is destructive for those both dominant and subordinated. Foucault accentuates the "*relational character"* of power, whose "*existence depends on a multiplicity of points of resistance"* (Foucault, 1980, p.95).

Examining the empirical-analytic ("quantitative"), interpretive-hermeneutic ("qualitative") and emancipatory-critical ("action research") paradigms, it is only the action research methodology of the emancipatory-critical paradigm which on the one hand explicitly engages with questions of power relations, ideology, and the influence of these on the process of creating knowledge, and on the other hand recognises that to do research is to take action

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which holds the potential of shifting those power relations (indeed should do so), not only between the researched and the researchers, but in society at large for emancipatory purposes. Given that my point of departure is that of a feminist activist, and that the research goals of this thesis seek to ultimately make a contribution to better care for IPV survivors within the PHC system, there is no other methodology that would mesh with these aims:

"[Action research] requires intelligent, choiceful application guided by the fundamental action research values and epistemologies ... notably a grounding in living issues, a participative / emancipatory ethos, and a spirit of inquiry" (Reason and Bradbury, 2008, p.235).

A commitment to dedicated integration of knowledge and action in inquiry as a practice of living are, according to action research authorities Reason and Bradbury (2001, p.xxiv), the defining characteristics to permit inclusion within the action research paradigm. The action research paradigm comprises a range of approaches and practices, each rooted in different traditions, philosophical and psychological assumptions, and each pursuing varying political commitments. One of these approaches is professional action research, to which we now turn our attention, since professional action research is the particular strand of action research used within this thesis.

2.3.2 Professional action research methodology

The professional action research paradigm is ideal for innovation of alternative service delivery systems within the health care context and hence was the method of choice for this project.

The co-operative inquiry group method was adapted by Mash and Meulenberg-Buskens (2001) to model medical education materials, and has been the overarching action research methodology utilised in this project. Reason describes it as a technique for working with professionals who would like to change their practice. In our research project for this thesis, the 'insiders' referred to by Peter Reason above, were the research team. As Mash and Meulenberg-Buskens articulate, the underlying foundation of the co-operative inquiry is a continual cycling between research ideas and reflections on the one hand and action and experience on the other (2001, p.1108). This establishes a process of constant feedback that refines, diversifies and deepens both the ideas and the actions. This fits well with my feminist standpoint, which critiques voyeuristic research, such as the multiple prevalence studies that

contribute very little to constructive change for IPV survivors, as well as hardly anything to our knowledge base of IPV.

The co-operative inquiry group method works with the standard action research cycle, comprising four steps which should include all the following features (Mash & Meulenberg-Buskens, 2001, p.1108):

Planning: Group members align themselves with the purpose of the inquiry, develop their own questions and actions to explore these questions in their own practice and decide on how they will observe and record their experience.

Action: Group members engage in the agreed action.

Observing: Group members observe and record their experiences.

Reflecting: The individuals meet at regular intervals to reflect on their experience and develop new insights, understanding and ways of seeing the problem. They reconsider their original propositions and questions and reframe them for the start of a new cycle.

The underlying assumption of the co-operative-inquiry group is that participants can learn and create knowledge on the basis of their concrete experience; by observing and reflecting on that experience; through forming abstract concepts and generalisations; and by testing the implications of these concepts in new situations, which will lead to new concrete experiences and hence the beginning of a new cycle.

A co-operative inquiry group process can be a potent structure for solving complex problems and promoting capability. As Fraser and Greenhalgh (2001, p.801) assert, in a small group, the combination of individuals can achieve more than the sum of its parts, as social interaction between members stimulates learning, raises an individual's confidence, and increases motivation. The use of process techniques, within the co-operative inquiry group meetings, facilitates learning which has a flexible and evolving content.

The construction of knowledge by a process of consensus building is required to be fair to, and consistent with, the experience of group members. Consensus in the co-operative inquiry group means holding all the individual contributions together and finding a framework or metaphor that can connect them to produce meaning. Significantly, seemingly paradoxical findings may represent different perspectives and the interconnections may still be emerging (Mash, 2002).

A standard critique of the action research paradigm, applicable to a co-operative inquiry group, is that it does not necessarily produce generalisable knowledge because social systems are infinitely varied and complex. Therefore the relevance of findings to other contexts may very, and need to be engaged with critically.

Eight themes dominate quality assurance in the co-operative inquiry group (Mash & Meulenberg-Buskens, 2001, pp.1110-1111):

Alignment with purpose involves assessing oneself, the purpose of the research and choosing the most effective stance in relation to both. This alignment of the team with the purpose of the research both drives the process and acts as the contract between members.

The **transfer of ownership of the inquiry** from the initiating researcher to the group members is a gradual process that begins with a commitment to the research purpose and understanding of the research methodology, and ends with the maturing of each individual inquirer and documentation of their personal inquiry findings. The initiating researcher needs to transfer power, knowledge of the research methodology and ownership of the research questions and process so that after the cooperative inquiry group is established s/he does not dominate the inquiry.

Development of reflectivity is an ongoing process that deepens as the inquiry progresses. As group members are both researchers and researched, the quality of the inquiry relies on their capacity to witness themselves. A reflective stance characterised by heightened awareness, open-mindedness, critical questioning and commitment to dialogue is essential.

Democratic and collaborative group dynamics and facilitation where the facilitator strives for a genuinely collaborative and democratic group process. The attainment of trust is related to telling the truth without judgment and staying within the common purpose.

Commitment to practical action and reflection: a **balance between action and reflection** is vital.

Recording: The following three aspects of the process must be documented in each cycle: the individual experience or action; the developing reflections (new ideas and further questions) and the practical plans to engage with these new ideas and questions in ongoing practical action. From the research perspective the group's consensus regarding their learning and new knowledge is constructed and eventually reported at the end of the inquiry.

Transferability: the group's findings should be reported in rich **contextual** detail to enable readers to comprehend what dimensions of the inquiry can be utilised in their own context.

The purpose of the co-operative inquiry group is to construct practical knowledge through cycles of action and reflection. The **acid test** of the research quality is in the practical usefulness of this new knowledge.

As a form of professional action research methodology, the co-operative inquiry group provides a perfect example of a living system. Living or complex adaptive systems are concepts at the core of complexity theory. Like feminism, both action research and complexity theory provide alternative theoretical models to mainstream research practice. They are both concerned with how relationships evolve, since power is understood to exist in the connectivity of the living system. They are also open to the enormous creative potential that is part of unpredictability. The co-operative inquiry group accords with complexity theory's principles of how a living system actually works. It is organisationally closed, but has an open boundary to the environment; the group strives for meaningful interaction and feedback; it adapts as the process unfolds; new action and knowledge is created through the emergent properties of the system and it thrives on learning and change which can't be controlled or predicted. In section 2.4 below we explore the connections between complexity theory, action research and feminist approaches, but before that we round off this section on our action research methodology by setting out the specific techniques and methods used to advance each of the three research goals.

2.3.3 Action research methods employed for each research goal

Reason and Bradbury (2008) emphasise that action research allows many choices and argue that the key to quality is becoming aware of these choices and understanding the consequences thereof. Professional action research was the methodological paradigm of our study. The following overview of the specific, albeit rather eclectic, mix of methods was facilitated by the possibilities afforded by professional action research.

The first research goal aimed to identify the standard of care for IPV in primary health care within the Western Cape by analysing participants' medical records. The International Classification for Primary Care (WONCA International Classification Committee, 1998) was used to code all reasons for encounter and diagnoses made during the previous 24 months. The International Classification for Primary Care was originally developed because other classification systems were too restrictive for primary care. The International Classification

codes the whole process of primary care, rather than only diagnoses. Thus it offered techniques to compile a comprehensive profile of participants' mental and physical health scenarios, and so was our methodological choice. This quantitative approach was subsequently triangulated with first and follow-up interview qualitative material to deepen the interpretation in Chapter Six.

The second research goal required the implementation of a protocol for the screening and management of IPV (Martin and Jacobs, 2003). The researchers conducted comprehensive first and follow-up interviews with each study participant. Both included quantitative and qualitative findings. In order to better understand the context and viability of routine care for IPV survivors, the principal investigator conducted in-depth interviews with key informants; focus groups were conducted with the health care professionals at study sites; co-researchers provided field notes; and the content of cooperative inquiry group meetings were all analysed to produce Chapter Seven.

The third research goal aimed to learn from the process of training researchers new to the action research paradigm. Interviews were conducted with each researcher to appreciate how they had understood the action research experience and this was triangulated with their field notes and participation within the cooperative inquiry groups to produce Chapter Eight.

2.4 Complexity theory

Nesting within the broader framework of open systems theory, complexity theory has emerged as a recent theoretical development in the arena of health. Focusing on the value of observing, understanding and improving systems as interactive, living wholes, instead of a collection of discrete components, complexity theory engages with healthcare environments as complex adaptive (living) systems, not as complicated machines (Grol, Wensing & Hulscher, 2005, p.31). A mechanistic approach to managing health care understands the system to be a particular combination of components, whereas a managerial approach informed by complexity theory is more in line with Foucault, who offered us a uniquely sophisticated and explicit analysis of power which is further explored in Chapter Four. Foucault's theoretical framework locates power within individual and spontaneous reactions, rather than in planned, directed struggle (Foucault, 1977).

This chapter argues that the metaphors and insights of complexity theory are closer to how living / human systems actually work. When organisations are designed and managed as

machines, friction is created in terms of how people actually work together. Often people continue to work in a hidden, subversive way in order to get things done, by creating communities of practice that work across the mechanistic lines. Often these people create pockets of innovation, creativity and life despite the organisation. They tend, however, to become frustrated that their innovations are not recognised or supported. Others seem to see work as a necessary task that must be survived in order to put food on the table, but suffer from a lack of personal meaning, coherence and value in the practice of that work. This thesis argues that people naturally tend to form complex adaptive (living) systems wen they work together and that this is hidden within the mechanistic perspective, often invisible, or seen as an unwelcome disturbance.

The term 'complexity theory', like 'feminism' and 'action research', is a misnomer, since it implies a monolithic, co-ordinated theory. In fact, multiple competing discourses share the label 'complexity theory'. Cilliers distinguishes strongly between a general theory of complexity that acknowledges the complexity of phenomena one is dealing with using a number of general arguments about complex systems for substantiation on the one hand, and the mathematically oriented theory of the Sante Fe group which grew out of chaos theory. The latter focuses on fractals, attractors and phase space (Cilliers, 2007). Arguably, most complex systems are anything but chaotic and nature is neither fractal nor self-similar.

As a philosopher, Cilliers critiques the search for universal patterns to provide immutable characteristics of complex systems, as a return to a reductionist, positivist epistemology. A key epistemological issue underlying this thesis is that when one analyses complex things one always has to reduce the complexity to some sort of order to make it manageable and in that process something is lost. At some level this implies that the learning through action research is always an attempt to make sense of complexity through a process of reflection that extracts some sense of order and is therefore always a partial articulation of the whole. The whole can never be completely known or understood. As a researcher, I shall therefore proceed with a spirit of 'humility and ignorance' as recommended by motivational interviewing (Miller & Rollnick, 2002) when trying to make sense of change and personal complexity. An understanding of the co-operative inquiry group as a living system or community of practice, seeking to engage with and make sense of their own broader, complex organisational and professional systems, should make one wary of the assumption that understanding IPV in a PHC context can produce simple, generalisable algorithms that 'fix' the whole problem through linear cause-effect relationships.

A key commonality between action research, feminism and complexity theory is that each has no single method or theoretical base. Yet they share a profound connection between empowerment and the relational processes possible within living systems. Action research works with the relational processes inherent in many feminist methodologies, which are also at the core of complexity theory. In complexity theory, relational processes are understood as connectivity. Feminists argue that empowerment and relational processes are profoundly linked, in that people transform in the context of human relationships (Maguire, 2001, p.63). Committed to action, action researchers create living or complex adaptive systems, to search into and constructively change behaviours, relationships, and the often unseen institutional and organisational structures and relations which form our lives, work, love and play (Maguire, 1996). A wholehearted response to this call to transformational action, structural and personal, is a keystone of feminism and feminist scholarship (Maguire, 2001, p.59).

Having pulled together the threads of feminism, action research and complexity theory which form the theoretical and methodological web within which this thesis was spun, it is clear that at meta-methodological and ontological levels I am working within the emancipatory-critical paradigm. Yet I also drew on methodological approaches more usually characteristic of interpretive-hermeneutic and empirical-analytic paradigms, which are contextualised in the next two sections.

2.5 The interpretive-hermeneutic (qualitative) paradigm

Significant dimensions of the study design fell within the interpretive-hermeneutic paradigm, since we were aiming for a deep, fine-grained, contextually accurate understanding. Interpretive-hermeneutic strategies aim for objectivity that is sensitive to the importance of subjective meaning and individual action (Morgan, 1983, p.296). Qualitative researchers such as anthropologists work with an insider's (emic) perspective on social action to describe and understand rather than to measure and predict human behaviour. Consequently the emphasis here is on methods of observation and analysis that stay close to the research subject and work constructively with the subjectivity of the researcher. The focus is on the researcher doing the interpretation or qualitative analysis, as an interpreter of others' experience. Opposing alignment with 'truth, objectivity, neutrality and reason', much feminist work fits within the interpretive-hermeneutical paradigm because it recognises its own position as context and observer dependent (Grosz, 1987).

The original hallmarks of the anthropological method were fieldwork and ethnography. Both involve immersion in the relevant cultural milieu, combined with the tools of systematic observation, recording and analysis of findings. As such, the participant-observer ethnographer occupies a liminal position within the culture, both in and out. The validity of findings is embedded in the understanding acquired via the *depth* and *extent* of interactive involvement within the research context, instead of via statistical sampling techniques (Hoff, 1992, p.23).

Babbie and Mouton (2001, p.54) distinguish between four phases in the history of the qualitative paradigm:

1. The early years: rise of field research in anthropology;

2. The Chicago school: 1915–1940;

3. The establishment of participant observation; and

4. The 1960s and thereafter: methodological and epistemological legitimisation.

In the 1960s, work done on the epistemological foundations and assumptions of the qualitative paradigm showed it to be rooted in influential philosophical and sociological traditions or meta-theories such as phenomenology, symbolic interactionism, pragmatism and existentialism. Babbie and Mouton (2001, p.58) comment that these efforts to ground the qualitative approach in relevant meta-theories reflected the need to legitimise and justify the existence of the qualitative paradigm in response to the growing quantitative dominance in social research in the 1950s and 1960s.

This project used qualitative techniques, which owe allegiance to the interpretive-hermeneutical paradigm. The interpretation of first and follow-up interviews, the views of doctors and nurses regarding their attempts at screening, and my own analysis of the co-operative inquiry groups' transcripts is qualitative. At the heart of the research project however was the implementation of the protocol by co-researchers, including myself. If the study design had been confined to the interpretive-hermeneutic paradigm, I could have simply interviewed the co-researchers about their experience and then interpreted it myself. This would, however, have prevented all co-researchers from engaging in a cyclical process of action and reflection that allowed for adaptation and the emergence of new ways of doing things and new ways of making sense of them in an ongoing way. It would also have downplayed the importance of collective interaction, feedback, reflection and transformation

within the co-operative inquiry group where people were encouraged to engage with the research question by sharing ownership of the inquiry and to consciously plan changes to their own professional activities in a collaborative manner. At the heart of the research was a question about, "How to do something new?" which went beyond the question, "What do you think, feel or believe about your experience?" or even, "How have you previously been doing something?"

This question about how to transform or change a situation can be tackled in a professional action research paradigm in an ongoing prospective way while in the interpretive-hermeneutic paradigm, it can only be reflected on in a retrospective manner. In some ways the action research cycle includes steps where an interpretive-hermeneutic stance is useful, namely observing and reflecting on one's experience. Even so, the interpretive-hermeneutic techniques can only enable the reflective portion of the cycle. The techniques of the interpretive-hermeneutic paradigm therefore may be seen as compatible with the process of action research, since they function as elements within it.

2.6 Empirical-analytical (quantitative) paradigm

The dominant paradigm of social science and health research has been the quantitative, empirical-analytical paradigm. It is based on the belief that a natural science of society can only be value-neutral if prejudice, subjectivity, bias, chance and confounding factors are ordered by the systematic, dispassionate application of statistical techniques (Babbie & Mouton, 2001, pp.49-53). The bedrock belief is that quantitative data gained by wholly objective means, within strictly controlled laboratory-type conditions, is more inherently valid than data obtained from subjective interpretation of others or one's own experience. However, depending on the research design and questions, quantitative research methods in the social sciences can be applied and interpreted with sophistication, are not necessarily predicated on an assumption of value-neutral objectivity, and can be used with great effect to complement qualitative methodologies.

Nevertheless, the paradigm tends to be characterised by certain assumptions, including:

A belief that the best way of measuring phenomena is to numerically measure the perceived qualities of things.

A belief that observation does not alter the phenomenon being observed (quantum theory shows that this is not the case even for physical phenomena).

A belief that there is an objective universal truth to explain the phenomenon that can be measured and generalised, in the form of cause-effect relationships.

A central role is accorded to variables in describing and analysing human behaviour.

Control for the sources of error in the research process is highly prioritised and takes the form of experimental and statistical controls which reveal the underlying positivist assumption that the social sciences should be modelled according to the natural sciences.

By the 1950s and 1960s the quantitative paradigm had become the dominant social science research approach, and was accorded the greatest respect and prestige. This research approach has dominated much of the IPV literature, producing, for example, a plethora of articles on the prevalence of IPV in multiple contexts, which contribute little more than similar findings that it is surprisingly common. Radical feminist theory contests the scientific relevance and ethical justification of quantitative social science research by challenging the legitimacy of positivist methods of inquiry in its production of social theory. At the core of the debate is the assumption that the natural and social world can be objectively studied, without consequent loss of meaning and context in aggregate data. This point is of major concern, since a lynchpin of feminist theory is an understanding of the social construction of knowledge, and the centrality of context for the interpretation of meaning. However, as we saw earlier even the self-confessedly political action research is also largely at fault for a lack of feminist discourse and practice within the field.

A feminist analysis can be used to expose blind spots in experimental designs which strip the data of contextual meaning. For example, statistical data produced by the Conflict Tactics Scale (Straus, Gelles & Steinmetz, 1980) is widely used. However, the Conflict Tactics Scale measures IPV by adding individual acts of violence by husbands and wives without regard to the severity of injury, or the issue of self- defence. The most controversial finding was:

> *"1.8 million wives are physically abused by their husbands each year while nearly two million husbands are physically abused by their wives"* (Gelles & Straus, 1979, p.26).

According to Yllö (1988, pp.40-41), Straus et al. have spent subsequent years explaining that they did not consider the context of the violent acts and that most of the women's violence was certainly in self-defence. However she notes:

"Though they have stated that wife abuse, not husband abuse, is the pressing problem, the damage was done. Those few simple numbers and the notion of the 'battered husband syndrome' (Steinmetz, 1978) have been a powerful influence on policy makers and the public ... most disturbing is that the criticisms of the Conflict Tactics Scale seem to have gone unheeded ... [the] highly controversial statistic from the 1975 study is confirmed by the 1985 study."

Similarly, Spiegel's discussion of the ironies surrounding post-apartheid interdisciplinary possibilities in research shows how the use of ethnographic methods as adjuncts to official positivist forms of large-scale data collection has proven problematic (Spiegel, Watson & Wilkinson, 1999, p.181). The translation of 'stories' into statistically representative 'data' was extremely difficult and complex. Since everything was limited to what could be included as numerically indexed responses to the confined questions of the survey formats, interesting, 'thicker' aspects were simply absent from the data presented in the survey findings. He concludes:

"The analytic grid imposed by the necessity for numerical coding of survey data would seem to preclude any really consequential engagement with the textured detail of people's changing lives and cognitive frameworks over time"
(Spiegel, Watson & Wilkinson, 1999, p.182).

Yet, it is the argument of this thesis that while such issues necessitate careful consideration, they do not justify the elimination of empirical-analytical techniques from the social science researcher's repertoire of methods. For example, in this study the International Classification for Primary Care coding used to identify the standard of care was a vital technique in achieving our first research objective. Similarly, quantitative aspects of the first and follow-up interviews, have provided extensive data on multiple aspects of participants' life circumstances and practices. Speaking to this point, True (1990, p.298) argues that epidemiological perspectives offer a bridge between medical anthropology's traditional focus on environmental and social aspects of disease causation and the focus on definition, aetiology, and classification so characteristic of biomedicine. True insists that the roots of epidemiology fit squarely in the anthropological tradition of understanding how the holistic health of humans is significantly impacted upon by their cultural, social and physical environments:

"By engaging in the all-too-familiar occupational hazard of talking to ourselves about the problems of other disciplines, we lose a valuable opportunity to move our discipline in exciting new directions" (True, 1990, p.299).

The obsession with formulating hypotheses that can be proven or not, fails to see how drastically such preconceptions limit the research process. The arrogant assumption that science is innately superior creates a blind spot for seeing how narrow and reductive it often is. The need by scientists for laboratory-type conditions to do 'real' science seems to underlie the positivist stripping of context which characterises their experimental design.

The British Medical Research Council's approach to the evaluation of complex health interventions (such as that envisaged by the IPV protocol of our research) advises a series of steps from theory to modelling to clinical trials of a new intervention (MRC, April 2000). Arguably, this study fitted into the modelling step of this progression. If one is not bound within the empirical-analytical paradigm, then action research possibilities for constructing a new model can be very useful. The Council's approach however, still assumes that the next logical step is to test this complex intervention in a clinical trial, to see if it really has efficacy or effectiveness; thus demonstrating their allegiance to (and limitation by) the empirical-analytical paradigm. If one sidesteps that mindset, and opens oneself to the rigour of the emancipatory-critical paradigm, the effectiveness of the IPV protocol model of our research could be carefully established, albeit within the rather more complex and challenging paradigm of professional action research.

2.7 Conclusion

The political worldview that informed me in undertaking this thesis was feminist, which led me to the topic of IPV and the need to contribute to doing something about it. The thesis itself is seen as an act of feminist activism. Ethical considerations were paramount from the outset of designing the methodology, but it is important to note that research ethic protocols, even feminist ones, cannot fully cope with the responsibility of intervening in IPV survivors' situations, given that lives are at stake. Feminism and action research complement each other ontologically as strategies to effect social transformation, so I adopted action research as the methodology for this research. While the methodological point of departure of this thesis is that of the emancipatory-critical paradigm, through the prism of action research the study pulled in quantitative and qualitative techniques and methods from the empirical-analytic and

interpretive-hermeneutic approaches. A key action research method for the study was the co-operative inquiry group of the research team. Since the milieu to be potentially transformed is the PHC system of South Africa, it is useful to understand this system, the research sites and indeed our own research team from the point of view of complexity theory, which allows for the transformation of dynamic, interconnected open and living systems.

CHAPTER THREE

OVERVIEW OF INTIMATE PARTNER VIOLENCE LITERATURE

"Silence can be a plan
rigorously executed"
(Cartographies of Silence, Rich 1978)

3.1 Introduction

Coming from Chapter Two's meta-methodological perspective, the feminist framework is expanded on more concretely in this chapter, which reviews the literature about IPV in four sections: firstly arguing the case for seeing IPV as a medical and not simply a social problem, secondly describing the phenomena of IPV, thirdly trying to understand the inadequacies of healthcare responses to IPV, and lastly drawing on recommendations about screening and intervention.

IPV resides on the dark side of what it means to be human. It emanates from the more sinister and painful aspects of the human condition. As we will see, it raises difficult issues for health care providers. The literature identifies widespread health care provider resistance to diagnosing and managing this issue. This literature review describes the historical neglect of the needs of abused women within health systems and tracks recent changes. Intimate partner violence (IPV) against women was originally identified in health-related literature in the USA as an area of major concern. This review looks thematically at the growth of such literature over the past three decades, seeking to identify trends and emphases. This thesis argues that failure to intervene reflects a fundamental neglect of one's ethical responsibilities as a health care provider.

In Section 3.2, the chapter opens with early feminist work which shattered the silence surrounding IPV as a major healthcare problem and identified it as one aspect of male violence against women. Feminist hermeneutics is used to uncover ways of (not) talking about and shaping the understanding of gender relations and IPV, before the endemic violence against South African women is exposed as embedded in male/female relations which serve to keep women subordinate. In an attempt to unpack why the rate of IPV is twice as bad in

South African rural as urban areas, we examine the position of farmworkers within gender and economic relations in selected rural settings. Having made the case that IPV is a product of, and perpetuates, oppressive gender relations, the scope for tackling IPV as a social issue is found within South Africa's rights-based public policy.

In Section 3.3, literature which attempts to quantify and describe IPV is reviewed, and some methodological problems with collecting data about prevalence and experiences are raised. IPV remains a statistically significant problem, not least since South Africa has the highest reported intimate femicide rate in the world. Studies triangulating IPV with economic, demographic, situational and behavioural factors, including the possibility of screening men for being perpetrators of IPV, are looked at before exposing the physical and mental health consequences of IPV. Besides the immediate direct injuries, survivors also suffer longer term physical conditions, and indirect health consequences. Even one assault has a negative impact on relationships and mental wellbeing, and the cumulative effect of IPV on mental health are debilitating for individuals and family systems at large. At worst, IPV leads to death. Some studies looked at the incidence and impact of IPV during pregnancy. One way to measure the impact of IPV is to count the increased health care costs compared to those for the general population. In a climate of coercion and violence by men, women's capacity to resist behaviours which increase the risk of contracting HIV is compromised, so IPV has a knock-on effect for other health issues. Women appear to become trapped in a cyclical pattern of IPV, with brief moments within the cycle when they are more likely to seek help, which creates windows of opportunity for intervention.

Section 3.4 looks at what the literature has to say about the role of health workers in addressing IPV. While mostly abused women don't experience health care providers as helpful, they want to be asked about IPV, want compassion, find it helpful to have IPV identified as abusive and themselves as not deserving of abuse, and may act on practical advice made available, even if not immediately. But IPV is not recognised, or is ignored or minimised when it is, or the victim is blamed for 'causing' it, which only further erodes the IPV survivor's trust in the health care provider. Studies of health care workers response to IPV and the nature of care offered to survivors of IPV provide a backdrop and information for the first research goal of this thesis: to identify the current nature of care offered to survivors of IPV in the primary health care sector of the Western Cape. Reasons why health care providers do not respond constructively to IPV are interrogated.

In attempting to overcome barriers to adequate IPV care, training interventions are examined and reveal that attempts to change attitudes do not change nurses' behaviour as much as change of documentation requirements might. The attitude change needed is a shift towards feminist understanding of gender relations, combined with the implementation of revised documentation to provide IPV-related details, including care provided. In the course of this chapter, I highlight issues pertaining to practices of health care providers that were relevant for the design of our research process.

In Section 3.5 the differences between the realities of South African healthcare provision and that assumed in the international literature, which largely comes out of a first world context, are highlighted. Post-apartheid health care policy, challenges and implementation gaps are discussed, in particular with respect to primary health care. I then draw on the literature for findings and recommendations around screening for IPV, and having diagnosed IPV, what can be done to intervene, and what is most effective. Along the way factors hampering implementation of the universal screening of every woman patient that all seem agreed on as essential are looked at. The chapter ends with a critique of the heavy burden of proof of effectiveness and lack of harm sometimes placed on proposed IPV interventions. This last section is of relevance to developing screening protocols for IPV, thus feeding into the second research goal, namely to determine the feasibility of implementing a published South African protocol for screening and management of IPV.

3.2 Understanding IPV in the context of gender relations
3.2.1 Breaking the silence: Early feminist critiques

Following the emergence of feminist discourse in the 1960s, IPV against women was identified in health-related literature in the USA as an area of major concern. The body of literature essentially dates from around 1977 and I have included these 'older' texts because they provide valuable pointers to the development of the field and the issues involved.

Pioneers were Anne Flitcraft, a medical doctor, and Evan Stark, a sociologist. When the former asked Dr Frazier, a young plastic surgeon and director of the emergency room at Yale-New Haven Hospital, if she could do her thesis on "battered women" who used the service, he asked what a "battered woman" was!

> *"Dr Frazier was only the first of several sceptics who listened to us patiently and then gave us unselfish support. At the time there was no evidence that domestic violence*

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was a common health problem. What we had to offer, besides the partnership between a physician and a sociologist, was experience with shelters and hotlines that demonstrated that male violence against partners was epidemic. It seemed inconceivable that this epidemic could have bypassed the medical gaze" (Stark & Flitcraft, 1996, p.4).

Bio-ethical mores of the mid-1970s compelled Flitcraft's doctoral team to work only with women's medical records. The phenomenon they wanted to study was officially invisible, although the evidence was not. Flitcraft completed her doctoral thesis : *Battered women: An emergency room epidemiology with a description of a clinical syndrome and critique of present therapeutics* at Yale University School of Medicine in 1977.

In the same year Parker and Schumacher (1977) published their classic study, which is regularly cited by researchers across disciplines as one of the first controlled wife-abuse investigations. It found that health care providers were insensitive to the problem of intra-familial violence. While treating injuries, they ignored the cause. It also coined the term "battered wife syndrome" to describe a symptom complex that occurred when a wife received deliberate, severe, and repeated (upwards of three times) demonstrable injury from her husband (Parker & Schumacher, 1977). Walker (1979) expanded this early definition to apply beyond the confines of marriage but also suggested that "battered women" suffered a range of psychological inadequacies.

In 1979, Stark, Flitcraft and Frazier published *Medicine and patriarchal violence: the social construction of a "private" event*. They argued that health care providers' ignorance of IPV dynamics was at the root of a "staged" process beginning with medical treatment of symptoms and ending with the invention of the "battered woman syndrome" as a discrete pathology. The authors argued that this constituted a secondary victimization of women due to the healthcare system's neglect of IPV, which contributed significantly to the mental health sequelae that so commonly accompany abuse.

By extension, Stark and Flitcraft (Stark, Flitcraft & Frazier, 1979) also rigorously critiqued the treatment of depressive disorders, including suicide attempts, and substance abuse as primary problems, instead of addressing IPV the underlying cause, at psychiatric and social service referral points, suggesting that maintenance of the family, regardless of the cost to the woman suffering abuse, was often the strategic goal of such treatment.

This groundbreaking work fractured the silence within the health service around IPV, highlighting the need to appreciate how social forces contribute to women's entrapment in battering relationships. Working with an "index of suspicion" for the significance of what is implied or not said in the health field over the next two decades, Stark, Flitcraft and others interrogated the "code of silence".

Eagleton (1978, p.89) pertinently noted that:

> *"The task of criticism is to install itself in the very incompleteness of the work in order to theorise it – to explain the ideological necessity of the 'not-saids' which constitute the very principle of its identity."*

Among the "not-saids" unearthed by the early feminist theorists of the 1970s was the vast extent of male violence against women and that it is precisely this violence that maintains male power and privilege. Thus battering, rape and pornography were among practices unmasked as part of systemic patriarchal abuse of power by men over women's bodies (Chesler, 1972; Daly, 1978; Dobash & Dobash, 1978; Dworkin, 1981; Millet, 1977; Pizzey, 1974; Stark et al., 1979; Walker, 1979). More recently, Chesler (2001), in work reminiscent of the critiques of racism emanating from "black power" and negritude schools, has examined how women internalise oppressive notions of themselves. This comes up when discussing how women participate in sanctioning forced sex and infidelity in section 3.2.3 below, and we will explore internalised oppression extensively in relation to nurses in Chapter Four.

Following in the footsteps of this early feminist work, the theoretical approach governing this thesis is the feminist orientation that analyses "wife battering" in the broader economic, social and political context of sexism. It employs an index of suspicion towards the social construction of gender, and the violence that results (Dobash & Dobash, 1978; Ludsin & Vetten, 2005; Pizzey, 1974; Stark et al., 1979; Stark & Flitcraft, 1996; Walker, 1979). It also draws on the general social orientation approach, which analyses "wife battering" in the context of general violence in society (Goode, 1971; Straus, Gelles & Steinmetz, 1980). Feminist and social orientation theories agree that socialisation plays a key role in producing the battering situation, but they disagree over whether it is socialisation to sex roles or socialisation to violence that is the problem.

In breaking the silence surrounding IPV, it is useful to employ feminist hermeneutics to examine how what is said – and particularly *not* said – shapes the construction of sexism and our ability to even conceptualise gender oppression and the issue of IPV.

3.2.2. Not talking about the issue: From language to hermeneutics

Hermeneutics, or the science of interpretation, focuses on how people understand spoken language, written text, and themselves through language across socio-cultural environments (Bonomi, Allen & Holt, 2005). Feminist hermeneutics is based on the realisation that the absence of respect for women's lives and bodies is written into the heart of male theological doctrine and consequent theological anthropologies, into the structure of the patriarchal family, and into the language of patriarchal ethics and politico-economics.

The feminist hermeneutical process begins with the identification of oppressive areas of female experience. Language teaches us, below the level of consciousness and intentionality, about our sense of power-in-relationships. Harrison (1985) argues that a feminist ethic must include the critical assessment of all language in order to eliminate those patterns that reinforce unjust social relations. In the commitment to naming and examining oppressive phenomena in order to bring about change, a clear-sighted realism demands rigorous application of the hermeneutical principle of suspicion. She notes however that language may be appropriated to challenge previously unquestioned patterns of domination embedded within linguistic cultural expression.

Also drawing on the sociology of knowledge, which emphasises how humans evolve through ongoing conversation between themselves and significant others in their society, Demaris Wehr (1988) fleshes out the profound implications of the use of male generic language. She emphasises how this conveys a message of women's inferiority on a subtler, deeper level than the purely negative treatment of belittlement could, quoting Adrienne Rich (1980, p.37) to make the point:

> *"In re-reading Virginia Woolf's* A Room of One's Own *(1929) ... I was astonished at the sense of effort, of pains taken, of dogged tentativeness, in the tone of that essay. And I recognized that tone. I had heard it often enough, in myself and in other women. It is the tone of a woman almost in touch with her anger, who is determined not to appear angry, who is <u>willing</u> herself to be calm, detached, and even charming in a room full of men where things have been said which are attacks on her very integrity."*

In *Man-made Language,* Dale Spender (1981) reveals the potency of sexist language as a tool of patriarchal ideology. She argued that in making themselves normative, men have systematised the world from that reference point, constructing a symbolic system which mirrors patriarchal order. If contemporary linguistic philosophers are correct that language shapes our consciousness *more than* it expresses it, women are disadvantaged from the beginning of language acquisition by the culturally embedded notion of their own less-or-other-than normal status.

Shefer, Strebel & Foster applied this principle to their study of heterosexual patterns of early adult relationships, showing how words used to describe genitalia and sexuality highlight a relationship between violence and heterosexuality (2000, p.11). She refers to Mokwena's (1991) study on youth gangs in Soweto where the young men interviewed described sex as "*uka peita*" (to spray), *"ugushaya nge kauza"* (to hit her with the pipe), and *"ukuhlaba"* (to stab). Such signifiers construct masculine sexuality as an active agent that 'does it' to women, saturating it with images of invasion, humiliation and violation of women by men (Mokwena, 1991). With such strong associations between heterosexuality and violence against women, the prevalence, 'normalising' and indeed sanctioning of IPV should come as no surprise. In section 3.2.3 below, Rude examines the use of language in Zambian newspaper accounts of women killed as a result of IPV, which language reduced the attacks to disputes, concealed their brutality and blamed the victims (Rude, 1999).

In this thesis, the focus is the primary heath care system in relation to IPV, and it is to this that the hermeneutical principle of suspicion will be applied. For our purposes, Warshaw (1989) critiqued language used in medical records to describe injury-causing events that denied the reality of male violence towards women, and fostered the silence around the issue. Physicians tended to use passive, disembodied phrases that disregarded the presence of both perpetrator and survivor. For example, "hit on left wrist with jackhammer" or "blow to head by stick with nail in it" were recorded as causes of injury. The person wielding the hammer, his relationship to the victim and the circumstances of the attack were missing. Warshaw describes this medical shorthand as "*an important shaper of how physicians learn to organise their thinking*". Whether consciously or unconsciously deployed, such editing of the facts obscures the cause and meaning of women's suffering and exacerbates their isolation and despair (Warshaw, 1989, pp.512-513). Chapter Six, which focuses on participants' medical records to

identify the current standard of care for IPV at the study sites, demonstrates parallels with Warshaw's work in Chicago 20 years ago.

Despite feminism having broken the silence surrounding violence against women, allowing us to at least name the problem of IPV, it will be seen below that survivors and health care providers perpetuate IPV as a "not said" experience. A range of factors attributable to the oppression of women, the hierarchical organisation and biomedical practices of the medical system, the subordinate position and role of nursing within this – and the lack of a conversation about any of this – account for this continuing silence. We cannot intervene against phenomena that are unnamed.

3.2.3 Violence as part of the patriarchal subordination of women

"Men's experience of racism and economic deprivation often causes a reactionary backlash within the family – to the detriment of women – rather than opening up the space for resistance to race and class oppression" (Campbell, 1990, pp.13-14).

As an extensive characteristic of the powerfully racialised and patriarchal South African society, violence was deeply rooted both in colonial and apartheid administrative processes and practices, and in pre-colonial disciplinary practices (Glanz & Spiegel, 1996). It is the argument of this thesis that IPV reflects circumstances beyond the boundaries of the domestic group. This resonates with, for example, Van der Waal (1996) who argues that the pervasive violent interpersonal behaviour in a rural settlement in the Northern Province traces its origins to colonial and apartheid policies that shaped a racially unequal society and damaged the social fabric of all communities, placing the heaviest burden on African communities. He explains how this cultivated male perceptions of their own marginality and powerlessness, which in turn created a culture of violence against more vulnerable family members.

Identifying violence against women as "endemic" in South Africa, Vogelmann and Eagle (1991, p.218) argue that in many ways the ideological construction of heterosexuality, marriage and the family serves to conceal and mystify violence and abuse against women. They point to the absence of a broad-based feminist movement within South Africa where issues of the economic, political and social relationship of women can be addressed. In South Africa, as elsewhere, IPV tends to be a hidden phenomenon, remaining undisclosed to

relatives, neighbours, clinicians and researchers as a result of different cultural constructs about its significance (Fischbach & Herbert, 1997).

Internationally, traditional and cultural practices have been used to justify violence against women. Boyle et al. (Boyle, Robinson & Atkinson, 2004) inform that in Britain, prior to 1824, a husband was legally allowed to beat his wife with a stick smaller in diameter than his thumb, hence the expression "rule of thumb". This exemplifies how gender-based violence is reinforced by cultural and social norms that invest men with power and authority over women (Auerbach, 2005). In the southern African context, "culture" is often used to perpetuate practices harmful to women. Yet it should be noted that culture is neither static nor monolithic, and traditions are forever evolving. Further north, a Zambian study on 150 femicides between 1973 and 1996 explains that for many victims, death was the punishment for transgressing expected gender roles.

Rude shows how newspaper accounts masked the reality of intimate femicide by concealing the brutality of the attacks while blaming the victims. Described as "domestic disputes", the often-nameless victims were judged for "provoking" their perpetrators. Such comments, legitimising men's destructive behaviour, serve to sanction violence against women (Rude, 1999, p.7):

> "Almost nothing is known about Eunice Tembo, who was burned to death in April 1989 in Lusaka's impoverished Kalingalinga compound. In a short article, the Zambia Daily Mail reported that Eunice and her husband Edward 'quarrelled about the whereabouts of his shoes'. Edward then poured paraffin on Eunice and set her ablaze. He was charged with murder, but the outcome of the case was never reported in the press."

> "On 20 March, Margaret Bwalya's husband assaulted her for a full day. Believing that she had gone looking for him at his girlfriend's house, he punched her and dragged her, half-dressed around their shantytown neighbourhood. Despite her broken ribs, head injuries and the possible death of the four-month-old foetus she carried, he locked her in the family home for days. According to her mother and sister, Margaret died, five days after being rescued and taken to hospital. Later, police had to be persuaded to arrest (her husband) Costain Sitwala, a member of the Zambian

> *airforce. His charge of murder was reduced to manslaughter; he is now serving a three-year jail term"* (Bwalya, 1996, in Rude, 1999, pp.7-8).

Albertyn (2003) discusses how patterns of sexual and cultural inequality are frequently enforced by violence, which in South Africa is so endemic, that coercive and even violent sex is normative. She argues further that 'transactional' sex arises from income inequality combined with cultural norms. Increasingly, studies indicate that first sexual experience of young women is often coerced, and that such coercion is normative (Krug et al., 2002; Mash, Kerethi & Mash, 2006; Wood, Maforah & Jewkes, 1998; Wood & Jewkes, 1997). Just as disturbing is the South African finding that schoolteachers are responsible for 32% of disclosed adolescent rapes before the age of fifteen (Jewkes & Abrahams, 2002).

In a South African study, multiple modelling showed that both forced sexual initiation and unwillingness to confront an unfaithful partner were strongly associated with pregnancy in adolescents, and were also related to each other. Jewkes et al. (2001c, p.742) hypothesised that the high risk associated with forced sexual initiation and unwillingness to confront an unfaithful partner was mediated through inequalities in power relations within the relationships, and was reinforced by violence. Being beaten was common and some understood it to be an expression of love, particularly if they had received gifts of clothing and money. Women's inhumanity to women again reared its ugly head in that female peers reinforced the legitimacy of such coercive sexual experiences by communicating that submission and silence constituted the acceptable response (Wood et al., 1998).

Closer to this thesis' study sites, an urban Western Cape study highlights university students' construction of heterosexual relationships as strongly connected to power, violence and inequality (Shefer et al. 2000). Violence, male control and coercion over sexuality were found to be expected and assumed parts of 'normal' heterosexual relationships. Significantly though, challenges to unequal and coercive sexual practices also emerge that emphasise the need for communication, negotiation, equality and the realization of women's rights (Shefer et al., 2000, p.17).

The use of violence to assert dominance in interpersonal relationships is seen as a cornerstone of masculinity in South Africa. The critical import of changing men's behaviour is lifted out as a major challenge in violence prevention (Morrell, 2001).

The reported rate of IPV in rural South African settings was found to be twice that of IPV in urban settings (De Villiers, 1998). What is happening in these often marginalised areas is put under the microscope in the next section.

3.2.4 The subjugation of female farm workers in South African rural areas

Artz (1999) informs that while rural homes tend to be the hub of social and economic activity, they are frequently disrupted by alcohol abuse and aggression from male partners. She notes that women feel powerless to resolve the alcoholism within their communities.

Sandra Hill Lanz (1998) discusses how, by its very structure, rural society in the Western Cape compels women to be dependent on men. Women are bound to men by social and economic conditions, and are adversely affected by state policies, the welfare system and employment law, which make it virtually impossible to escape the cycle of rural poverty and dependence. Indeed, among farm workers the degree of interdependence between women and men is extreme. Women marry for access to housing and employment, while men marry for housekeeping services. At the time of her investigation, wives earned 50% of their husband's salary, working only five hours less per week. Their employment conditions and positions were not linked to their educational level, hence they lacked incentives for self-development and creative self-actualisation. In Hill Lanz's Lawyers for Human Rights study (1998), none of the 63 participants had written employment contracts.

Five years later Parenzee and Smythe (2003, p.3) reported that 51% of farmers, in their Western Cape study, assumed the services of a male worker's female partner in his employment contract; 60% of farmers insisted that the female partner should also be available to work, 52% of women interviewed as part of the study reported that their housing was linked to their partner's employment, and 49% of farmers indicated that if the male partner died or left the farm, his family would be evicted (Parenzee & Smythe, 2003).

An indication of their internalised oppression, a notion which is explored extensively in Chapter Four, is that these female farm workers did not value their own work. Status was derived from working in the men's team (Hill Lanz, 1998). The female farm workers' dignity and autonomy were also undermined by decisions being taken for them by farmers and significant male others, without consultation. Hill Lanz (1998, p.24) points to a lack of direct communication between female workers and farmers resulting in poor communication and absence of trust. Indeed, informal co-operation between farmer and male workers within the

patriarchal farm environment guaranteed the social and economic domination of these women. Parenzee and Smythe (2003, p.4) point out that given these unbalanced power relations between women and men, women living on farms are vulnerable to high levels of IPV. Rachel Rodriguez reports on similar hardships of migrant farm workers in the USA, focusing on women's experiences of IPV (Rodriguez, 1998).

Hill Lanz comments that beliefs that indicated a resistance to change, were not always openly expressed, but were evident in storytelling and through analyses of answers and discussions. Some of the reactionary beliefs about gender relations (born out of internalised oppression) shared by the group of women respondents were the following (Hill Lanz 1998, pp.32–32):

- a woman can't be raped by her husband;
- a woman must do all the housework – that's why a man gets married; and
- a man can hit his wife if he's sober and he has a "good reason" – for example, if the food isn't prepared.

Hill Lanz (1998, p.38) notes in conclusion:

> *"Women also said how isolated they feel on the farms with little to no time to broaden life experiences, to work together or even to stop and think creatively about their problems."*

The recommendations in Chapter Nine suggest construction solutions to address the isolation and disempowerment of these women affected by IPV.

3.2.5 Gender parity on paper in South Africa's rights-based public policy

Having analysed IPV as a product of gender relations, rather than an illness syndrome, one casts about for features of the South African landscape that support tackling IPV from this point of departure. Public and policy discourse in South Africa does recognise the oppression of women, seeks to liberate women and men from oppressive gender relations, and addresses violence against women as a social issue, so in principle the space is there.

An important element of the Constitution, which underwrites the new democratic South Africa, is the equal position it accords to women. However, extremely high levels of gender-based violence, poverty and HIV infection among women reveal a chasm between the daily

lives of female citizens and apparent gains in the public sphere. Thus South African women enjoy equality on paper, but not in practice. Much of this thesis is concerned with the consequences of patriarchal values and norms within family, community, cultural domains and health systems which continue to trap women in a subordinate and often violated condition (Salo, 2005).

Budlender (1997) points to the gulf between policy and practice, which is evident, for example, in regard to the constitutional provision for a Commission on Gender Equality. Not only was establishment of the Commission on Gender Equality offset by concessions to traditional leaders, who are mostly men with a conservative outlook, it also came into operation later than other rights bodies and with a significantly lower budget.

Within South African laws and policy, violence against women is acknowledged as a significant human rights and public health issue. South Africa's Domestic Violence Act (116 of 1998) includes a definition of domestic violence so comprehensive that it is recognised to be a legislative standard bearer internationally. It provides for an inexpensive, unsophisticated and relatively fast civil procedure for obtaining a protection order and clearly demarcates the duties of the police (Jewkes, 2001, p.65). There are however still some shortcomings at legislative and policy levels. One of the deficiencies in the Domestic Violence Act is that it fails to outline any specific responsibilities for the health sector. Nevertheless, Marais (2002, p.452) argues that health care providers need to know the provisions of the Domestic Violence Act as they have an ethical responsibility to at least inform patients of their rights and options under the Act. For example, the Act obliges police to assist IPV survivors to make arrangements for suitable shelter and medical treatment.

As Jacobs and Suliman (1999, p.35) and Artz (2001b) point out, women continue to suffer in the gulf between legal commitments and meaningful implementation. The application process for obtaining a protection order has proved unwieldy and is generally poorly understood. There has been inadequate healthcare provider training, and implementation of the Act has also been impeded by an under-resourced legal system (Jewkes, Jacobs, Penn-Kekana & Webster, 2001a; Parenzee, Artz & Moult, 2001).

This study was conducted within the primary healthcare system of the Western Cape, a province in South Africa. Under section 3.5.2 features of the South African health care system

and policies that take cognisance of the needs of women patients are looked at, particularly in redress of the service offered to poor and black women.

If South African laws and strategies for dealing with IPV are to work, then health care providers, the courts, police, professional agencies and survivor support groups must work together (Padayachee & Manjoo, 1996; World Health Organisation, 2005). An important step in this direction is the formation of Rape Forums, which facilitate such networking around community services for rape in the Cape Metropole and surrounding districts of the Western Cape. Another was the South African Gender Based Violence and Health Initiative formed in 2000 to encourage recognition of violence against women as a problem, conduct research to inform policy on gender-based violence and to train health care providers (Cooper et al., 2004; Jewkes et al., 2001a).

3.3 Features of IPV and its significant burden of disease
3.3.1 Prevalence of IPV, including femicide

> *"What mostly affected me was my father. He likes beating my mother. That disturbed my mind; that's when I started to get into crime. Sometimes I would leave the house, angry that my father had beaten my mother – I didn't want to be at home" (*Stephen, 2007, p.10).

During the 1980s and 1990s, a proliferation of predominantly US and Canadian studies sought to examine the incidence, prevalence, and severity of domestic violence. Prevalence estimates vary markedly for reasons including differing definitions of violence, varying data collection methods, and non-congruent time periods used in different studies. Shipway (2004) a British IPV specialist argues that the statistics are potentially misleading. Rapes and sexual assault statistics aside, she sees the hidden crime figure for IPV as larger than any other crime category. In a recent report, Nathanson, head of the British Medical Association's Science and Ethics Committee, concurs that prevalence statistics for IPV are likely to be "grossly underestimated" (Kmietowicz, 2007). The issue of underreporting also arises below when analysing the 1998 South African study by the Medical Research Council (Jewkes et al., 2001b).

The latest WHO multi-country study reports that between 15% and 71% of women experience sexual or physical violence from male partners at some point in their lives (World Health Organisation, 2005). Taket et al (2003) report that in the United Kingdom over 23% of

women aged between sixteen and fifty nine have been physically assaulted by a current or former partner. An Irish study reporting on the incidence of IPV discovered that 39% of their sample had experienced violent behaviour by a partner, but only 12% reported that their doctor had enquired about it. Some 69% reported controlling behaviour by their partner and 28% reported fearing their current or previous partner (Bradley, 2002). Among African-American adolescents surveyed by Easley, 60% of those who had dated said that they had experienced a violent episode by their final year of high school (Easley, 1996).

In South Africa, the first major community-based prevalence study by the Medical Research Council was conducted in three provinces in 1998 (Jewkes et al., 2001b). Stratified, multi-stage, random methods were used to draw the sample, and 1 306 questionnaires in the participants' mother tongues, were completed by interviewers, giving a response rate of 90%. The mean prevalence of reported:

- Lifetime physical abuse by a current or ex-partner was 25%.
- Abuse in the prior year was 9%.
- Rape (acknowledged as such) was 5%.
- Emotional abuse, for instance the mean prevalence for a partner boasting about or bringing home another partner in the previous year, was 7%.
- Violence during pregnancy was 7%.

Jewkes raised concerns about the problem of underreporting in cross sectional surveys. She attributed this silence to the shame that women feel, their loyalty to their partners, and the stigma around IPV as a private matter. Subconscious defences such as denial and rationalisation of their experiences as "normal" could also have affected their responses. A curious anomaly is that the highest proportion of women injured was from the province where the incidence of physical violence had been reported as the lowest. This disproportionately high incidence of women reporting injury and seeking medical treatment suggests either that partners were frequently very brutal, or that there was underreporting of less severe forms of physical violence (Jewkes et al., 2001b). Noteworthy, too, was that sexual coercion by partners was underreported since many woman believed that a male partner has a right to have sex with her whenever and however he wants it (Jewkes, Penn-Kekana, Levin, Ratsaka & Schreiber, 1999).

A 1999 Health Systems Trust study, in an urban community health centre of the Cape Metropole found that 48% of participants had been abused in the past or were currently

enduring abuse (Jacobs & Suliman, 1999). Emotional abuse affected 33% of the sample in these relationships. Seventy percent of those experiencing emotional abuse also reported sexual or physical abuse (Jacobs & Suliman, 1999).

Investigations in health care settings show a variable incidence of physical assault, with smaller percentages in well educated, middle-class samples and larger numbers in samples of poorer women (Humphreys, Parker & Campbell, 2001, p.277). However, the gap narrows for lifetime prevalence of physical assault, 33% and 39% respectively. Humphreys et al. (2001, p.278) note that educational and economic resources do not necessarily protect women from abuse, but do perhaps enable them to escape or end the violence against them. Thus poverty may be less a risk factor for a woman being abused by a male partner in the first place than for her becoming entrapped in an abusive relationship.

Regarding frequency of abuse, in the early 1990s, statistics generated by a Canadian women's shelter revealed that 31% of battered women in their shelter were beaten weekly or daily and another 26% were beaten at least once a month (Ferris, 1994). In the USA, a study of abused women presenting at emergency rooms found that 20% had presented 11 times previously and 23% had presented six to ten times previously, and that the violence had increased in severity (in Sisley et al., 1999, p.1107).

The most frightening prevalence statistic relates to femicide victims. Shipway (2004) reports the United Kingdom Home Office (2000) finding that two women per week were murdered by a current or ex-intimate partner in Britain, a statistic confirmed by Taket et al (2003). Intimate partner homicide is the single largest category of femicide in the USA, with women most commonly killed by their current or previous male partner (Sharps et al., 2001). Femicide is overall one of the leading causes of death for young African-American women aged between fifteen and thirty four (Easley, 1996). Note here again the vulnerability of adolescent and young women to dysfunctional relationships.

In a national study of female homicide in South Africa, Mathews et al. (2004) found that where relationship status could be established, 1 in every 2 women killed by a known perpetrator was killed by an intimate partner. This gives South Africa the highest reported intimate femicide rate in the world: 9 per 100 000 women (Krug et al., 2002; Norman et al., 2007; South African Comparative Risk Assessment Collaborating group, 2007). The study

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concludes that in South Africa, a woman is killed by her current or ex-intimate partner every six hours (Mathews et al., 2004).

Fifteen percent of the latter sample had been sexually assaulted, although in 21% of the sexual assault cases a genital forensic swab had not been taken. Samples had been sent for DNA analysis in only 3% of the intimate femicide cases (Mathews et al., 2004). While the history of previous IPV was considered to be very important in order to secure a conviction, it was only documented in 34% of the cases.

It must be noted that certain methodological techniques of collecting data for measures of IPV prevalence or experience, are limited if not flawed. Browne (1993) emphasises that surveys relying on self-reports obtained via telephone markedly underestimate the problem they are investigating. In the USA, surveys typically exclude those who don't speak English fluently, whose lives are especially chaotic, military families living on base, and individuals who are hospitalised, institutionalised, homeless, or incarcerated at the time the survey is conducted. Thus, estimates relate only to those who are available and willing to talk with interviewers, and who are willing to report, even anonymously, acts of violence they have experienced or perpetrated in their relationships. By contrast, the importance of assessment in a face-to-face interview has been clearly documented. In a family planning setting in Texas, the prevalence of women's self-report of abuse was 7.3%, whereas in the nurse interview group it was 29.3% (McFarlane, Christoffel, Bateman, Miller & Bullock, 1991). These diverse methods of obtaining self-reported experience of IPV are too seldom linked with interpretive frameworks that critically evaluate the language used by health care providers, the language of the IPV tools themselves, and the discourse in the communities where women live (Bonomi et al., 2005, p.2).

Whatever the exact figures for prevalence may be, IPV is now internationally recognised to be of major consequence to women's mental and physical health (Krug et al., 2002). Before we examine these health impacts, we review literature that investigates the risk factors for IPV: are there certain economic or demographic groups of women more likely to experience IPV, certain conditions they are situated in that have been found to have a predisposition for IPV, or certain behaviours of partners or themselves which carry a greater risk for IPV to occur?

3.3.2 Risk factors for IPV

IPV exists amongst all socio-economic strata, demographic groups, and religions. However, women in certain groups or situations may be at higher risk. As noted above in section 3.2.3, the rate of IPV in rural South African settings was found to be twice that of IPV in urban settings (De Villiers, 1998), given a complex interplay of gender and economic forces (with inextricable racial factors coming out of an apartheid history) which maintain women in the abusive situations. Humphreys et al. (2001) note that economic and educational resources do not necessarily protect women from abuse, but do perhaps enable them to escape or end the violence against them. Thus poverty may be less a risk factor for a woman being abused by a male partner in the first place, than for her becoming trapped in an abusive relationship. Studies consistently show that rates of IPV are highest among younger women (McCauley et al., 1995; Sharps et al., 2001). Sisley reports that emergency department visits for IPV are highest among women aged between 25 and 34, and rates of violence are highest for couples younger than 30 years old (Sisley et al., 1999, p.1106). Mathews also correlates rural origins and unemployment with victims of femicide attributable to IPV, but found more victims to be women older than 30 (Mathews 2009).

Women in inter-racial or inter-religious relationships (possibly due to their relative isolation from support networks) as well as separated, divorced and single women are at a higher risk (McCoy, 1996). McCoy tested the predictive validity of her/his thesis, by administering a brief violence screen and found that 67% of separated women with positive violence screens were re-victimised within four months. Far from guaranteeing safety, separation of IPV survivors from their partners may in fact enhance their risk in the short term (Koziol-McClain, Coates & Lowenstein, 2001). Indeed, a battered woman is most at risk of being killed when she leaves her abuser or convinces him that she is leaving for good (Campbell, 1992).

The presence of weapons, specifically guns, in the home – or perhaps the mindset that goes with this – would seem to increase the severity of IPV. McFarlane et al. (1998) investigated the relationship between abuse of pregnant women and gun access by the abuser. They found no significant differences by ethnicity among the 41% of abused women who reported that their male partner had access to a gun. Of this sample, 17% reported the abuser kept the gun on his body. Women reporting that their abuser had access to a gun also reported significantly increased levels of abuse on all measures of abuse in the USA. This was confirmed by Naeema Abrahams and her work in South Africa for the Medical Research Council (key informant interview, April 2007).

Women who are socialised to adapt to and submit to male authority, and who may have been subjected to men's sexual and physical violence, may not have developed adequate self-protection skills as children, especially if they come from childhood homes in which females were victimised (Viken, 1982; Walker & Browne, 1985).

The association between violence and alcohol or other substance use is consistent and complex. A recent Breede Valley study (Stellavato & Gossage, 2007) found that in both urban and rural settings, the quantity that the male partner drank was significantly associated with physical assault. Likewise, for all these women sexual coercion was four times more likely when the male partner consumed alcohol. These results suggest a significant co-morbidity between alcohol abuse by the perpetrator and IPV.

A correlation between alcohol abuse by the victim and IPV has also been reported. Bergman, Larsson, Brismar & Klang (1987) found that 50% of IPV survivors attending an emergency department in Sweden were heavy consumers of alcohol. At three trauma centres in Michigan, Melnick et al. (2002, p.35) found that 65% of patients who screened positive as IPV survivors also screened positive for alcohol abuse. Thirty three per cent of these women were depressed compared to 6% of the control group (Bergman et al., 1987). A recent South African study (Mathews 2009) reveals that 62% of intimate femicide victims had a positive blood alcohol level with a mean of 0.20/100ml, which is extremely high. Blunt force, stabbing and strangulation were associated with drunk victims, whereas the sober victims were more likely to be shot. Mathews found an association between murder by an intimate partner, and a positive blood alcohol level at death and being unemployed, older than 30, and rural. This data speaks to factors in South Africa pertinent to risk evaluation for intimate femicide, particularly in considerations related to issues of safety.

A study from Boston University provides evidence of a strong relation between the use of alcohol by pregnant women, the use of illicit drugs by her male partner, and violence during pregnancy (Amaro, Fried, Cabral & Zuckerman, 1990). A Harvard study found among all women, acts of violence were associated with her having a drinking problem and "being down" and among white women with a drinking problem, "being down", and being hit as a child or as an adult or both (Wyshak & Modest, 1996).

Instead of asking which women are at greater risk of experiencing IPV, we can look at which men are more likely to perpetrate IPV. This could provide a vital new strategy for detecting IPV: the screening by primary care physicians of male patients for aggressive behaviour towards their female intimate partners (Oriel & Fleming, 1998). Wyshak and Modest's study (1996) found that acts of violence and feelings of anger were most highly associated among men with experiences of having been hit as a child, use of drugs, and symptoms of nervousness. Oriel and Fleming (1998) also found a heightened possibility of IPV in men who had been subjected to abuse as children, abused alcohol, and were depressed. These three clinical variables increased a man's risk from 7% at baseline to 41% if all three factors were present. Oriel and Fleming (1998, p.496) point out that a history of childhood victimisation is usually not addressed in male patients, but their findings suggest it is quite common and is linked to violent behaviour.

Particularly high rates of violence were found in perpetrators where alcoholism was co-morbid with antisocial personality disorder and/or recurrent depression (80–93%) (Bland & Orn, 1986). Bland and Orn suggest that psychiatric disorders are strongly related to violent behaviour, and they do not therefore accord with the predominant sociological explanations of family violence that characterised the 1980s. The counter-argument though is that the social may in turn trigger or contribute to the psychiatric condition.

3.3.3 Physical and mental health consequences of IPV

IPV is identified as a significant public health and human rights issue (Heise, Ellsberg & Gottmoeller, 2002). Battered women seek care for their injuries in all healthcare settings, including primary care and mental health services, obstetrics and gynaecology, dental and gastrointestinal specialities. The health consequences of IPV can be categorised as fatal and non-fatal (Abrahams, 2001). Fatal outcomes include femicide, suicide, maternal mortality, antepartum haemorrhage, abortion, stillbirth and AIDS.

Non-fatal consequences of IPV include burns, fractures, chronic pain syndromes, problems with hearing and sight, arthritis, seizures, headaches, sexually transmitted infections, HIV, and pelvic inflammatory disease. Indirect consequences of IPV include stomach ulcers and other gastrointestinal disturbances, heart disease, hypertension, unwanted pregnancy, low birth weight and premature labour (Abrahams, 2001; Burge, 1989; Campbell, 2002; Campbell et al., 2002; Danielson, Moffitt, Caspi & Silva, 1998; Golding, 1999; Humphreys, Parker & Campbell, 2001; Kmietowicz, 2007; Krug, Dahlberg, Zwi & Lozano, 2002; Lo Fong Wong,

Wester, Mol, Romkens & Largo-Janssen, 2007; Nixon, Resick & Nishith, 2004; Orava, Mcleod & Sharpe, 1996; Sisley, Jacobs, Poole, Campbell & Esposito, 1999; Cherniak et al., 2005). Indirect health consequences also include abusers compromising their partners' health by withholding medication, changing a prescription, cancelling appointments, or keeping partners awake (Lamberg, 2000).

The impact on a woman of even a single incident of physical violence in an intimate relationship should not be underestimated. Any use of violence in a relationship can dramatically alter the balance of power, destroying a sense of openness and trust and resulting in a permanent sense of inequality, threat and loss (Browne, 1993). Recent findings of the World Health Organisation's (WHO) multi-country study on women's health and IPV suggest that the mental effects of violence last long after the violent episode. Moreover, cumulative abuse impacts powerfully on health (World Health Organisation, 2005).

International research on IPV undertaken within mental health care institutions and settings seems comparatively scarce. Yet a study combining samples from New Zealand, London and Wisconsin found that over 50% of women traumatised by IPV suffered a psychiatric disorder. Most notable were the elevated rates of mood and eating disorders (Danielson et al., 1998). Similarly, in an English primary health care context, Coid et al. (2003) found that IPV showed a strong association with most mental health conditions, particularly for experiences in the past year.

Trauma specialist Judith Herman (1992) reviews the evidence for the diagnostic validity of a complex form of post-traumatic stress disorder in survivors of prolonged, repeated trauma. In contrast to a single traumatic event, prolonged, repeated trauma can only occur where the victim is in a state of captivity, under the control of the perpetrator, such as in the case of an abused woman. Apart from increased levels of distress, detailed inventories of IPV survivors' symptoms show significant pathology in many domains: somatic, affective, cognitive, relational and behavioural (Herman, 1992, p.379). Focusing on the physical and mental health needs of extremely poor female survivors of IPV, Bassuk, Melnick & Browne (1998) found the health needs of this group to be substantially more for both acute and chronic illness. For example, over 33% suffered from post-traumatic stress disorder, a rate they report to be three times higher than in the general population of the USA.

In a comprehensive meta-analysis of predominantly USA studies, Golding (1999) showed that the risk for depression and post-traumatic stress disorder associated with IPV was even higher than that resulting from childhood sexual assault. A South African study found a significant association between IPV and both post-traumatic stress disorder and major depression, with these diagnoses indicative of increased severity of abuse and increased morbidity. The study recommended that patients with a history of domestic violence should be assessed for depression and post-traumatic stress disorder (Marais, de Villiers, Moller & Stein, 1999). Significantly, therefore, a recent British publication suggests that IPV can be recognised in clinical practice by utilising the diagnoses of post-traumatic stress disorder and depression as well as recognising low self-esteem (Duxbury, 2006b). The findings reported in Chapter Six reinforce these views, and are built into our recommendations in Chapter Nine.

A 15-year longitudinal study of 117 battered women in Sweden found that in the five years following the cessation of battering, women did not reduce their use of hospital care (Bergman & Brisman, 1991). If this indicates the potentially severe long-term impact of battering on health, then surely at an ethical level the women's mental and physical health should remain a priority?

A study on the burden of disease attributable to interpersonal violence concludes that interpersonal violence in South Africa is the second leading cause of lost healthy years of life after HIV and AIDS (Norman et al., 2007). IPV accounts for 62% of the total interpersonal violence burden in females. Other types of violence are community and family violence (excluding IPV), and child sexual abuse. Norman's is the first South African attempt to quantify the burden of disease from exposure to this range of interpersonal violence (Norman et al., 2007).

3.3.4 IPV in pregnancy

There is little information on the prevalence of IPV during pregnancy in sub-Saharan Africa. In one study conducted in South Africa (Mbokota & Moodley, 2003), 38% of pregnant women sampled had a lifetime experience of domestic violence, 35% had been abused during their current pregnancy and physical abuse (52%) was the most common form of abuse. Seventy eight percent experienced psychological problems during pregnancy although no explanation was given as to how this was assessed (Mbokota & Moodley, 2003, p.456). Most women (63%) were reconciled with the abusers: 92% for financial reasons; 6% for emotional reasons, while 2% were forced to reconcile.

Research in the late 1990s validated previous findings, included new variables and tested nursing interventions. According to US researchers King and Ryan, abused women are twice as likely as non-abused women to only begin prenatal care in the third trimester or to miscarry. They are also four times more likely to deliver low birth weight babies (King & Ryan, 1996). A Canadian study found a significant increase in physical abuse in the three months postpartum period (Stewart, 1994). Health care providers are alerted to the importance of making specific enquiries of postpartum women if there is a history of abuse, current injury of depression or anxiety.

3.3.5 A note on the financial cost implications of the IPV health burden

In an USA study, IPV patients' health costs were estimated to be 92% more than the comparative random sample of female patients. Contrary to findings in other studies, use of emergency room services did not influence the higher costs (Wisner, Gilmer, Saltzman & Zink, 1999) which correlated with higher use of mental health service.

The World Health Organisation (Krug et al., 2002) addresses the costs to employers of violence against women and concludes that they comprise:

- direct costs related to injuries sustained, illnesses, disability and deaths due to violence, absenteeism and turnover of staff;
- indirect costs related to decreased work functionality, inferior quality of outputs and service and lack of competitiveness; and
- less tangible costs related to poor organisational image, decreased loyalty, less creativity, lack of motivation and morale, and environmental conditions not conducive to productivity.

3.3.6 Links between male coercion, IPV and HIV / AIDS

Emerging evidence connects the rapidly expanding HIV epidemic and gender-based violence, particularly among young women (Bauer et al., 2002; Duffy, 2005; Dunkle et al., 2004a; Dunkle et al., 2004b; Garcia-Moreno & Watts, 2000; Gupta, 2000; Jacobs, 2003; Jewkes et al., 2002; Krug et al., 2002; Lary, Maman, Katebalila & Mbwambo, 2004; Lichtenstein, 2005; Lichtenstein, 2006; Maman, Campbell, Sweat & Gielen, 2000; Maman et al., 2002; Martin & Curtis, 2004; Raj, Silverman & Amaro, 2004; Stevens & Richards, 1998; Turmen, 2003). The 2004 UNAIDS Report on the Global AIDS Epidemic revealed that in sub-Saharan Africa

females account for 76% of HIV infections among young people aged between fifteen and twenty four (AMFAR AIDS RESEARCH, 2005). An analysis of the relationship between gender and HIV/AIDS exposes how gender inequalities have fanned the epidemic in South Africa. It also requires that we confront how the power men have over women is constructed, strengthened and renewed through cultural norms about sexuality and gender (Albertyn, 2003; Tallis, 2000):

> *"HIV/AIDS is often said to follow the path of least resistance, tracking the economic and social inequalities that exist ... Although physiology affects women's greater risk of HIV transmission (women are said to be two to four times more susceptible than men) it is women's lack of power over their bodies and their sexual lives, reinforced by their social and economic inequality, that makes them so vulnerable to contracting HIV/AIDS"* (Albertyn, 2003, p.597).

The following quote highlights beliefs that compromise women's capacity to refuse sex or to negotiate and implement protective strategies, such as barrier methods, during sex:

> *"If a husband initiates sex, his wife may not refuse him; the same applies in relationships outside of marriage. This makes it impossible for women to protect themselves from HIV/AIDS by initiating non-penetrative sex ... or insisting on fidelity or condom use. Women are ... also products of this culture and may themselves have internalised ideas of manhood that make it appropriate for men to have many partners and to manage sexual relations while they accept their partner's dominance and remain faithful"* (Klugman, 2000, p.147).

A study conducted in the slums of Chennai, India, revealed that sexist community norms tacitly sanction IPV and interfere with HIV-preventive behaviours. Forced to choose between the immediate threat of violence and the possibility of HIV infection, women frequently resigned themselves to the sexual demands and indiscretions that might increase their risk of HIV acquisition. The authors recommended that AIDS-prevention interventions should interrogate gender-related social issues in settings where male partners strictly enforce their locus of control. HIV-prevention messages targeting men could reduce women's exposure to HIV/AIDS (Go et al., 2003).

In South Africa, Dunkle et al. (2004a) found that violent, controlling behaviour from male partners was strongly associated with increased risk of HIV infection among women. Although awareness of the role of IPV in the HIV epidemic among women has grown, to date there is a paucity of rigorously designed and evaluated interventions to address this.

The HIV epidemic also disproportionately affects women and girls in their gendered role as caregivers within families and communities as they bear the largest burden of caring for those with AIDS-related illnesses (Cooper et al., 2004, p.78). This reduces time available for income-generating activities or education, potentially exacerbating their poverty and increasing their economic dependence on men.

3.3.7 The cycle of violence within abusive relationships

Walker (1979) identified a cyclical pattern of three phases of violence in abusive relationships:

- tension-building phase;
- acute battering incident; and
- calm (honeymoon) period.

She argued that during these phases women's behaviour was characterised by denial of this violence, their injuries, or that there may be alternatives.

A grounded theory study in a critical care setting in the state of Washington identified the presence of an 'Open Window Phase' of help-seeking behaviours by battered women (Curnow, 1995). This phase was found to occur between the acute battering and honeymoon phases, when the IPV survivor was able to see the reality of her victimization and reach out for help. This study stresses the responsibility of the health care provider to intervene at this crucial time, even if only to refer appropriately.

Romero (1985, p.541) compared IPV survivors to prisoners of war and pointed to three commonalities: psychological abuse, within the context of the threat of violence resulting in dread and the debilitation of the victim; intermittent strengthening of emotional dependence; and isolation from friends and family that served to validate the assailants' beliefs and behaviour. With good reason, women who reported IPV were 32 times more likely to be afraid of their partner than those who did not report IPV (Bradley et al., 2002). This finding amplifies the problematic nature of health care providers' impatience and lack of empathy for women unable or unwilling to extricate themselves from their relationship.

Within this cycle, abused women do try repeatedly to leave their abusers and escape the prisoner syndrome. The World Health Organisation reports that on average IPV survivors leave their abusive partners four times before finally exiting the relationship (Krug et al., 2002). Such women may appear compliant and passive because they have learned that such behaviour blunts the pain of living with abuse. Warshaw identifies this as an appropriate response to ongoing danger (Lamberg, 2000).

3.4   The role of health workers in addressing IPV

What kind of interventions do abused women want from health care providers? In England, IPV survivors identified doctors as the individuals they would most like to talk to about their situation (Rodriguez et al., 1999; Gerbert et al., 2000). A recurrent theme is the desire for compassion, which builds trust between IPV survivors and health care providers. In a US study published in 1987, Limandri found that IPV survivors required the comfort of trust and rapport with health care providers to feel comfortable enough to disclose the abuse. Compassionate, validating statements were specified as the most desirable interventions, along with safety planning and offering referrals. These women highlighted that validation had assisted them, regardless of whether abuse was identified or disclosed. Eight years later in a US study by Bauer and Rodriguez (1995), abused women again expressed a strong desire for compassion, trust and understanding. These elements were felt essential in establishing rapport, 'opening the door' to disclosure, and facilitating the process of healing. Many participants expressed a strong desire to be listened to. They felt compassion and respect were demonstrated when health care providers allowed the woman to talk without interruption. The participants were also sensitive to subtle communication cues such as eye contact and voice tone. The content and delivery of healthcare providers' discussions both played a role in conveying their compassion and sensitivity. Women controlled by abusive actions of their intimate partners reported that signs of compassion and caring from health care providers made a difference, planting seeds for change.

3.4.1 Not doing what is needed for identification and intervention

Primary health care providers are ideally positioned to identify and intervene in order to break the cycle of abuse because of the continuity of care they provide to patients, and the role they could fill as sympathetic listeners and patient advocates (AAFP Commission, 1994; Burge, 1989). Primary care providers are also in a key position to offer referral for intervention since

IPV survivors commonly present with multiple somatic complaints as well as mental health or stress-related illnesses (Sugg & Inui, 1992).

By the late 1980s, North American research revealed that only about 5% of women were identified as battered in medical records (Tilden & Shepherd, 1987; McLeer & Anwar, 1989). Numerous studies in a range of healthcare settings in the developed world revealed that rates of detection and intervention in cases of IPV remained inexcusably low (Warshaw, 1989; Henderson, 1992; Motsei, 1993b). Some health care providers may misguidedly feel that to do nothing is at least to do no harm. Failure to acknowledge the woman's abusive experience is psychologically damaging in itself. Disconfirmation of abuse by a health provider can be an important factor in the development of subsequent psychopathology (Randall, 1990). Furthermore, if identified, abuse was frequently minimised or ignored, with health care providers focusing only on physical injuries and subtly blaming the women for their abuse (Campbell & Sheridan, 1989; Warshaw, 1989). This feeds into the workings of secondary victimisation laid bare in Stark, Flitcraft and Frazier's groundbreaking *Medicine and patriarchal violence: the social construction of a "private" event* (1979), introduced in section 3.2.1.

Later studies confirm these patterns: even when health care providers acknowledge the incidence of domestic violence, they frequently do not ask patients about the cause of their injuries (D'Avolio et al., 2001), nor do they adequately document such injuries (Covington, Maxwell, Clancy, Churchill & Ahrens, 1995), let alone dig behind other symptoms that women present with. Studies of chronic pain, pelvic inflammatory disease, depression, and eating disorders reveal a history of violence as a major risk factor that was seldom assessed by health care providers in the US (Campbell, 1992a). Sharps et al. (2001) caution health care providers to be more vigilant about preventing the most serious form of violence against women – intimate femicide. Sixty six percent of femicide victims had utilised healthcare facilities for injuries or mental or physical health problems, but the issue of IPV was inadequately addressed. The ethical argument for increased detection and intervention in all arenas of the health sector is clear.

A serious omission from IPV-related debates is the field of oral health. US dentists and oral hygienists reported the least education about IPV, the lowest rate of suspecting abuse, and the largest proportion, compared to other health professionals, who do not see themselves responsible for intervention (Tilden et al., 1994). Participants who had received education on

the topic more commonly suspected abuse in their patients than those without, although this did not ensure their intervention.

Notably the aspects of compassion and understanding that IPV survivors sought were often absent in the medical encounter (Gerbert et al., 2000). Such experiences included health care providers who neglected to inquire about symptoms or injuries or to intervene, lacked understanding or were judgmental towards the women. Participants' distrust was because of their perception that doctors were usually judgmental and unsympathetic to their difficulties. Thus they lied about the source of their injuries, partly because they felt unsafe, vulnerable and afraid that they would not receive support. Many participants argued that treating only the injuries and illness, or prescribing sedative and pain medication, undermined the patient-provider relationship, particularly when patients needed compassion and psychological support. They also identified healthcare system shortcomings, such as language barriers and time constraints (Gerbert et al, 2000).

Tilden et al. from the USA report that health care providers who intervene tend not to report abuse to the appropriate authorities (1994, p.632). Health care providers explained that reporting led to a series of events out of their control which are often counter-therapeutic. The ethical dilemma between their perceived duty to report and their lack of confidence in the system's ability to respond effectively seemed to result in inertia.

Given the above denial, neglect or mismanagement of IPV – sweeping it under the carpet – it is unsurprising that abused women often consider health care providers to be the least effective source of help among formal support systems. In spite of the high prevalence of IPV, less than 15% of female patients report being asked about abuse by health care providers or disclosing abuse to them (Bradley et al., 2002; Friedman et al., 1992; Rodriguez, Quirogo & Bauer, 1996; Sethi, Watts, Zwi & McCarthy, 2004). Survey results of 1 000 Australian abused women revealed that they ranked health care providers lowest in terms of effective assistance, lower than battered women's shelters, social service workers, clergy, police, and lawyers (Egger & Crancher, 1982). A later US study shows that while 62% of abused women reached out to physicians for help, only 37% rated them as useful (Rodriguez et al., 1999). In contrast to the findings above, in another study, most patients favoured inquiries about physical and sexual abuse, and believed doctors could help with these problems (Melnick et al., 2002). Many IPV survivors encounter social, institutional, and provider barriers to obtaining help from the healthcare system. Rodriguez et al. (1996, p.153) suggest that these

barriers can be overcome by understanding the social context of IPV and the survivors' needs. They recommend that intervention may be improved through a trusting patient-provider relationship and by direct questioning about IPV.

Failure to diagnose and intervene in IPV represents a lost opportunity to arrest the cycle of violence. In section 3.3.1, in the Sisley et al. USA study (1999, p.1107), women experiencing IPV had presented repeatedly at hospital emergency rooms, with increasingly severe injuries. This thesis argues contends that failure to intervene reflects a fundamental neglect of one's ethical responsibilities as a health care provider. Why are health workers not responding appropriately to the major health issue that IPV presents? The answers are to be found in dynamics that are wider than the narrow lens of disease and health care provided by a biomedical framework, and bring the social relations introduced in section 3.2 to bear upon the role of health providers. We examine the psychosocial barriers next.

3.4.2 Barriers to providing care for IPV

Gremillion and Kanof (1996) identify a number of themes that describe the barriers to the involvement of health care providers in IPV as follows:

- **Contemporary social issues:** societal tolerance of violence, desensitisation through exposure to violence, implicit and explicit social norms, and power inequalities in relationships;

- **Personal factors:** sexism, personal history of abuse, idealised concepts of family life, privacy concerns, sense of powerlessness;

- **Professional factors:** time constraints, inadequate skills, professional relationship with abuser, professional detachment; and

- **Institutional and legal factors:** fear of legal reprisal, limited institutional resources, inadequate or unclear policies.

In fleshing out some of these barriers below, this useful categorisation and sequencing is followed.

Social issues, prejudices and myths, which arise from social relations, come to the fore in the following studies. Campbell (1991) found that, in the USA, nurses blamed IPV survivors for their abuse more if they were women of colour, on welfare, did not fit the profile of the pathetic victim, if they had left the abuser and returned, and particularly if they did not have clearly formulated plans to leave the abuser. Health care providers often unconsciously framed their clinical interventions (or lack thereof) around key contemporary social myths:

IPV is uncommon; occurs primarily in certain cultural, class, ethnic or age groups and only in 'problem' families; is usually linked to substance abuse and rarely occurs in pregnancy. Subtler myths see IPV as a private issue and frame abused women as helpless (King & Ryan, 1996). A large-scale study across multiple communities in the USA found that in every community studied the healthcare system's capacity to address IPV was significantly affected by individual providers' prejudicial attitudes (e.g. class elitism, homophobia, ageism, racism, sexism) toward both survivors and perpetrators of violence (Cohen, De Vos & Newberger, 1997).

An important South African contribution on this topic is that of Christofides and Jewkes (2007). In 2005 lay counsellors who offer HIV pre-and post-test counselling at a primary health care clinic in Johannesburg were trained to offer universal screening for IPV to women. The results of a pre- and post-training attitudinal score for health care providers revealed that although there were some improvements after training, there was no change on two attitude items: "If she doesn't leave she only has herself to blame" and "She nags him about his drinking, that's why he beats her". Christofides and Jewkes stress, therefore, that a key barrier to change was the negative gender attitudes held by several participants (2007, p.7). The lack of gender sensitivity and entrenched sexist beliefs that reinforce a patriarchal society, evident among some counsellors, appeared to influence whether they would consider screening women for gender based violence. It also affected the quality of their counselling (2007, p.9). Christofides and Jewkes emphasise that voluntary counselling and testing (VCT) services should focus on gender-sensitive training to inform discussions regarding disclosure of HIV status to partners, living positively and health-seeking in general (2007, p.27). Importantly, they recommend that selection criteria for counsellors are revised to exclude those with chauvinistic attitudes and that adequate supervision of counsellors is ensured. This thesis contends that we need to transfer some of these learnings to the IPV health care context.

The studies cited above, in which social barriers to adequate IPV care are foregrounded, lend weight to my view that within the South African health care system effective change with respect to IPV intervention must involve shifting these prejudices, particularly that of sexism, by giving practitioners access to a feminist perspective.

Attitudes of nurses have been explored by King and Ryan (1989) and compared with other health care providers by Rose and Saunders (1986). In the latter, both physicians and nurses believed some of the myths about battered women including that women are somewhat

responsible for their victimisation. Campbell (1992b) asserts that while Rose and Saunders' (1986) study seems to indicate that nurses were less victim-blaming and more empathetic than physicians, gender rather than profession was the differentiating factor. This point is supported by a comparative survey of levels of detection, knowledge and attitudes in health care providers in Oxfordshire, England (Cann, Withnell, Shakespeare, Doll & Thomas, 2001). It found that female doctors, nurses, and community mental health workers had significantly better knowledge and more positive attitudes. Rose and Saunders found that nurses with the most liberal attitudes about women's roles were least likely to blame victims, and particularly those with the most intensive training on the topic held victims less responsible and were more willing to help them (1986). Some notes of caution need to be sounded though: Cann et al. reported that the response of health care providers to IPV was frequently confused and inappropriate, indicating that identification alone is not enough. King and Ryan's work documented the tendency of clinical nurses to assist abused women with a paternalistic rather than empowering approach (King & Ryan, 1989), so 'assistance' that lacks a feminist approach can be less than helpful.

Most clinicians personally struggle with the issue of addressing IPV. Some find it traumatic to listen to a patient's report. Others have trouble empathising. Some are involved in abusive relationships themselves, either as victims or perpetrators (Anonymous, 2007; Lamberg, 2000). Bauer and Rodriguez (1995) argue that health care providers' discomfort with IPV impairs their ability to establish rapport and effectively intervene.

In a study subtitled "Opening Pandora's Box", Sugg and Inui (1992) explored health care providers' experiences with IPV survivors to determine the barriers to problem recognition and intervention in the primary health care setting. Health care providers cited multiple barriers to intervention, including patient non-disclosure (a product both of social factors and the very barriers here being interrogated); fear of offending the patient, close identification with patients, feelings of inadequacy (personal factors); limited time, lack of training, patient's unresponsiveness to advice (professional factors); lack of support resources, inability to "cure" the problem, lack of effective interventions (institutional factors), and the frequently cited fear of opening "Pandora's box". These themes were also uncovered in other studies (Brown, Lent & Sas, 1993; Ferris, 1994; Ferris & Tudiver, 1992; Gerbert et al., 2000; Kurz, 1987; Waalen et al., 2000). Furthermore, many health care providers have unrealistic expectations and become frustrated by a perceived lack of progress, particularly in cases of repetitive violence (Sugg & Inui, 1992).

Factors I have categorised as 'professional' and 'institutional' in the list of Sugg and Inui's barriers above can be ascribed in part to how the health care system is organised, how the work is structured, and the role expected from health care providers, including the dominant biomedical discourse. This is examined in more depth in Chapter Four. The biomedical model itself creates a barrier as many physicians give prescriptions for analgesic and psychoactive agents without exploring the reason for their patients' complaints. It is important to note that this tends to exacerbate patients' feelings of isolation and despair (Lamberg, 2000).

At an institutional level, the large multi-community-based qualitative USA study cited above (Cohen, De Vos & Newberger, 1997) found that:

- The primary prevention of family violence was not a priority for the health care system, or any other related system, in any of the communities. Prevention efforts identified were conducted by private advocacy groups.

- Despite some efforts to establish protocols, case review meetings, or other mechanisms, informants in all communities revealed a lack of effective coordination among agencies responsible for addressing IPV.

- Care for survivors of family violence was driven by committed individuals within the health care system. Some of these 'champions' had established well-respected programmes, which nevertheless had not become institutionalised. When the charismatic leader left the programme, the programme withered or disappeared completely.

Health care providers who do not manage to establish themselves as charismatic champions have been found to pay a price for attending to IPV issues. Health care providers who elected to work in any consistent way with IPV described being marginalised by their colleagues and institutions and reported serious social, psychological and economic disincentives to providing care for this population (D'Avolio et al., 2001).

Thus socio-psychological factors come through strongly as barriers to effective IPV intervention within the health care system. Training of health care providers is typically used as a response to the need for change of attitudes and behaviours within health care. I thus review some of such training initiatives in the next section, and probe uptake of them and their efficacy.

3.4.3 The quest for quality psychosocial care: IPV training and other interventions to change care

In the USA prior to the 1990s, assessment for violence and appropriate interventions was mostly absent from the curricula for nurses and midwives (King & Ryan, 1996). Finley's exploration of the strengths and limitations of a battered women's shelter in Montana as a clinical placement for student learning was unique for its time (Finley, 1984). However, from the 1990s, academic nurses across the USA and Canada set about addressing this training deficit in nursing curricula. Literature came from Canada (Henderson, 1992, Henderson & Ericksen, 1994; Ross, Hoff & Coutu-Wakulczyk, 1998; Ross & Hoff, 1994; Sword, Carpio, Deviney & Schreiber, 1998) and from the USA (Campbell, 1992; Helton & Evans, 2001; Mandt, 1993; Urbanic, Campbell & Humphreys, 1993; Woodtli, 2000; Woodtli & Breslin, 1995; Woodtli & Breslin, 1996; Woodtli & Breslin, 2002). Ross comments that the topic of violence presents a major challenge to most educators and clinicians charged with teaching and role-modelling. Added to the usual complexities of psychosocial health care, violence links to values and structures that are deeply rooted in conscious and unconscious responses to the subject (Ross & Hoff, 1994, p.33).

In South Africa under apartheid, the subject of IPV was completely absent from education and training of health providers, despite some isolated efforts by Rape Crisis organisations dating from the late 1970s to raise awareness within state institutions. Jewkes (2001a) describes three types of in-service training about gender-based violence that were prevalent throughout South Africa in the decade post-apartheid. The most common training course was a session of one to six hours. It introduced the issues in an attempt to sensitise staff towards abused women. Importantly, this short training was found inadequate to overcome staff prejudices about gender, to deal with unresolved experiences of gender based violence or to ameliorate deficiencies in their communication skills. Longer courses of three to five days aimed to enable staff to identify women who had experienced IPV, and refer them for further assistance and/or provide counselling. Some provinces focused on recruiting mental health nurses for this training. Forensic training for staff to deal with sexual assault examinations and associated medico-legal issues forms the third type of training. Note that developing IPV-related skills appears neglected within these curricula. During this period, a Victim Empowerment Programme tried to equip health care providers to respond to 'victims', but without focusing awareness on the dynamics of gender, abusive relationships and concerns regarding future safety (Jewkes, 2001).

How effective were these initiatives in South Africa? In-service training in psychosocial care is resisted as it is seen to remove scarce staff from health service delivery (Jewkes, 2001). As set out above in section 3.4.3, training does not always shift entrenched beliefs, as when Christofides and Jewkes (2007) found that a training intervention left counsellors' attitudes that *"if she doesn't leave she only has herself to blame"* and *"she nags him about his drinking, that's why he beats her"* untouched. Even if it does change the trainees, the benefits of training are often minimised because staff are frequently prevented from implementing their new skills because of a lack of management support (Jewkes, 2001) or even active sabotage (Mgoduso & Butchart, 1992; Seedat & Nell, 1992). A prevalent assumption is that training will produce changed practice without addressing the logistics and support necessary for the implementation thereof within the health system.

Overseas studies that directly examine the effects of training have produced conflicting results depending on the type of training and the length of follow-up (Harwell et al., 1998; McLeer & Anwar, 1998; Saunders & Kindy, 1993). One is left wondering whether educational interventions are simply ineffective, or whether continuous reinforcement as well as regular opportunities to apply what has been learnt, are needed to sustain the effect.

Vetten and Liebowitz-Levy (2003) argue that in order to be effective, training must be approached as an integrated and wide-ranging process. They specify that the development of a training programme to improve screening for IPV requires committed co-operation from management. Further, implementation of training requires prior consultation with key stakeholders, regarding the benefits and nature of screening guidelines. They recommend that the training programme itself would require more emphasis on screening guidelines, essential listening and other interpersonal skills, as well as self-care with regard to dealing with IPV. Furthermore, Vetten and Liebowitz-Levy prioritise focused exploration of nurses' own experiences of IPV and their willingness to engage with IPV in the work context. They make recommendations for a host of follow-up measures to embed and evaluate the new screening procedures learnt and indeed, since the emotional impact of screening is ongoing, a nurses' support group is recommended (Vetten & Liebowitz-Levy, 2003).

Without structural changes, for example the modification of documents such as the emergency department chart, institutional policies, and regular in-service training, health care provider training is unlikely to be sufficient to change clinical practice (Davis, Thompson, Oxman & Haynes, 1995; Harwell et al., 1998; McLeer et al., 1998; Olson et al., 1996;

Rodriguez, Bauer, McLoughlin & Grumbach, 1999). Olson et al. (1996, p.744) conclude that structural or environmental changes are often more successful injury-prevention interventions than educational interventions alone. The literature emphasises the introduction of IPV protocols to improve health care providers' awareness and strengthen their clinical skills needed for effective intervention. Many studies refer to McLeer and Anwar's work, which found that the introduction of a domestic violence protocol in the USA increased the identification of battered women from 6% to 30%. However, they neglect to mention that on follow-up eight years later, the identification rate had dropped back to 8% (McLeer, Anwar, Herman & Maquiling, 1989).

An assessment of twelve further studies from the USA revealed that interventions limited to the education of providers had no significant effect on IPV screening or identification rates. However, most interventions that incorporated strategies further to education (such as providing specific screening questions) were associated with significant increases in identification rates (Waalen, Goodwin, Spitz, Petersen & Saltzman, 2000). In their analysis of 12 studies, Waalen et al. (2000, p. 235) conclude that barriers to IPV screening and interventions to change IPV screening practices – are remarkably similar across diverse specialities and settings. They recommend that interventions designed to overcome these barriers and increase IPV screening rates in healthcare settings would be more effective if they included strategies other than provider education.

Clearly, from the literature one would conclude that education and training do not alter health care providers' behaviour nearly as effectively as changes to documentation requirements do. Health policy for provision of IPV care needs to take this conclusion seriously. Chapter Seven reflects on and interrogates this conclusion, by reflecting on the efficacy of introducing our protocol in effecting behaviour change among health care providers to the benefit of IPV patients.

Jewkes (2001a) cautions against "medicalising" gender based violence within health sector training. I would also argue that extending health sector responses to IPV requires health care providers to develop a feminist understanding of the social dynamics of gender relations and how transforming these should be a focus of health care, and motivate this further in Chapters Four and Seven:

"We have to confront attitudes, not just teach facts. We have to get away from the banking model of teaching that Freire (1976) describes as just depositing facts and progress to a pedagogy of dialogue and mutual respect and empowerment"
(Campbell, 1992a, p.468).

The historic lack of attention to gender-based violence in the curricula of health care providers, combined with time and resource constraints, are currently held responsible for health care providers' apparent reluctance to deal with IPV beyond taking care of the injuries suffered by women. Such practice obscures the direct and indirect mental and physical health sequelae for IPV survivors, hampering the provision of essential care for individuals and family systems.

3.5 What is to be done? Interventions for IPV within health care settings
3.5.1 Relevance of international IPV literature for the South African context

Current models for promoting health care providers' capacity to identify and address IPV have emerged largely in the context of developed countries (Kim & Motsei, 2002). They have focused primarily on integrating the knowledge, skills and attitudes necessary for dealing with gender based violence in well-resourced health settings. Therefore, they are helpful to a point, provided that the limitations of transposing them directly to the South African context are clearly considered and explicated.

To start with, in the USA, Canada and Britain, doctors (physicians) are the key players in primary health care, while in South Africa primary care is nurse-driven. Furthermore, whereas the socio-economic infrastructure of the first world facilitates, for most, a life above the breadline, in South Africa poverty is the norm. This relates directly to the extent of the demands made on the primary health care system, because by inference, a greater proportion of the South African population is reliant on state-provided healthcare. Similarly in Britain, the National Health System serves almost the entire population.

A pertinent problem for South Africa is the scarcity of referral resources, particularly since these are such a vital component of a healthcare intervention for IPV. Strategies for addressing violence are especially challenged in resource-scarce rural areas where there is barely access to shelter, let alone counselling services or the judicial system. The comfort

with which first world authors speak of what needs to be done to assist an IPV survivor assumes available, accessible and appropriate services:

> *"The most significant catalyst for change ... is the level of resources available to the woman... (the health care provider's role) ... includes enhancing social support aimed at decreasing isolation, providing economic and housing resources, facilitating the acquisition of effective legal assistance"* (King & Ryan, 1996, p.440).

Similarly, an Australian study, which confirms the prevalence of IPV shown in US emergency departments, found that most IPV survivors presented between 17.00 and 08.00 hours. The provision of appropriate back-up referral services, such as after-hours social work services, is recommended (Roberts, O'Toole, Raphael, Lawrence & Ashby, 1996). In South Africa, research for this thesis revealed that social workers are in severely short supply and patients wait months for less than optimal service. The luxurious option of after-hours back up referral services is out of the question.

Another problematic deficiency within South Africa is our lack of a broad-based feminist movement to address issues such as IPV (Vogelmann & Eagle, 1991). By contrast, Campbell (1992, pp.467–468) describes the US battered women's movement as a "*wonderful example of the kind of community-based, system-changing, advocacy movement. It grew out of the second-wave feminist movement of the early 1970s"*. She explains that this movement is embodied by national and individual State Coalitions Against Domestic Violence that create partnerships towards social change in order to decrease violence against women. Her comments speak to a unity of focus that is sorely lacking in our fragmented South African context.

3.5.2 The South African primary health care context

The primary health care context in South Africa has undergone major change since 1994. In 1990, the African National Congress (ANC) established a health commission bringing together anti-apartheid theorists and activists to plan the transformation of the health sector into a single system with an equitable distribution of resources and expanded service delivery. Thus, transition from apartheid rule to democracy in South Africa was accompanied by the vision of a national health care system based on the principles of universal primary care, entrenched in the White Paper on the Transformation of the Health System in South Africa (Government Gazette, 1997). The National Health Plan dovetailed with the Reconstruction

and Development Programme in 1994 that intended the transformation of the entire state service. The goal of redressing past neglect of the health needs of poor, black women was considered central (Cooper et al., 2004) to the Reconstruction and Development Plan's aim for an equitable role for women in the broader politico-economic and social arenas.

Primary health care ideals focus on health as a human right with decentralised services aimed at promoting local health needs and community involvement through the district health system, equity in resource distribution, expanded access, and preventive and promotive healthcare. The restructuring of mental health care towards a comprehensive community-based mental health system within primary health care was a key policy principle (African National Congress, 1994; Petersen, 1998).

These broad health system changes for post-apartheid South Africa were envisioned and implemented in a flurry of policy formation that aimed to leave behind old ideologies, practices, and structures of segregation (Gibson, 2001). However, limitations in the capacity of the public health sector to plan and implement the new policies and services, and to manage and monitor their implementation, have beleaguered progress overall (Fonn, Xaba, Tint, Conco & Varkey, 1998). The new government also faced huge challenges in condensing the multiple health administrations into a unitary system, while simultaneously attending to fundamental health problems and health service delivery issues (Cooper et al., 2004). The authors refer to delays and difficulties in implementing the district health system that destroyed confidence in health service governance and its organisational structures. Low morale among public sector health care providers have made it difficult to secure and/or retain skilled personnel (Health Systems Trust, 2000). There is evidence that the low morale so clearly depicted in Chapter Seven, was already surfacing in 2000. Importantly also, the HIV epidemic was gathering ground as the new government addressed transformation of the health care system. The scale of this epidemic has constantly threatened to overwhelm plans and policy.

Public health care services, especially in the rural areas, have been compromised by insufficient financial and human resources combined with increased use of the public health care sector (McIntyre & Klugman, 2003). Personnel scarcity and the inability to recruit and retain skilled personnel are the worst constraints on effective healthcare provision in the public sector (Andrews & Pillay, 2005). Andrews and Pillay (2005) found that only 40% of facilities are staffed by qualified clinical nurse practitioners and suggest that apart from

redressing the inequitably low nursing salaries, the government should address factors relating to poor supervision and human resource management that cause demoralisation. The theory and findings discussed in this thesis speak to these issues.

Andrews and Pillay's assessment of progress points to the silence regarding the mainstreaming of gender in the health sector. It is suggested this reflects ineptitude at addressing and resolving problems that require an integrated rather than a 'disease-oriented' approach which has been exacerbated by a lack of collaboration and co-ordination within the Department of Health (Andrews & Pillay, 2005). Since the idea of "mainstreaming gender" in the health sector would mesh with my thesis that feminist theory and practice needs to be "mainstreamed" within the primary health system to effect adequate IPV intervention and care, it is instructive to consider forces that have kept gender sidelined. In 4.5.2 I make the similar argument that the 'disease-oriented' approach of biomedicine is one such obstructive force.

3.5.3 Bringing it to light: screening for and diagnosing IPV

Clearly, complex issues surround the identification of IPV. However most USA and Canadian contributions to the issue of screening and intervention follow a fairly standard format in terms of the elements of care they recommend (Alpert, 1995; Barrier, 1998; Buel, 2002; Chescheir, 1996; Eisenstat & Bancroft, 1999; Fishwick, 1998; Grunfeld, 1997; Langford, 1996; Moss & Taylor, 1991; Neufeld, 1996; Osattin & Short, 1998). The elements of care consist of screening for a history of abuse, identification and assessment of relevant physical and historical findings, documentation thereof in the medical record, treatment, risk assessment, safety planning and referral to appropriate services. It is ubiquitously assumed that it is vitally important to conduct universal screening. The same elements of care form the components of the South African protocol we implemented as our second goal, see 5.7 (Martin & Jacobs, 2003), which is also based on the assumption that every female patient should be screened. The process around the formation of this protocol is discussed in Chapter Five. Here the recommendations about screening from the IPV literature are collated in order to learn from them.

It is noteworthy that women patients themselves consistently show support for IPV screening in overseas studies. In a Canadian emergency department most patients supported universal screening for IPV of adult female patients (McFarlane et al., 1991; Hoyle, 1998; Matthews & Abrahams, 2001). In an Irish study, 77% of the entire sample, comprising women who both

had and had not experienced IPV, wanted routine inquiry about IPV by their general practitioner (Bradley et al., 2002). In addition, 94% of women participating in a study conducted in a trauma service in Michigan recommended screening for IPV. All patients who screened positive for IPV indicated that questions about IPV should be asked (Hurley, Brown-Maher, Campbell, Venugopal & Baggs, 2005).

The silence surrounding IPV is reflected in the patients' denial, hesitance to disclose, or indeed active cover-up, of the reasons for the injuries or mental health malaise, often mirrored by complementary behaviour on the part of the health care provider. Bauer and Rodriguez (1995) refer to a 'code of silence' that stems from the women's reluctance to disclose their abuse and the health care provider's failure to create an environment conducive to disclosure. Randall's warning (1990), mentioned above in section 3.4.1, needs to come to mind: failure to acknowledge, amounting to disconfirmation of the woman's abusive experience, particularly by a health provider, is psychologically damaging in itself and can contribute to subsequent psychopathology. Correspondingly, Chescheir (1996, p.766) maintains that the clear indication to patients that violence is not a taboo subject is in itself a vital therapeutic component of any intervention.

Women in the English study by Gerbert et al. (2000) discussed the potent psychological constraints and personal agendas for withholding information from health care providers. Fear of retribution by the abusive partner, psychological barriers of embarrassment, low self-esteem, denial, and the sense of obligation to family or partner were predominant reasons given. Importantly, contrary to popular belief, most IPV survivors want the violence, not the relationship, to end (Kmietowicz, 2007; Bauer & Rodriguez, 1995). This is important information for health care workers who become frustrated when unable to effect the 'cure' of an IPV survivor leaving the abuser. (I submit that not wanting to be offered an unpalatable solution, with a resulting impatience if one refuses to swallow it, may in itself be a reason not to speak up about IPV.)

Patients may attempt to hide their injuries with extensive clothing, jewellery, wigs and heavy make-up (Alpert, 1995; McCoy, 1996). Any injury requires thorough physical examination. Injury patterns of IPV against women tend to be on defensive regions of the body (ulnar aspect of forearm) and/or centrally located on face, neck, chest, torso or genitalia while accidental injuries tend to be circumferential (Alpert, 1995). Any wound within a wound suggests intentional injury, as does bruising that is confined to the buttocks, legs, back and

back of head. All genital trauma should be carefully assessed for patterns of injury produced by IPV including sexual assault with resultant lacerations, haematomas, vaginal or rectal foreign bodies (McCoy, 1996). Abusers also tend to choke their partners. McCoy, a US physician, asserts that all physicians working in emergency medicine should learn the dynamics of IPV and commonly associated injury patterns. This thesis expands this assertion to include all primary health care providers.

Best practice has evolved, with certain components. When conducting interviews with potential IPV survivors, the health care provider should ask her directly and not with some vague inquiry about how things are at home (Campbell, 1992). In contrast, Bradley et al. (2002) suggest that asking women about fear of their partner and controlling behaviour may be a subtle means of identifying those who have experienced IPV (perhaps useful if women are not forthcoming after a direct approach). Curnow (1995, pp.163-164) found that victim-blaming questions discourage a battered woman from opening up about abuse – they shift the focus onto the woman's behaviour and she becomes defensive, and Boyle et al. also recommend non-judgmental and simple, direct questions are best (Boyle et al., 2004). Innovatively, Davis et al. (Davis, Parks, Kaups, Bennik & Bilello, 2003, p.352) suggest that screening for IPV may work better if assessed as part of the discharge planning.

Mbokota and Moodley (2003) note that while clinical practice recommendations in the USA and UK stress the importance of enquiring about IPV, in scarcely resourced contexts (such as those found in South Africa) screening may add to the workload of health care providers already burdened by high prevalence rates of HIV. Ferris may provide a way forward. While universal screening for IPV is commonly endorsed by international guidelines due to the desire to identify as many hidden cases as possible, she recommends case identification methods based on the presentation of specific signs or symptoms of abuse, because this serves to focus resources and time on identifying the people who are in immediate need of health care (Ferris, 2004). Moreover, she recommends that clinicians should assess for current mental health complications, especially depression, as this is strongly associated with IPV – and evidence exists for the effectiveness of screening for and treating it (Hegarty, Gunn, Chondros & Small, 2004). It is noteworthy that the physicians in Ferris' study who said they had a standard method for detecting cases of wife abuse also reported significantly higher detection rates (Ferris, 1994, p.1171). See Chapter Seven for a similar finding.

The introduction of screening practices in the primary health care situation presupposes training of health providers, at a minimum in the screening guidelines. Under section 3.4.3 above, we drew on Vetten and Liebowitz-Levy's (2003) proposals for the process, format and content of such training, which included unpacking nurses' own experiences of IPV. Their recommendations for post-training follow-up have relevance here, and some would hold long-term impacts on how the health care site is run. Practical follow-up in the form of role-playing screening guidelines, observing actual screening procedures and follow-up meetings to discuss difficulties in implementing guidelines could be combined with systematic implementation of a formalised monitoring procedure of screening. They recommend that support staff facilitate the effective implementation of screening guidelines, and so clinic and regional managers are encouraged to actively address work conditions and include health promoters and volunteers wherever possible (Vetten & Liebowitz-Levy, 2003). Since the emotional impact of screening is ongoing, they recommend a support group for nurses involved in IPV screening – which group I suggest could also extend support on other issues, such as HIV/AIDS and indeed workplace dynamics, making for a more 'conscious' and supportive organisation.

It is useful to reprise Christofides and Jewkes' findings (2007, p. 7) that some counsellors in their study displayed a lack of gender sensitivity and entrenched sexist beliefs that reinforce a patriarchal society, which appeared to influence whether they would even consider screening women for gender based violence. This underpinned Christofides and Jewkes' call for gender-sensitive training, which this thesis would endorse.

Christofides and Jewkes (2007, p.20) question whether screening for IPV serves only as a referral gateway, or whether screening itself can be an intervention that leads to change for the IPV survivor. Participants in their study identified potential benefits of IPV screening pertinent to three primary themes: screening as a gateway to other services, as an intervention, and as prevention. Fourthly, counsellors could also potentially provide information about available legal options. This takes us into recommendations on the next stage of health care for IPV, that of intervention.

3.5.4 Breaking the cycle of IPV: intervention and referral

The World Health Organisation and the Federation of International Gynaecologists and Obstetricians outline the following duties when assisting IPV survivors, and in so doing create a framework for positive interventions (Boyle et al., 2004; Hoyle, 1998):

- Do no harm to your patient.

- Always ensure confidentiality of the patient's records.

- Where possible, universally screen all female patients.

- Recognise the existence and occurrence of IPV by being aware of the signs and symptoms of abuse.

- Develop appropriate tools and interventions to deal effectively with IPV in the health care setting.

- Manage all physical injuries and psychological trauma and document these in detail.

- Ensure that patients are referred to appropriate community, social and legal services.

- Health care providers must share their knowledge of abused patients with the criminal justice system and social services.

These pointers are used to organise the recommendations and lessons about interventions and referral gleaned from the literature below.

Issues of language, messages and establishing trust arise again. As noted above, Curnow (1995, pp.163–164) identifies that victim-blaming questions discourage a battered woman from sharing the reality of her abuse, as they focus on her behaviour as the problem. Examples of such questions are:

- Why do you take that kind of abuse?

- Why don't you just leave him if he treats you like that?

Instead it is vital to give positive affirmation, acknowledge lethality, offer safety plans and referral, and to document all details accurately (Curnow 1995, pp.164–165).

Gerbert et al. (2000) conducted focus groups with 45 San Francisco Bay Area physicians committed to offering quality health care for IPV survivors. They were selected from primary care (family practice and internal medicine), emergency medicine, obstetrics and gynaecology. Use of compassionate messages validating the woman's inherent value as a human being was the most common practice. Secondly, within the framework of a trusting relationship, these physicians tried to pierce the ambivalence displayed by IPV survivors towards their mates by labelling the abuse as criminal. Listening non-judgmentally, documenting, helping the patient plan for safety, referring and using a team approach were other prominent patterns. Significantly, even these committed 'champion' physicians admitted to sometimes feeling frustrated, incompetent and overwhelmed when dealing with IPV.

Waller, Hohenhaus, Shah & Stern, (1996, p.754) describe the development, design, and validation of an emergency department protocol for the identification, documentation and referral of IPV survivors. Lack of staff interest and expressed time constraints were identified as key obstacles to the implementation of the screening and referral protocol. They conclude that evaluation of such a protocol is imperative in order to determine the actual clinical impact (Martin & Artz, 2006). It is hoped that this thesis' research goals 2 and 3 contribute to such an evaluation of our selected protocol in the local context. Olson et al. (1996, p.742) found that modification of the emergency department chart to include a specific question about IPV significantly increased the recognition rate. By contrast, an educational intervention did not.

While attending to medical needs is vital, it is equally important to avoid prescribing medications that will alter a woman's judgment or impair her ability to protect herself (Chescheir, 1996, p.768). In addition, healthcare practitioners need to know that a battered woman is most at risk of being killed when she leaves her abuser or convinces him that she is leaving for good (Campbell, 1992). These recommendations – to incorporate concerns about a patient's situational safety into one's clinical care decisions – would be in line with the standpoint taken by Stark, Flitcraft and Frazier (1979) against a process of secondary victimisation, as referred to in section 3.2.1. In both the way the research was conducted and the recommendations for interventions, this thesis also seeks to avoid narrow biomedical approaches which can be tantamount to the disempowerment of the IPV survivor through the medical process.

Thoroughly documented records are the best assistance the health profession can provide for abused women seeking justice in the courts. Access to the records must be limited to professional staff (Easley, 1996). Even if health care workers do not themselves refer a patient to other sources of help, such as social workers, shelters, police, at least referral resources should be available to IPV survivors in the form of a leaflet containing telephone numbers and addresses of appropriate organisations (Bowker & Mauer, 1987; Sisley et al., 1999). A Texas study on the impact of an intervention found that resource use was significantly related to the severity of abuse, irrespective of whether the women had received the intervention. Women using resources at six months were still using them at twelve months. The study postulates a "survivorship model" whereby women persistently and assertively seek a variety of community resources to end the abuse (McFarlane, Soeken, Reel, Parker & Silva, 1997). In their sample of 604 randomly selected South African pregnant women, Mbokota and Moodley (2003) found women seeking social support comprised 42%, 19% did not seek

support and the rest (39%) did not have access to support. The sources of support included government services (14%), non-governmental organisations (13%), a relative (16%) and friends (57%).

Regarding referral resources, refusal by victims of IPV to allow police involvement is common in the UK and may frustrate health care providers. The reasons are often complex, including low self-esteem and self-blame, concerns about children, and a fear that action will lead to further violence (Boyle et al., 2004).

Do interventions help? A study conducted in Texas tested a three-stage counselling intervention to prevent abuse of 132 pregnant women. A comparison group of 67 abused women were offered merely a list of community resources. Both groups were followed up at six and twelve months post-delivery. Significantly less violence was reported by women in the intervention group. The latter also used significantly more safety behaviours than the comparison group (Parker, McFarlane, Soeken, Silva & Reel, 1999). Humphreys et al. (2001) reported that women who received an intervention designed to provide them with information on the cycle of violence, a danger assessment, the options available to them, safety planning, and resource referrals in an empowering manner, had significantly lower scores for both physical and non-physical abuse at six and twelve months post-intervention than women who had received no intervention. Recently, a combined micro-finance and training intervention in South Africa aimed at improving women's self-efficacy, negotiation skills and economic independence from men, led to a reduced level of IPV in programme participants (Pronyk, Hargreaves, Kim & Morrison, 2006). The conclusion is encouraging, namely that economic and social development interventions can ameliorate situations of IPV, and reflects the contention that poverty and social factors help keep women trapped in abusive relationships.

3.5.5 Methodological issues in the IPV intervention literature

As detailed in Chapter Two, the use of non-feminist research methodologies in IPV-related work is problematic as is the uncritical acceptance of the empirical-analytical paradigm to be the reference point from which all else is judged. A topic as complex, and politically and emotionally charged as IPV, should not unquestioningly embrace the validity of a quantitative approach to data, which strips the context of its relevance. For example, many studies have focused on the prevalence of IPV and forms of abuse, with a detached objectivity that smacks of voyeurism. How does such academic armchair work contribute to deeper understandings of the problem of IPV and ways to address it?

It is vital to interrogate methodological issues such as why Wathen and MacMillan decided to exclude qualitative studies from their systematic review of published quantitative studies assessing evidence for the acceptability and effectiveness of screening for IPV in healthcare settings (Wathen & MacMillan, 2003). They concluded that although IPV is a common problem with dramatic health consequences for women, implementation of screening programmes in healthcare settings could not be justified until evidence of the value of particular interventions and lack of harm from screening was provided (Ramsay, Richardson, Carter, Davidson & Feder, 2002). Consequently they favoured case finding and recommended that health services should aim to identify and support IPV survivors and highlighted the importance of the training and education of clinicians in promoting disclosure and appropriate responses.

Crucially though, Jewkes (2002, p.254) points out that while the lack of evidence of effectiveness of interventions may prevent action (Thompson et al., 2000) as Richardson et al. (2002) argue that it should, this does not prove **in**effectiveness. Further, Jewkes lifts out the vital argument by Bradley, Smith, Long & O'Dowd (2002, p.4) that inquiry about IPV should be regarded as a means of "*uncovering and reframing a hidden stigma*" and therefore that inquiry in itself is beneficial, even if no immediate action follows from it (Jewkes, 2002, p.254).

At a USA Centers for Disease Control and Prevention workshop, Sugg noted that surprisingly few clinical interventions were supported by evidence from clinical trials. "*I feel that people who want evidence for everything they do, just can't practice primary care medicine*" (quoted in Cole, 2000, p.553). So people use the lack of evidence argument to support inaction when it aligns with their perspective and ignore the lack of evidence when they are comfortable with the action.

3.6   Conclusion

The theme of the silence surrounding IPV has come up time and again in this chapter. Early feminist work broke open the silence that surrounded IPV in the late 1970s and feminist hermeneutics also calls hidden phenomena and social relations into the open. From these springboards, South African gender relations were examined as giving rise to IPV which also serves to perpetuate them. A spotlight was turned on IPV, to examine its prevalence, risk factors for IPV, the cycle of violence trapping women, the extensive burden of physical and

mental health consequences caused by IPV, not to speak of the impact of IPV on the HIV epidemic. While the ethical argument for increased IPV detection and intervention in all arenas of the health sector would seem to be clear, the widespread resistance to addressing IPV is an international phenomenon that has resulted in the neglected, under-reported, under-documented status of IPV, perpetuating the silences. In this chapter I attempted to make the case that IPV will only be effectively tackled if it is understood as a product of gender relations and the oppression of women. In South Africa, significant advances have been made to advance women's rights, but these still need to be translated into effective health practice. In the South African context major problems lie with the training process, in a situation where all health care providers are severely overworked. Structured systems for the screening, care and protection of IPV survivors need to be put in place and implemented. The last section of the chapter drew on lessons from the literature for effective screening and intervention practices.

Throughout this chapter, studies reveal that health care providers' attitudes and beliefs about gender relations, their own role, and IPV, affect their ability to provide intervention and care for IPV survivors. The literature reviewed also touched on limitations of the health care system and its institutions in providing effective IPV interventions. Chapter Four digs beneath these manifestations to the level of theory, and presents and discusses various theories about the subjectivity of nursing and its status and role, in order to shed light on organisational and professional issues pertinent to the recognition and management of IPV. While the literature surveyed in this chapter looked at all health care providers, in South Africa's primary health care system where most IPV survivors would initially present and where this thesis' research is located, it is nurses who are in the frontline. Hence the shift of focus to nursing in Chapter Four. Since it is a central contention of this thesis that a feminist framework is needed to adequately interrogate and address IPV and the health care system's response to it, Chapter Four mainly draws on feminist theories and their inheritors.

CHAPTER FOUR

"IF NURSES ARE THE BACKBONE OF THE HEALTH CARE SYSTEM, WHY ARE WE TREATED LIKE THE COCCYX?"

"Medicine, in its powerful mediation of human physical and emotional frailty, can similarly be understood in terms of its relationship to a larger social (political and economic) system in which it serves to conceal sources of injustice and suffering. From this point of view, medicine cannot be described apart from the relations of power that constitute its social context" (Rhodes, 1990, p.167).

"Woman must write herself into the text – as into the world and into history – by her own movement" (Cixous, 1981, p.245).

4.1 Introduction

Chapter Three's review of studies of IPV prevalence and the health burden it creates, and health care systems' response to IPV and abused women, revealed barriers to effective screening and intervention by health care providers, including social issues such as gender relations, personal factors including sexism, professional factors including status and role and institutional and legal factors. This thesis contends that feminist understandings and approaches – and others that place an emphasis on social context and construction, and not merely on the biomedical – would be central in overcoming the barriers and creating an adequate response. Thus, in Chapter Four I turn to some of the relevant theoretical work, in particular theory and research on nursing since nurses are at the forefront of dealing with IPV.

In terms of government policy in South Africa, the PHC system must be nurse driven by 2010. However, the systemic lack of support for nursing personnel is a fundamental fault-line in our health care system. It also mirrors more general gender oppression in its exploitation of a predominantly female profession. The nursing milieu is not a "holding environment", (Winnicott, 1960) which provides caring and supportive containment, and nurses occupy the lowest levels of the health care hierarchy. In this context of neglect, nurses have to develop their own resources. Note therefore that lay counsellors, home carers and health promoters are below them.

Given such obvious and challenging constraints as the current shortage of skills, widespread poverty and epidemic levels of virological and bacterial infections, it is not surprising that the primary health care sector resists the further challenge of feminist critique. Ironically, however, it is precisely the interventions suggested by such critiques that would enable PHC to become significantly more responsive to the needs of the most vulnerable without placing excessive demands on already strained personnel and budgets. This chapter seeks to outline the theoretical context for an appraisal of this claim.

After some initial meta-theoretical notes in section 4.2, section 4.3 reviews the history of the displacement of the holistic traditional healers of the Middle Ages by 'scientific' doctors as the bio-medical approach gained ascendancy by the 19th century. A similar process was taking place in the Cape Colony of the 19th century, with its added dimension of colonial relations. Given the prevailing gender relations, this process ultimately saw women relegated to the sidelines in the medical system, culminating in the ideal of the supportive and secondary Nightingale figure in modern nursing.

In section 4.4, I suggest that the role and position of nurses within the modern health system reflects the position of women in society, and nurses are mostly women and perhaps therefore subject to similar gender oppressions and possible IPV as all women. My observation from 20+ years of nursing-related experience, is that nurses share many features of an oppressed group. I have used Freire and related theorists to examine how the mechanisms of creating and maintaining hegemonic power apply to the medical context, and why and how the oppressed internalise the prevailing power relations. Nurses are continually subject to an authoritarian, bio-medical surveillance, which 'gaze' is internalised to police themselves (Foucault, 1973). In South Africa many women became nurses in order to escape their class, gender and racial oppression. For black women in particular, nursing was one of the few careers they were allowed into that could lift them from the working class into the middle class. Thus, it meshed with these women's interests to internalise and perpetuate notions of a nurse's status, a form of internalised oppression which kept them from solidarity amongst themselves, with their patients, and with working class communities. However, while the discourse is that nursing is a profession, the way in which South African nurses' labour was organised from the 1940s, and the position of nursing within the medical hierarchy, has been "proletarian" in nature (Rispel & Schneider, 1991), which contradicts the sense of status and which contributes to nurses' oppression and serves to disempower them from autonomy and operating holistically.

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Section 4.5 looks at the impact of these relations of oppression on the ability of nurses to provide effective IPV care. Through internalised notions of status in the context of being oppressed and socialised into an authoritarian, bio-medical system, nurses are separated from their patients and have difficulty providing the emotional labour needed for effective IPV care. In contrast to visions for PHC captured in policy documents, nurses are socialised into, policed and rewarded for bio-medical approaches which distance the health care provider from the patient, split mental from physical problems, individualise and decontextualise patients' concerns – all practices which run counter to the holistic approaches required to assist IPV survivors and disrupt the underlying power relations in which IPV thrives.

Section 4.6 explores management theories in order to understand how the health system became organised in ways which foster such 'cultures of control' rather than care, and bio-medical approaches over holistic ones. After the industrial revolution, theories of how to bureaucratise, divide and organise work strongly influenced nursing management. Weber outlined early 20th century shifts in ideas about the organisation of work, culminating in the 'scientific management' theories of Taylor, which taken to their worst conclusion would prefer robots to human workers. While scientific management lays claim to the ideal of total rationality in the workplace, there are complex and often invisible organisational dynamics and behaviours it does not acknowledge, which are better described by complexity theory. Not only do people work out their own unconscious dynamics in the workplace, as Taylor did in forming his theory, organisations themselves can be more or less conscious of their own dynamics.

This leads us to turn to psychoanalytic perspectives in section 4.7, for the insight they may provide on the nursing system. It starts with a brief explanation of relevant features of psychoanalysis and critiques of psychoanalytic theory, and how it is relevant to understanding organisational change. I then explore Menzies' analysis of nurses' defensive practices against anxiety (1960), including the mechanisms of task splitting, depersonalisation, emotional detachment, task ritualisation, and re-checking decisions. South African instances of these are cited. Drawing together threads taken from the idea of internalised oppression, the potential sickness of organisations' hidden undercurrents, and Menzies' mechanism of emotional detachment and denial of feelings, the effect on the relationships between nurses, and between them and others in the health system, is examined.

Since the action research undertaken for this project sought to catalyse a change in the nursing system to effect better provision of care for patients experiencing IPV, it is important to take note of what the theoretical frameworks explored and studies cited in this chapter may have to tell us about the levers of change of oppressive relations and dysfunctional organisations and practices – and the feasibility of operating these levers in the nursing system.

4.2 A theoretical bricolage

At a meta-theoretical level, theory for this thesis takes place within two potentially conflicting eras. The 'modern' era includes Freud and Marx and a rather concretised understanding of power. It includes all the liberation movements of the 1960s, Women's, Gay and Lesbian, Liberation Theology and Civil Rights, which were really gathering ground by the 1970s. So the most recent wave of feminism was born at a moment when the modern was still dominant, and called itself 'Women's Liberation'. Post-modernism disturbs it in the 1980s and by the 1990s queer theory has emerged. Queer theory refers to a collection of theories critical of traditional notions of sex, gender and sexuality. Such theories argue for multiple genders and sexualities, which need not be connected to each other rigidly as through the heterosexual construction of biological sex (Shefer, 2004, p.198). Now everything is fluid and in flux.

In this chapter, a range of theoretical approaches illuminate aspects of both the subjectivity of nursing and its more objective status and role. These include both modernist and post-modern discourses. The former offers such obviously pertinent conceptual tools as 'oppression', 'liberation' and 'ideology'. The latter opens up more subtle insights through such notions as 'surveillance', 'the internalised gaze', 'capillary power' and 'deconstruction'. Purists may object to this eclectic approach. I hope it will be seen as a legitimate contrapuntal technique. The aim is to expand the range of lenses through which problems may be viewed and solutions found, teasing from apparent oppositions a post-modern bricolage in which apposite strands speak to, challenge and refresh each other.

4.2.1 'Modernist' theoretical input: social relations, power, oppression and internalised oppression

The ways in which oppression is theoretically understood is especially critical to nursing research, and in particular to, research on violence against women. This is because violence is a complex, pervasive social problem emanating from and sustained by multiple forms of oppression, including gender, class and race. Varcoe (1996) emphasises that theories of oppression, informed by complex analyses of power and oppression, focus on the countering

of oppression by individuals, institutions and the state. Similarly, conceptualisations of violence that neglect analyses of power, oppression, agency and resistance may serve to support and sustain violence. Such analyses in nursing research can align nursing with structures that perpetuate violence and oppression (Varcoe, 1996). Thus power is at the heart of matters relating to internalised oppression in nursing, and how it impacts on nurses' capacity to care constructively and insightfully for IPV survivors.

Many of the problems related to the practice and potential of contemporary nursing in South Africa can be understood in terms of theories that construct internalised oppression as a significant way of being. Internalised oppression impacts on nurses' capacity to care constructively and insightfully for IPV survivors. Yet this major obstacle is only one among a multiplicity of oppressive elements operating within the South African nursing context. Critical medical anthropology attends to "*macro-structural questions, the role of power in social life, and the way in which biomedicine is culturally constructed*" (Lock, 1986, p.110). This chapter accordingly questions bio-medical theory and practice for its neglect of the social and cultural issues involved in individual patient care and for its immersion in, and simultaneous perpetuation of, dominant male-defined economic and political systems (Rhodes, 1990, p.159). Stigmatised areas of care, such as feminised IPV, present particular challenges.

At core, this chapter critiques how the relatively modern phenomenon of nursing was constructed as a mere adjunct to the medical enterprise. The systematic sidelining, and frequent denigration of nursing is viewed historically, revealing extensive disempowerment of formerly autonomous, independent female healers. In this sense, nursing itself is a battered woman, with all her wounds of low self-esteem, self-hatred, fear following silencing, the mask of the oppressed. Sadly, within South Africa at least, nurses, like battered women, appear to be unable to organise themselves cohesively. Internalised oppression whereby aligning with the dominant group is held as the 'right' way to go (section 4.4.2), the policing of oneself and fellow nurses (section 4.4.3), and clinging to notions of the status of the profession (section 4.4.4), mitigate against solidarity with other nurses and go a long way to explaining this – together with active efforts under apartheid to depoliticise nursing and ban collective organisation.

4.2.2 Postmodernist theoretical input: Foucault, and making marginal voices centre stage

The forms of discourse analysis relevant for the purpose of this work are the Foucauldian strands, which interpret discourse as social practice, constructing frameworks of meaning, including our subjectivities and our knowledge of ourselves. Foucault argues that we are born into discourse, that we are socially constructed through dominant discourses such as 'normality', 'masculinity' and 'femininity' which in South Africa are transcultural patriarchal discourses. He examines the relationships between knowledge (medicine, psychiatry, psychology, sexology and criminology), experiences (sexuality, self-identity, sickness and insanity) and power (Winch, 2005, p.177).

Thus feminist post-modern critique argues that violence against women, like HIV and AIDS, is an epidemic that is driven in critical ways by social norms about power, gender and violence (Peacock & Levack, 2004). Chapter Seven, which presents the findings regarding the implementation of the protocol for screening and management of IPV, makes this abundantly clear.

Post-modern feminist critical approaches to nursing theory and research challenge the bio-medical status quo both by foregrounding voices formerly relegated to the margins of dominant discourses and by interrogating dynamics of knowledge and power in nursing (Huntington & Gilmour, 2001, p.902). Huntington and Gilmour (2001, p.903) discuss how the critical activity of making new representations indicates a commitment to the Foucauldian concept of *"thinking differently rather than legitimating what is already known"* (Foucault, 1990, p.9) thereby recognising the feminist concept of writing as activism.

Waitzkin (1991, p.37) points out that silence can be an important mechanism for the reproduction of a dominant ideology. In other words, ideology manifests itself in part through a lack of attention to contextual difficulties and an absence of discussion of alternatives to the status quo. Accordingly, this chapter explores what is marginal to, or strategically excluded from, the dominant ideological representations of nursing and health care for IPV. In doing so it seeks to answer the question posed by Professor Judy Bruce of Nursing at the University of the Witwatersrand, "If nurses are the backbone of the health system, why are we treated like the coccyx?" (permission for inclusion granted by email, 1 July 2009).

Action research has promise as a method for both education and practice as a way of activating latent potential in nurses, to develop their flexibility in finding lateral solutions, reflecting on their practice, and so on – in part a remedy for the damage that this chapter deals with. The action research undertaken for this thesis, with its methods such as co-operative-inquiry group meetings, in-depth interviews, and focus groups, in itself tackled the issue of bringing the researchers and those being researched into the centre of the research process to speak with their own voices.

4.3 From healers to helpmeets: Power struggles preceding modern nursing

When searching down the margins of history and into the silences surrounding the role of women in healing prior to Nightingale, a startling history emerges of the overthrow of largely female and more holistic healers by male allopathic practitioners, aligned with emerging class, gender and racial power structures.

4.3.1 The overthrow of healers from the middle ages to the 19th century in Europe and the United States

The eradication of female healers in Europe was a pogrom that spanned the 14th to the 17th centuries. The extent seems unimaginable now. In 1585 in the Bishopric of Trier, two villages were left with one female inhabitant each. In certain German cities an average of 600 executions per year, or two per day excluding Sundays, were recorded (Ehrenreich & English, 1973, p.7). The State and Church (Catholic and Protestant) initiated, financed, and executed a carefully organised campaign of ritual patriarchal androcentric 'cleansing' of popular organised healing, guided by the sadistic *Malleus Maleficarum*, or 'Hammer of Witches', which was written by the Reverends Kramer and Sprenger in 1484. Spanning four centuries, three core accusations surfaced repeatedly: firstly, female sexuality, secondly, being organised, and thirdly having magical power whether used for harming or healing (Ehrenreich & English, 1973, p.10).

In 1322 Jacoba Felicie was charged with practicing medicine by the Faculty of Medicine at the University of Paris. The record said, *"she was wiser in the art of surgery and medicine than the greatest master or doctor in Paris."* (Walker, 1983, p.1083). By the end of the 14th century, the male medical profession's campaign against educated, urban female healers had been accomplished in Europe. "*If a woman dare to cure without having studied she is a witch and must die",* dictated the Church, well knowing that she had no way to study (Ehrenreich &

English, 1973, p.19). Ehrenreich and English argue that control of / power over female and/or peasant/folk subcultures of healing by male ecclesiastical and medical upper classes was ultimately the key issue.

Barbara Walker comments thus:

> *"Europe's traditional witch doctors were women: clan mothers, priestesses of healing shrines, midwives, nurses, vilas. In pre-Christian Gaul and Scandinavia, medicine was entirely in the hands of women. Even in the Christian era, the wis- woman was still every peasant's family doctor. Paracelsus said witches taught him everything he knew about healing."* (Walker, 1983, p.1082).

Ironically, many of the herbal remedies developed by these female healers / wise women / witches still have their place in modern pharmacology. Witches utilised ergot for labour pains while the Church claimed that pain in labour was the Lord's punishment for Eve's original sin. Ergot derivatives are still used today to hasten labour and aid in recovery from childbirth. Likewise digitalis, a contemporary drug for heart ailments, is said to have been discovered by an English witch (Ehrenreich & English, 1973, p.14). By contrast the remedies prescribed by medical men seem highly suspect:

> *"The physician to Edward II, who held a bachelor's degree in theology and a doctorate in medicine from Oxford, prescribed for toothache writing on the jaws of the patient, 'In the name of the Father, the Son, and the Holy Ghost, Amen,' or touching a needle to a caterpillar and then to the tooth. A frequent treatment for leprosy was broth made of the flesh of a black snake caught in a dry land among stones"* (Ehrenreich & English, 1973, p.15).

A powerful patriarchal discourse that has shaped the consciousness of Western and colonised people is the classical theological construction of sin, which gives ideological credence to the mythological Original Sin. Sin is believed to be passed on through generations in the act of procreation itself. The appearance in the final form of the doctrine in the fourth century was born out of, and in turn produced, a deep-seated hatred of women and revulsion for sexuality. Attempting to explain the paradoxical existence of evil in a world created by God, Eve, the eternal temptress is targeted as the cause of all human sin and consequent suffering. It is crucial to note that this symbol system formulates the specifics of a male-defined ideology of power and control, which holds the original female prototype responsible for the 'defective'

patterning of subsequent humanity. Christian theological anthropology thus locates humanity within a hierarchically dualistic paradigm. The transcendent spiritual principle, linked to the realm of intellect, is identified as male. The morally inferior and therefore lower material reality, that of body and nature, is female, and importantly, is ontologically dependent on its omnipotent, omniscient counterpart.

Important themes emerge when we excavate history using a feminist hermeneutical lens that seeks to discover women's experience as distinct from the male frame of reference which both names and negates it. The distinction between 'male' medicine and 'female' superstition was entrenched in the roles of doctor and witch in the trials. Each powerfully established the male physician on an intellectual and moral plane vastly superior to the female healer he was called to judge. While he was aligned with God and the Law, she was relegated to the realms of evil and magic. Ehrenreich and English (1973, p.19) conclude that physicians owed their new status not to scientific or medical achievements of their own, but to the Church and State they served. Here we see how relations of power so effectively discredited female healers among the emerging middle classes that in the 17th and 18th centuries male practitioners were able to muscle in on the last preserve of female healing – midwifery. Barber-surgeons, claiming superiority on the basis of their use of the obstetrical forceps, rapidly developed the formerly community-oriented home-birth practices into a lucrative industry. The forceps were legally classified as a surgical instrument, and women were legally barred from surgical practice (Ehrenreich & English, 1973, p.20).

In the United States, the medical profession was financially empowered by the emerging business establishment of the Rockefellers and Carnegies, far more than by modern science. Certain authors have shown how doctors and hospitals have benefited from their exploitation of nursing (Ashley, 1976; Ehrenreich & English, 1973; Lovell, 1981). Such work was part of a wave of feminist nursing literature that emerged from the United States in the 1970s. It revealed that since the Middle Ages, as a professional group, medical men used mechanisms of occupational displacement to disrupt the social status of women in health care (Lieb, 1978). This is particularly clear in the marginalisation of female midwives, and the rise to dominance of male obstetricians in the United States during the 19th and 20th centuries (Ehrenreich & English; 1973; Roberts & Group, 1973). A similar phenomenon occurred in the Cape Colony in the first half of the 19th century (Deacon, 1998).

The transformation in power relations between female and male birth attendants occurred within several legal systems, national policy frameworks and regionally diverse medical markets, resulting in significant regional differences. Midwives in continental Europe remained empowered as birth attendants for far longer than in America and Britain (Deacon, 1998, p.273). The key questions become why and how did one specific set of healers: male, white, middle and upper class, manage to marginalize all competing midwives and healers, both male and female, who had dominated the South African, American and European medical scene until the 19th century? As alluded to above, the answers lie in the political gender / class struggles for power that epitomised these issues (Ehrenreich & English, 1973, p.21). This becomes clearer in examining how women healers and midwives were elbowed out of medical practice in the 19th and early 20th centuries in South Africa, specifically the Cape.

4.3.2 Midwives and medics in the Cape Colony in the 19th century

In the Cape Colony of the early 19th century, the implementation of training and licensing programmes for midwives suggests that midwives were viewed as junior partners instead of competitors. The primary focus of the training programme was not their education, empowerment and welfare, but rather the elitist regulation of urban, predominantly white, midwifery practice. Deacon (1998, p.278) informs that the midwives' oath dictated terms of professional conduct favourable to doctors looking for obstetrical work. Licensing procedures did not provide midwives with the legal rights and protection afforded doctors and were poorly administered until the 1890s. To their discredit, midwives did not organise into professional lobbying groups and so comprised a loose, varied group of poor practitioners with little social status in colonial society, subject to the professional validation of the higher-status doctors (Deacon, 2004, p.72):

> *"At the Cape, the denigration of untrained midwives focused on black women. This provided an opportunity for a neat combination of the European image of the 'untrained' midwife as a dirty, ignorant, drunk and gossipy old woman, refusing doctors' aid, protecting immoral mothers and procuring abortions, and the colonial image of the Khoisan and slave woman as a dirty, lazy, primitive, inebriated and immoral 'creature'...this was part of a general pattern of settler racism towards black women"* (Deacon, 1998, p.275).

The steep decline in the ratio of black midwives recorded in the street registers of the 19th century Cape colony was part of a trend towards the disappearance of black women from those represented as selectively employed (Deacon, 1998, p.283). By contrast, during this period, although doctors were interested in practicing midwifery, they did not publicly discredit midwives' ability to attend normal births, unlike their contemporaries in America and Britain. However, by the end of the 19th century, professional medical overcrowding and rising Afrikaner nationalism resulted in the criticisms previously aimed primarily at black midwives, being specifically extended to poor white midwives too (Deacon, 1998, p.292).

In relation to broader medical practice, the 19th century was a crucial time for the integration and establishment of the professional, economic and social status of the allopathic medical profession in the Cape as it was elsewhere. Cape doctors sought to distance themselves, socially and clinically, from the alternative healers who so outnumbered them. It was their social and legal status that protected their niche within the competitive medical market (Deacon, 2004, p.39).

Louisa Mvemve was a highly successful herbalist, 'women's healer', fertility expert and chemist, who combined the skills and networks of many nineteenth century practitioners. From 1914 to the early 1930s she attempted to "…*be granted the might of a medical man to examine the people who want to be cured by my herbs and Root Mixtures"* (Burns, 1996, p108). Louisa explained herself and pleaded her case via discourses of good healing, Christianity and civilisation. Ultimately, however, she was unequal to the gigantic obstacles she faced in her efforts to win recognition, legality and financial success. The 1920s and 1930s witnessed the growing systematisation of oppressive practices and laws, which impacted on the lives of black South Africans, in particular black women (Burns, 1996, pp.110-111). Louisa Mvemve's struggle for recognition as a woman with valuable healing power, talents and skills in a specialised arena, provides a vital contribution to the history of healing and medical care in Southern Africa:

 "But Louisa Mvemve embarked on this journey to fashion a new craft from the skills of her ancestors and the techniques of biomedicine at just the time when the Medical Academy in South Africa began closing its ranks, centralising its authority, and undermining the independent expertise of a host of practitioners such as midwives and herbalists" (Burns, 1996, p.112).

Recent research into Eastern Cape narrative and oral traditions has suggested that historically women played a crucial role as local experts in the fields of medical and historic knowledge. Nongenile Zenani's specialist knowledge as a healer and herbalist offers a parallel to Louisa Mvemve. Burns reports that interviews with herbalists and midwives in the Eastern Cape region suggested that a body of knowledge and practice relating to pregnancy and birth had survived into the 1990s.

4.4 Internalised oppression in nursing

Largely female holistic healers having been displaced by mainly male doctors, and women having been redrafted into biomedical practice as nurses, we come to the era of modern nursing characterised by the Florence Nightingale figure. I draw on both 'modernist' and post-modern theoretical frameworks to examine the oppressions operating in nursing, of and by nurses, and of the suppression of holistic, caring approaches to care by biomedical and controlling approaches.

4.4.1 Modern nursing mirrors broader social gender relations

The role of nursing in the health field is the epitome of women's role in a patriarchal society. Of all the professions, nursing seems to have been most influenced by sexist social perceptions of the nature of women. Modern nursing evolved out of the Victorian period, where the role of women was to serve male needs. Nursing leaders of the 20th century seem to have been strongly influenced by such Victorian subservience. Their consequently conservative approach to solving problems resulted in conciliatory, often self-deprecating, attitudes and behaviour. Nursing analyses of our own professional social and political problems as women at the mercy of a paternalistic system, then and now, remains, for the most part, sadly lacking.

Ashley (1976) analyses the politics of the evolution of the nursing profession, as constrained by the sexist attitudes and paternalistic practices of the medical elite. She notes that in the early 20th century only a few eminent medical men spoke out against the repressive and narrow-minded views of their male medical colleagues. She cites Winford Smith of The Johns Hopkins Hospital who in 1912 publicly accused his colleagues of their blatantly unfair opposition to advancements in nursing:

> *"The development of nursing has been the strongest of all factors contributing to present hospital efficiency, and this development has resulted almost entirely from the*

> *earnest efforts of members of the nursing profession, in spite of unwarranted*
> *opposition and in the face of adverse criticism"* (in Ashley, 1976, p.86).

A South African mixed method study, which trained 38 PHC nurses about gender-based violence, concluded that since nurses are people first, they have internalised similar cultural values and levels of violence as the clients they are required to counsel and treat (Kim & Motsei, 2002). They emphasised the urgency of understanding and addressing the lived experiences of nurses, and the duality of their roles as professional and community members, before promoting the training of nurses as an effective strategy for dealing with gender-based violence.

4.4.2 Locating nursing in the oppressor / oppressed power nexus

Nurses have been described as an oppressed group. Both historical and contemporary evidence exposes the dominance of nursing by medicine (Torres, 1981). Internationally the cultural narration of nurses is to be subordinate (Freshwater, 2000, p.481). Extensive literature supports this view, indicating that nurses lack autonomy, control (Ashley, 1976) and self-esteem (Randle, 2003). They also fear success (Lieb, 1978), display the submissive-aggressive syndrome (Stein, Watts & Howell, 1990), and experience a contradiction between their official roles and organisationally determined powerlessness (Mgoduso & Butchart, 1992).

Educator, sociologist and initiator of participatory action research, Paolo Freire, (1972) provided an analysis of the major characteristics of oppressed behaviour in relation to dominant ideologies. He exposed the power that dominant social sectors have to identify their norms and values as the 'right' ones and to enforce them by exploiting others. In the Foucauldean strand of discourse analysis, this has come to be understood as the productive role of discourse in creating and maintaining dominant forms of power, often as norms. A consequence for the oppressed can be that they believe that imitating their oppressor is their only avenue for gaining power and control and thus they perpetuate the cycle (Roberts, 1983).

Having internalised the system, these nurses derive self-worth by imitating the dominant group. Freire explained this phenomenon in terms of oppression theory where the oppressive state distorts reality for both oppressed and oppressor, in that the consciousness of the more privileged and powerful group is absorbed and taken to represent reality in the world. Applying this to health care, the powerful group refers to the predominantly male medical and

management coteries. Until 1940, the medical men were dominant, but in the 1980s and 1990s stronger health management structures such as the National Health System in the United Kingdom gained ground internationally. These elites determine the norms, values, structures and worthwhile goals of health care systems. Note that at philosophical and ethical levels, this distortion can be seen to dehumanise both groups.

Ironically, the barriers to achieving freedom and justice become rooted in the consciousness of the oppressed (Torres, 1981, p.4). They include the:

1. oppressed group's idealised internalised image of the oppressor as 'powerful' and 'right';

2. internalisation of the oppressor's view and definition of reality;

3. oppressed group's fear of freedom;

4. tendency to conform to the prescribed behaviours set forth by the oppressor and to perpetuate them; and

5. inability to take risks in achieving freedom.

A poignant example of internalised oppression is the way in which certain nursing theorists have turned the 'clinical gaze' on nurses and explain the pitfalls of nursing practice in terms of deficient personality characteristics, thereby psycho-pathologising oppression:

"...studies indicate that nurses have certain kinds of personality characteristics associated with this stereotypic perception of the nursing profession ... the predominant personality structure of nurses tends to support dependent, submissive roles. Definitely lacking in the nurse's personality structure are psychological characteristics like autonomy, ingenuity, initiation of and adaptability to change" (Roberts & Group, 1973, pp.319-320).

Since it is in the perceived best interest of the powerful group to maintain its privileges, which depend on the continued domination of the less powerful group, the oppressors use different means to assure continued domination. These include limiting the quality and extent of the education of the oppressed group, keeping the oppressed group divided amongst themselves, and elevating members of the oppressed groups to high-status positions (Freire, 1972; Torres, 1981). All the above features are powerfully present in both the 'developed' world and South African nursing contexts.

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4.4.3 Surveillance / the internalised gaze

Foucault's theory of disciplinary power emerged in opposition to Marxist notions of sovereign power. At the core of this theory is the notion of surveillance, where people feel themselves to be observed by some authority, under a gaze of surveillance, which, over time in the system, they internalise. Nurses are actually directly observed by a whole hierarchy of authorities, including unit managers, matrons and hospital management. And indeed, nurses police themselves and each other better than any other profession. Foucault argued that the major way of imposing this disciplinary gaze is through the establishment of particular kinds of norms.

Foucault's concept of panopticism speaks to the way in which nurses police themselves better than any other profession (internalised surveillance). In return they stand to gain access to power, status and rulership within the dominant bio-medical model. Arguably, a significant hurdle for nurses to overcome is to realise that this dominance is not a natural and right phenomenon. Consistent with the theory of oppression, nurses seem to have internalised the belief that it is natural for biomedicine to maintain control of the entire health care enterprise. In support of this view, Lovell (1981) argues that the control, domination, intimidation and nullification of individual will, implicit in a system of medical patriarchy, produces many nurses who do not recognise their abused situation.

The 'birth of the clinical gaze' is the term Foucault (1973) used to describe the male medical search for and seizure of power over female bodies and midwifery. In 4.3.2 above, this phenomenon as it occurred within the Cape Colony in the 19th century was explored. Now let us turn to modern nursing in South Africa with its distinctively South African intersections of gender, race and class oppressions.

4.4.4 Buying into the 'status' of nursing in the context of South African race and class oppressions

Marks (1994, p.7) outlines how the divisions in nursing were congruent with the gender, class and race stratification emerging in the late 19th and early 20th centuries. Since the 1940s South African nurses have complained of "*poor working conditions, excessive discipline, long hours of duty, too heavy restrictions on personal freedom, and extremely low salaries*" (Searle, 1965). Given the increasing demand for nursing personnel internationally, it is a frank indictment of nursing leadership's inadequacy that the supply-demand principle has not been used to advance a more lucrative and appealing occupation (Cleland, 1971).

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However, in South African black communities, nurses have enjoyed considerable social status, being placed at the top of the social structure of township communities (Marks, 1994). Rispel and Schneider (1991, p.119) conclude that in the early 1990s grim working conditions were obfuscated by a smokescreen of status. This also explains why many South African nurses are resistant to identifying with their working class origins. This is consistent with the finding of Van der Walt's research on nursing for tuberculosis, namely that the more closely the patient represented the nurse's origins and/or community, the less empathic was s/he able to be, hence the 'too close for comfort' thesis of her argument (van der Walt, 1998).

As discussed below, one of the specifics of the South African situation is the way the educational advances in nursing have mirrored class and racial interests. The rise to power of the National Party in 1948 had a number of effects on nursing education. Qualifications for white nurses improved, and many more black nurses were trained to provide for the health care needs of the growing black urban workforce. A concerted effort to foster apartheid in the profession was achieved by the 1957 Nursing Act, which enforced statutory segregation of training facilities (Rispel & Schneider, 1991, p.113). The doyenne of South African nursing history, Charlotte Searle, justified it thus:

> *"With problems of language, culture and adjustment to an alien environment to be considered, experience has shown that it was necessary to prescribe a longer period of training with additional subjects for the Bantu nurse. The Nursing Act of 1944 did not empower Council to discriminate in the training curricula of nurses to meet such a situation. It was not a question of prescribing a lesser training for non-whites. On the contrary, it was an effort to improve the professional ability of the Bantu nurse"* (Searle, 1965, p.235).

We should be cautious that distorted notions of internalised oppression do not lead us to frame nurses as hapless victims, rather than active human agents in their own lives. Rispel and Schneider (1991, p.114) argue that black nurses' enthusiastic use of educational opportunities speaks of their desire for upward mobility to decisively advance themselves out of the working class via one of the few channels available to black women; taking advantage of the apartheid government's plan to create a stable black middle class. Interestingly a similar process took place in the 1950s when white nurses distanced themselves as far as possible from black nurses who were considered to be from a lower class.

4.4.5 Professionals or proletariat? Disempowering South African nurses

Historically, nurses in South Africa have been organised as a hierarchical and passive group. While claiming professional attributes, nursing education has on the whole been a rigidly defined and authoritarian socialisation process (Rispel & Schneider, 1991). Historically speaking, yet of relevance to most nurses currently practising, curriculum contents were a closed set of ideas and procedures pertaining primarily to a bio-medical approach to health care. Despite contemporary shifts towards community-based learning, and the integration of gender-based violence as a health concern, nursing education still tends to reward conformity and discourages a questioning attitude. Thus it minimises elements, which should be central to professional identity, such as autonomy and use of initiative. This stands in sharp contrast to current medical education where questioning, reflection and critical appraisal are encouraged, and up-to-date surveillance of relevant literature is required.

Rispel and Schneider (1991) trace the process of professionalisation of South African nursing during the 20th century, arguing that the development of features usually assigned to professions was undercut by an opposing trend of proletarianisation. By this they mean fragmentation of nursing into tasks, the de-skilling of individuals, and loss of personal autonomy within nursing practice. They liken the daily work of most nurses to that of a factory worker performing a series of defined tasks, noting that there is neither time for, nor emphasis on, holistic involvement in the recovery of patients. This theme emerges clearly in Chapter Seven.

Furthermore, a distinctly hierarchical form of nursing organisation means that most nurses inhabit a subordinate position within their own hierarchy, with nursing as a whole subordinate within a hierarchy of health care occupations dominated by medical doctors (Gardner & McCoppin, 1986). Rigid control is enforced by nursing bureaucracies and nurses have minimal autonomy in regard to the pace or content of their work. Active efforts to depoliticise nursing were evident in the creation of a taboo around trade unions for nurses in apartheid South Africa. Rispel and Schneider (1991, p.118) highlight nurses' fear of opposing these authoritarian structures for fear of victimisation, which may entail lack of promotion opportunities, unnecessary transfers, and denial of privileges such as study leave. They conclude that this hierarchical organisation tends to result in an intense awareness by all nurses of their positions in relation to others, and constrains their ability to act collectively.

4.5 The impact of oppression on the ability of nurses to provide effective IPV care

4.5.1 Cultures of care versus cultures of control

Marks (1994, p.208) discusses how the deeply entrenched ideology of professionalism and emphasis on status, as well as the middle-class aspirations of registered nurses often divides nurses from their patients and from other categories of nurses and hospital staff. Rispel and Schneider (1991) mirror this view, arguing that just as medical training educates doctors into attitudes of arrogance and formality, nursing education socialises nurses into attitudes of authoritarianism and victim-blaming toward patients and communities. The deluge of literature on bullying in nursing over the past decade testifies to how this extends to nurses' relationships with each other, reflecting one of the saddest ironies of internalised oppression (Farell, 2001; Hutchinson, Vickers, Jackson & Wilkes, 2006; Lewis, 2001; Quine, 2001; Randle, 2003).

Nurses' educational and professional status, therefore, distances them from the working class and establishes them in a position of authority relative to communities. Thus it is possible to argue that nurses have been socialised into a hierarchical system and within the bio-medical model, trained to give advice rather than to listen, and respond to community needs. Autocratic supervisors seem to have difficulty being democratic facilitators (van der Walt & Matthews, 1994).

In the previous chapter I suggested that extending health sector responses to IPV would require health care providers to develop a feminist understanding of the social dynamics of gender relations. In the absence of such understanding, a battered woman describes her experience of the health care system as follows:

> *"...but people just don't understand. So, they like, 'if you want to get out, get out.' It's not that easy. You walk around in a cage. And it's a real cage you walk around in"* (Bauer & Rodriguez, 1995, p.462).

This thesis argues for a feminist perspective for health care providers who deal with IPV because the problem of IPV is indivisible from the society in which women are subordinated. Feminism pays attention to and honours IPV survivors' subjectivities within the complex power dynamics that can entrap them. Post-modern feminists, drawing on Foucault's notion of 'capillary power', understand how the multiplicity of oppressions experienced by the IPV

survivor are suffused into the very minutiae of her life, squeezing off her vital flow and contributing to depression, anxiety and other suffering. As the previous chapter attempted to show, an approach uninformed by such insights medicalises the problems experienced by IPV survivors, labelling their body-mind symptoms as 'dysfunctional', or 'disordered'.

A code of silence stems from IPV survivors' reluctance to disclose their abuse and the healthcare providers' failure to create an environment conducive to disclosure (Bauer & Rodriguez, 1995). Many participants expressed a strong desire to be listened to. They experienced compassion and respect when the health care providers allowed them to talk without interruption. The participants were also sensitive to subtle communication cues such as eye contact and voice tone. The content and delivery of health care providers' discussions both played a role in conveying their compassion and sensitivity. Women controlled by the abusive actions of their intimate partners report that signs of compassion and caring from nurses have made a difference, planting seeds for change (Gerbert et al., 2000).

Emotional labour, a highly devalued form of skilled social labour, remains largely undefined, unexplained and unrecorded within health care. James (1989, p.16) argues that defining the skills required for emotional labour is incompatible with dominant medical phraseology where 'intuition', 'instinct' and 'emotion' are rejected as vague, unscientific terms. However, she fails to acknowledge the use of empathy in nurses' interactions with patients. This thesis argues that emotion, and the social regulation thereof, should be priorities for inclusion in academic discussion of health care systems theory.

When James searched for references to 'feelings' and 'emotion' in abstracts, she found 'disorder' to be the most common association (1989, p.17). Emotion is rarely seen as structured or systematic. It is often opposed to 'rational'. Indeed, Webster's Collegiate Dictionary (1939) defined 'feeling' as "*formerly opinion, now unreasoned opinion, sentiment*" (in James, 1989, p.17). If emotions are perceived as 'irrational', it is hard to link them to a systematic approach, yet managing them nevertheless necessitates anticipation, planning, timetabling, problem solving, like all other paid and unpaid work (James, 1989, p.26).

It is important not to conflate 'emotional intelligence' with 'emotional labour'. Emotional intelligence is necessary in order to provide emotional labour. Both are key requirements if health care providers are to deal effectively with IPV-related needs. James (1989, p. 26)

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argues that emotional labour is flexibly organised to be responsive to others' needs and centres on the values expressed by a culture of care:

1. being able to understand and interpret others' needs;
2. being able to provide a personal response to others' needs;
3. handling the delicate balance of individual and organisational dynamics within a group; and
4. being able to pace the work, alongside other responsibilities.

This analysis fits with Sartre's description of emotion as 'having meaning and signifying something', 'not a chaotic relationship between the self and the universe; it is an organised and describable structure' (Sartre, 1981, p.34). Yet doctors tend to focus on their script, to the exclusion of the patient's needs, suggesting a bio-medical culture of control rather than one of care. Waitzkin (1991, p.28) argues that doctors' interruptions are essentially aimed at minimising storytelling by patients:

"...the story may not contribute to ... reaching a diagnosis; ... may be confusing or inconsistent; ... may take more time than is perceived to be available; or ... may create feelings that are uncomfortable for the doctor, patient, or both ... what is interrupted, when it is interrupted, what reason is given for the interruption ... are important, especially to the extent that they cut off concerns about the social context of the medical encounter. Predictably, the present illness is a critical junction, during which certain elements, though they may be quite important in the patient's experience, come to be excluded from discourse, while other elements are included."

This phenomenon is nowhere better exemplified than in the treatment of IPV survivors. Warshaw's (1989, p.506) analysis of medical records of women at risk for abuse revealed that the doctor-patient interaction obscured rather than clarified knowledge of abuse. Physicians did not create an opportunity for the battered woman to discuss her underlying reasons for seeking assistance. Instead of responding to the distress for which her physical symptoms provided clues, they medicalised her reason for the encounter, treating only the physical symptoms, thereby reinforcing her sense of isolation, futility and helplessness at not being understood (Warshaw, 1989, p.511). In failing to do any emotional labour, they obfuscated the key connection between her injury and how it occurred, who did it, what her relationship to the perpetrator was, how it impacted on and what the consequences were for the IPV survivor in her life at large. Significantly, Warshaw (1989, p.512) reports that

'disconfirmation' by caregivers of abusive experiences is an important factor in the development of subsequent psychopathology.

4.5.2 Dominance of biomedical over holistic approaches

Hippocrates, the father of modern medicine, established the basis for the contemporary influence of holism by conceptualising a healthy body-mind as an interactive whole. However, the evolution of modern medicine was powerfully influenced during the Middle Ages and Renaissance by the church's claim to the study of mind as its domain. This materialist direction was reinforced by other notions of *"the body as a machine, of disease as a breakdown of the machine, and of the doctor's task as repair of the machine"* (Engel 1977, p.131). Hoff points to the ensuing neglect of social-psychological aspects of illness:

> *"This medicine also radically separates body from nonbody; the body is thought to be knowable and treatable in isolation ... not just a matter of vocabulary but of epistemology; biomedicine participates in deep-seated cultural assumptions about what it means to know the body"* (Rhodes, 1990, p.160).

This is vividly illustrated in medical responses to patients suffering from IPV, where staff deal with the presenting physical problems but make no further assessments or referrals. The lack of psychosocial and advocacy resources within the narrow range of allopathic health care is exacerbated by the victim-blaming discourse prevalent in bio-medically-oriented health care providers. Among other things, victim-blaming discourse conceptualises health problems as diseases. Thus it tends to locate problems within the individual, and fails to consider contextual factors.

Foucault's account of the historical inextricability of bio-medical knowledge as a product of particular cultural and social assumptions reveals medicine to be one of a number of related disciplines that have shaped the body as a vulnerable site for the articulation of social relationships. In *The Birth of the Clinic* (1973) Foucault argues that modern medicine had its birth in the period around 1800 when medicine became clinically based and concerned with both the inside of the body and the control of the health of populations (Rhodes, 1990, p.162). Using a feminist lens to track the relevance here for IPV, we leave Foucault behind to see that a strongly chauvinistic discourse has shaped so many international cultural and social assumptions about the female body-mind to produce the medicalised frame of reference that underlies the pervasive neglect of IPV as a crucial health issue.

Petersen (2000a, p.325-6) argues that nurses play the role of 'cultural brokers' for bio-medical discourse, which locates itself within a matrix of superior power and status (accorded at some level by the broader community). This serves the purpose of creating distance, which protects nurses from becoming overwhelmed by patients' problems, and seems particularly important in contexts lacking other forms of distance (e.g. where a nurse lives in the same community she serves). As cultural brokers, nurses introduce patients to, and subsequently reinforce, bio-medical values relating to health, work and family life. Petersen argues that this socialising function is facilitated by the power differential that exists in primary health nurse-client relationships. Nurses' status provides a mechanism which facilitates social control, a narrow range of allopathic health care and the distance that nurses rely on to protect themselves from burn-out (Petersen & Swartz, 2002; van der Walt, 1998).

An important theme of my thesis is the disjuncture between policy and practice. Petersen (2000b) interrogates the gap between policy and praxis with regard to comprehensive integrated primary mental health care in South Africa. She argues that the integration process of mental health into PHC has been narrowly interpreted, resulting in an add-on approach. Here psychiatry, which focuses on caring for the seriously mentally ill, is added to the workload of PHC personnel. Thus there is an emphasis on developing community-based systems of care for patients with serious mental, particularly psychotic disorders, at the expense of caring for patients with more common mental health, behavioural, and psychosocial problems. She suggests that while the ideology of PHC promotes comprehensive care, the implementation of the bio-psychosocial model is reformist, with resultant care remaining largely bio-medical and technical in orientation. Here Petersen (2000b, p.53) critiques the bio-psychosocial model within family medicine for not truly providing an alternative conceptual framework to biomedicine. In terming it reformist, she challenges the perpetuation of epistemological dualism in the static power relations between health care provider and patient. The health care provider remains the expert, and the consultation remains authoritarian and directive. Further, she draws on Lowenberg & Davis (1994), to argue that the bio-psychosocial model unhelpfully extends biomedicine into different aspects of the patient's life such as interpersonal relations and spiritual well being.

Petersen's (2000a, p.328) KwaZuluNatal study within the PHC setting revealed that nurses' performance was evaluated according to daily records which measured quantity rather than quality, diagnosis rather than understanding, and drugs administered rather than emotional

care provided. In fact, there was no space to record interventions other than medicines administered. Thus we see that nurses were evaluated not according to principles underlying PHC, but rather on their provision of bio-medical care. This directly contradicts the holistic theory which PHC professes to uphold and clearly indicates a lack of structural alignment between espoused theory / values and actual group behaviour / practice. This alignment is expressed through rules and regulations. The assessments designed by the nurse educators reveal a lack of congruency between policy (ideology) and practice. The implied lack of organisational integrity reduces employee trust in the organisation, and consequently reduces group cohesion and resilience.

In terms of a sense of well-being across cultures, mental health refers to a state of spiritual, physical and emotional well-being determined not only by disease process, but also by cultural, material and social conditions (African National Congress, 1994; Freeman & Pillay, 1997). Petersen (1998) asserts that the narrow approach described above cannot offer the comprehensive integrated primary mental health care envisioned by the White Paper for South Africa. This necessitates a comprehensive discourse of care, which understands illness as emerging out of an interaction of biological, cultural, psychological and social imperatives (Hahn, 1995). This approach to care requires a patient-centred stance, which takes seriously the subjectivity of the illness experience for the patient. Petersen (2000b) emphasises that such care should also include all commonly understood principles of PHC, namely: promotion of healthy lifestyles; intersectoral collaboration; and empowerment of individuals and communities to increase control over and improve their health.

It is the argument of this chapter that bio-medical ideology decontextualises and individualises social problems, thereby entrenching power relations that exist in the broader society. Petersen (2000a, 2000b) relates this both to the form of care provided and also to the micro-politics of nurse-patient interactions where nurses act as socialising agents or cultural brokers for the broader status quo (bio-medically-oriented care). This view reinforces Rispel and Schneider's (1991) argument that the holistic ideology of nursing care within South Africa has been subsumed by biomedicine. Medical history of colonial India and Africa suggests that successful transmission of bio-medical ideology was enhanced when mediated by people of the same culture (Marks, 1994). Nurses are ideally placed and arguably cultivated to provide this function.

Zooming out from the focus on nurses, their role, position and how their work is organised to reinforce this, we look at the health system as an organisation. Applying a feminist perspective to the South African PHC sector, one is struck by the patriarchal features, consistent with a male-defined, male-oriented value-system. A bureaucratic approach to organisation rewards analytic, rational features associated with the Western stereotype of maleness, while undervaluing abilities like empathic support and intuition which have traditionally been regarded as 'female' (Morgan, 1997, pp.226-227). Moreover, military and religious orientations, which share authoritarian and patriarchal characteristics, have powerfully influenced the development of modern health care systems. In the next section we examine management theories, which have shaped how the health system is structured and run, which not only hold nurses in their subordinate position but also resonate with biomedicine's mechanistic approach.

4.6 The organisation of health care as a machine

Analysis of the South African 2010 Health Care Plan reveals the PHC system to have been re-structured as if it were a machine. Within this policy document, emphasis has been placed on algorithms that specify a hierarchy of discrete components such as facility service points in relation to population density, staff/ post allocations for different facilities, distribution of beds and allocation of minutes per consultation (PGWC, 2006). This mechanistic structure is amplified by characteristic mechanistic practices.

Although lip service is paid to the necessity of holistic care, in practice most healthcare providers have been trained and function within a bio-medical model. The clinical focus is essentially task-oriented and framed by an ethos that equates effectiveness with speed. This non-alignment of espoused organisational values and actual behaviour creates mistrust and a lack of cohesion within the organisation. Furthermore, a lack of structural alignment in the form of congruence between espoused values / principles and the rules, regulations, procedures and assessments reveals a lack of organisational integrity.

Margaret Wheatley, (2002, p.73), a leader in the field of complexity theory, comments thus:

> *"We've taken the essential elements of being human – our spirits, our imagination, our need for meaning and for relationships – and dismissed them as unimportant. We've found it more convenient to treat humans as machines ... After years of being bossed around, of being told they're inferior, of power plays that destroy lives, most people are*

exhausted, cynical, and focused only on self-protection. Who wouldn't be? These negative demoralised people have been created by inhumane organisations and governments ... when obedience and compliance are the primary values, then creativity, commitment and generosity are destroyed. Whole cultures and generations of people have been deadened by such coercion."

Her words apply powerfully to nurses, particularly within South Africa's PHC system, coming out of a legacy of apartheid as it does. What thinking about management and structuring of work has implicitly informed how the South African 2010 Health Care Plan envisages the PHC system? We turn now to management theories that emerged after the industrial revolution, about how to structure work and the modern workplace.

4.6.1 Weber: bureaucracy, hierarchy and the division of labour for 'efficiency'

Around the turn of the 19th century, efforts were being made to systematise and develop ideas that could produce efficient organisation and management of work. These followed on from Scottish economist Adam Smith's publication of *The Wealth of Nations* in 1776, which emphasised the value of division of labour at work. A major contribution to the development of a comprehensive theory of management and organisation was made in the early twentieth century by German sociologist Max Weber. His work demonstrates the first comprehensive definition of bureaucracy as a type of organisation that values speed, accuracy, lucidity, reliability, regularity, and efficiency by means of formulating rigidly divided tasks, hierarchical supervision, and detailed rules and regulations (Morgan, 1997, p.17).

Significantly, Weber was critical of the social consequences of the proliferation of bureaucracy particularly in terms of its capacity to erode the human spirit and capacity for spontaneous action. Further, he was mindful of its potentially damaging political consequences in restricting the potential for more democratic forms of organisation (Morgan, 1997, p.17). He saw complicated organisations, which were ordered, stable and thought to be predictable rather than complex organisations, which were networked, less predictable and more resilient and able to adapt.

The underlying fear in bureaucracy is that people cannot be trusted, that things will fall apart if order in the form of strict controls is not maintained. Bureaucracy (which literally means control of the office) and hierarchy feed off each other by giving people power over others.

Barrett (2006) argues that this leads to cultural entropy. The result in nursing can be seen in the dependent and submissive characteristics of nurses described by Roberts and Group (1973, pp.319-320), quoted under section 4.4.2 above. Section 4.4.5 drew on work by Gardner and McCoppin (1986) to describe the impact of hierarchy in the medical system, and the subordinate position of nursing within that, on nurses, where rigid control is enforced by nursing bureaucracies and nurses have minimal autonomy in regard to the pace or content of their work.

Seedat and Nell (1992, p.186) discuss how the organisation of the Soweto PHC clinic system was controlled by a management clique responsible for implementing policy decisions made at a higher level. Decisions relating to personnel, health policy and administration descend this hierarchical chain of command as directives, relayed by the managers, primarily the matrons. This centralised administration generates a clear division of labour and a close-knit bureaucracy with demarcated levels of authority and resulting gradations of status and powerlessness (Seedat & Nell, 1992, p.186). Tensions between authority and power were prevalent. By entering a managerial position, black nurses acquiesced to, and internalised, the norms of submission and authoritarianism (Seedat & Nell, 1992, p.188). This echoes the point made under 4.4.4 above, about black nurses buying into the 'status' of the nursing profession. Similarly, in a Cape Metropole study, facility managers complained that certain policies prevented them from finding creative solutions to problems such as staff shortages and heavy workloads while other policies set impossible standards that left them feeling intimidated and inadequate (Sandenbergh et al., 2002, p.7).

The key theme of classical management theory and its modern application positions organisations as rational systems that function with mechanistic efficiency. Although the classical theorists paid lip service to the necessity of achieving a balance between technical and human aspects, particularly via appropriate selection and training procedures, it is clear that their essential aim was to fit humans to the requirements of mechanical organisation (Morgan, 1997, p.22). Even today we have departments of human resources which treat people as commodities / inputs to be selected, fitted, controlled, assessed, replaced and so on. The epitome of reducing human beings to cogs in a rational machine is reached with Taylor's scientific management.

4.6.2 Taylor: splitting planning (mind/theory) from doing (body/praxis)

Frederick Taylor's principles of scientific management furnished the keystone for work design in the first half of the 20th century and had a particularly powerful influence on the development of nursing management internationally. Morgan (1997, p.23) summarises Taylor's five essential principles as follows:

1. All responsibility for the planning and design of work to rest with the manager.
2. Scientific methods must be used to determine the most efficient way of doing work.
3. Choose the best person for the job.
4. Train the worker to perform the work efficiently.
5. Monitor worker performance to ensure work procedures are followed and appropriate results are achieved.

The principle of splitting the planning and design of work from its implementation is frequently viewed as the most destructive element of Taylor's approach to management. The rationale was that the jobs workers were required to perform were optimally simplified so that workers would be cheap, quick to train, easy to supervise, and easy to replace. We saw this principle – and indeed rationale – at work in section 4.4.5 above, in Rispel and Schneider's (1991) description of what they term the 'trend of proletarianisation' of South African nursing, which saw the fragmentation of nursing into tasks, the de-skilling of individuals, and loss of personal autonomy at work, akin to the daily work of a factory worker. Under 4.7.3 below an alternative psychoanalytic explanation for the fragmentation of nursing into tasks as a defence mechanism against anxiety is offered from Menzies.

While Taylor has been vilified for creating scientific management, he was essentially part of a far broader social trend involving the mechanisation of life generally. Indeed he gave voice to a dimension of the trend towards mechanisation, specialisation and bureaucratisation that Weber identified as such a powerful social force (Morgan, 1997, p.25).

Arguably, the notable feature of Taylorism is not that Taylor attempted to mechanise the organisation of people and work, but the extent to which he was able to achieve this. In a key sense, Taylor's workers can be seen as precursors to the artificial brains that are now replacing them:

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"His principles of scientific management make superb sense for organising production when robots rather than human beings are the main productive force, and organisations can truly become machines" (Morgan, 1997, p.26).

But since we are not machines, it is the argument of this thesis that such mechanistic principles underlie many modern organisational problems. Arguably much of the carelessness, apathy and lack of pride so evident in the modern workplace (including in the health system, as described above) have been promoted by a mechanistic management style. These features of nurses and nursing workplaces were found to hamper our research, as will be described in Chapter Seven.

4.6.3 Hidden currents subverting scientific management

It is worthwhile considering how the metaphors and insights of complexity theory are closer than classical (mechanistic) management theory to how living and human systems actually work. When organisations are designed and managed as machines this creates friction with how people actually work together. Often people continue to work in a hidden or subversive way to get things done by creating communities of practice that work across the mechanistic lines. Often these people create pockets of innovation, creativity, and life despite the organisation. However they may well become frustrated when their innovations are not recognized or supported. Others seem to put work into the category of a necessary task that must be survived in order to put food on the table but suffer from a lack of personal meaning, coherence and value. So it would appear that people naturally tend to form complex adaptive (living) systems when they work together and that this is hidden within the mechanistic perspective (often invisible or seen as an unwelcome disorder).

Stokes (1994, p.121) refers to Lawrence (1977) who showed that while an organisation may have one publicly declared concept of its primary mission or purpose, frequently there are also hidden agendas operative. In other words, there is the level of 'what we say we do' but there are also two other levels of 'what we really believe we are doing' and also 'what is actually going on' – usually the members of an organisation are unaware of the last.

In the South African PHC context, the lack of congruency between policy ('what we say we do') and practice ('what we really believe we are doing') breaks staff trust in organisational integrity and leads to disaffection ('what is actually going on'), which does not create an environment for introducing authentic change such as meaningful responses to IPV. This lack of congruence has been pointed out above under section 4.5, in discussing the disparity

between the lip service paid in policy to the necessity of holistic care, and the bio-medical model that frames the training and practices expected of health care providers. A particular example was given in section 4.5.2, from Petersen's (2000a, p.328) KwaZulu-Natal study of how nurses' performance was evaluated on bio-medical criteria and not according to espoused holistic principles underlying PHC. Similarly counselling in HIV clinics is usually seen to require and empathetic, supportive and personalised consultation, yet it is assessed in terms of numbers seen and items completed on a checklist.

4.6.4 Unconscious factors at work in organisations

Biographical details about Taylor reveal that he was obsessed with control. He was raised in a wealthy puritan household, where discipline, work, and the suppression of emotions were key values. Regimenting himself became his *raison d'être*. Childhood friends described how their games were all subjected to strict rules and exact formulas (Morgan, 1997, p.221).

From twelve years onward Taylor was plagued by insomnia and terrifying nightmares. Noting that the worst dreams occurred when on his back, he constructed a harness of straps and wooden points that would wake him if he were moving into this position. In later years he preferred to sleep upright, propped up by pillows. If, while away on business, these were in short supply, he would sometimes spend the night propped up by cabinet drawers (Morgan, 1997, p.222).

It would seem that Taylor's theory of scientific management was the manifestation of the inner struggles of his disturbed and neurotic personality. His efforts to organise and control the world, whether in childhood games or scientific management, were a projection of his pathological drive to organise and control himself. In turn, unconscious concerns and preoccupations embedded in his theories impacted many organisations over generations.

The relationship between Taylor's approach to life and the organisational style embraced by scientific management raises a number of incisive questions about organisational styles in general. Morgan (1997, p.224) asks:

1. To what extent it is possible to understand behaviour within an organisation as an external reflection of unconscious motives?
2. Is a pattern discernible in the extent to which organisational strategies institutionalise defence mechanisms?
3. Do tightly controlled bureaucratic styles reflect the influence of

compulsive preoccupations?

4. Do they attract and reward people who share these traits?

Barrett (2006) would say that organisations attract people at a similar level of consciousness, while repelling others who are not at the same level of consciousness. An organisation operating at a less conscious level will attract people concerned with safety, security, control, power and efficiency and repel people looking for personal congruence, who are able to provide service and make a difference.

There are indeed important parallels between human psychic and institutional processes. From a psychoanalytic perspective, it is a recipe for disaster to ignore the underlying difficulties in individuals, be they personal, or familial. 'Coping' by denying and repressing difficulties inevitably produces further disturbances. Obholzer (1994, p.169) advises that to avoid the underlying difficulties in institutions and to simply 'manage' them away has similar repercussions. Awareness of underpinning anxieties and fantasies enables us to manage ourselves and our systems, so as to make best use of our psychological and physical resources. Obholzer comments that in his experience of consulting to institutions in England, he regularly finds that no attention whatsoever is paid to social, group and psychological phenomena. He concludes that by neglect, the factors that should be an integral part of good management become those that sabotage the venture.

A PHC system run along scientific management lines, with an organisational culture unaware of and unwilling to discuss its own undercurrents and hidden agendas (including sexism and biomedicine), is perhaps unlikely to attract or develop the kind of nurse needed to address IPV. It is my contention that feminist consciousness-raising could bring the dynamics of oppression to light, and create space for a different organisational culture more conducive to holistic care. I now turn to psychoanalytic theory to see what insights it holds for this thesis.

4.7 Psychoanalytic perspectives on nursing systems
4.7.1 The relevance of psychoanalytic theory to organisations
Psychoanalysis, as a method of intervening and a process of analysis (Hinshelwood & Skogstad, 2000; Kruger, 2006; Menzies Lyth, 1991), is a particular kind of psychological discourse, which has been used extensively for interpreting dysfunction on many different levels. By analysing the defences that have been constellated and by interpreting the meaning

of these defences, it offers a psychological perspective on individual, organisational and systemic levels of functioning.

A distinguishing feature of psychoanalysis is a central belief in the existence of the unconscious, a storehouse for repressed and sublimated psychological experiences, and a space of mental functioning, which is not usually within the reach of awareness. Many of the unconscious contents are psychically uncomfortable (e.g. childhood conflict and trauma) and are therefore usually kept out of awareness by the development of defences. Defences are automatic unconscious behaviours, which function as an interface between the individual's mental experience in relationship to others. A central aim of psychoanalytic method is to assist people to become aware of unconscious, particularly pathological, defences. Some defences are healthy and developmentally appropriate, others are unhealthy and may lead to extreme dysfunction.

The psychoanalytic conceptual framework and its associated construction of dysfunction has been significantly critiqued in terms of its methodology and social relevance and hence its cross-cultural generalisability. In particular, the Oedipus complex as a necessary developmental phenomenon has been the source of much critique (Bertold, 1998; Izzard, 2002; Swartz, 2007; van Zyl, 1998) due to the historical and cultural association of Oedipus with middle class, European / Western nuclearity (Mitchell, 1974). Furthermore, critique of clinical psychology for being dislocated from its socio-political context, was aptly made during the apartheid era (Dawes, 1985).

Sey (1998) draws on Foucault's famous elaboration in *The Order of Things* (1970) of psychoanalysis as a 'counter-science' – a science concerned with the secret and unspoken object of all knowledge, a science concerned with the knowledge of the Other:

> *"Psychoanalysis is thus founded as an epistemology on the great foundational division in knowledge itself (attributed to modernity by Foucault) between unconscious and conscious processes, between the self and the not-self, between Nature and Culture"* (Sey, 1998, pp.3-4).

Notwithstanding these significant critiques, psychoanalysis is capable of providing valuable techniques for understanding the links between individual and organisational unconscious defences. Freud's watershed discoveries turn around the complex destinies of repressed

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material revealed in the psychoanalytic symptom and as such provide psychoanalysis' major contribution to a set of broader social questions (van Zyl, 1998).

The psychoanalytic theory of organisational functioning argues that organisations are developed for a reason, part of which is to contain society's projections. For example, the organisation of health is partly structured to cope with human mortality and the associated unconscious fear of annihilation, which in South Africa is very real. In response, organisations develop defensive structures to help society deal with these fears. Psychotherapy with individuals and groups shows that defences are hard to change when people are mature in years. Similarly, as a well established, ancient social structure, the organisation of health might be very resistant to change (Obholzer, 1994). According to Jaques (1955), in order to sustain change in individuals who work in the organisation, the organisation might have to change first. Wheatley (1994) shows how complexity theory supports this position. Jaques also explains that difficulties in achieving social change relate to difficulties in tolerating the anxieties that are released when social defences are restructured, and it relates to difficulties in addressing individual and organisational resistance. The culture of an organisation may not only be understood in terms of levels of defensive functioning but also in terms of the emotional milieu of the organisation (Hinshelwood & Skogstad, 2000).

A persistent theme of this thesis is the need to drive social and organisational change in order to provide better care for IPV survivors within the health system, and our action research process was partly intended as a catalyst for this on a micro scale, at least at the sites where research was conducted. Psychoanalytic dimensions of organisational change, as sketched above, impacted powerfully on the data collection and research experience. Thus these dimensions are explored in greater depth below.

4.7.2 Defence mechanisms in individual–organisational dynamics of nursing

The Tavistock model of organisational functioning, which draws on Klein's theoretical framework, is utilised in this analysis. At an individual level, Melanie Klein's analysis of object relations teaches that adult experience replays defences against anxiety originally formed during infancy. Accordingly, the defensive techniques of denial, idealisation, splitting, projection and introjection influence how we form relations with our external world. At an organisational level, Klein's approach understands the culture, structure, process, and even the

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environment of an organisation in terms of the unconscious defence mechanisms formed by its members to cope with individual and collective anxiety (Morgan, 1997, p.231).

Isobel Menzies' (1960) pioneering work on mainstream nursing practices as organisational defences against anxiety is accepted as a classic within psychodynamic theory. Significantly, although this publication continues to inform dynamic organisational consultancy in diverse areas such as business management, education and social welfare, internationally, nursing has neglected its value (Van der Walt & Swartz, 1999, p.484). Menzies' theory deals with the same phenomena characterising the nursing environment that Rispel and Schneider theorise about, but Menzies provides a psychological explanation for these phenomena, which enables her to comment with accuracy on options for change and potential future outcomes.

Menzies (1960, p.118) proposes that an understanding of social or organisational defences is a vital diagnostic and therapeutic tool for facilitating social change. She identified key organisational defences that characterised the nursing context in her analysis. These defences are problematic because they inhibit the capacity for creative, symbolic, abstract thought and for conceptualisation. They inhibit the full development of the knowledge, insight and skills that enable reality to be handled effectively thus preventing the mastering of pathological anxiety. Hence nurses trained within this system tend to feel helpless in the face of new or strange tasks or problems (Menzies, 1960, p.116).

Focusing on sources of stress in nursing, Menzies (1960) identified that nurses confront suffering and death like few others do; working with ill people who themselves are experiencing enormous stress. In South Africa today, nurses in particular are furthermore expected to respond to an expanding range of problems in a context of shrinking resources and pressures placed on services by HIV and AIDS. Nurses thus need to deal with extreme demands for sympathy and compassion:

> *"Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting, and frightening ... The work situation arouses very strong and mixed feelings in the nurse: pity, compassion, and love; guilt and anxiety; hatred and resentment of the patients who arouse these strong feelings; envy of the care given the patient"*
> (Menzies,1960, p.98).

Later she adds: *"They are often expected to do the impossible in the way of providing comfort or cure"* (Menzies, Lyth, 1988, p.101).

Even though the very nature of the nursing profession puts the nurse at significant risk of being flooded by unmanageable anxiety, it was not enough to account for the extreme anxiety so apparent in the nurses of Menzies' study. Therefore she examined the techniques used in the nursing service to modify and contain anxiety.

Since contact with patients creates anxiety in the nurse, it follows that the closer and more intense this relationship, the more likely the nurse is to experience anxiety. Menzies' theory (1960, p.101) proposes that **splitting** is a key social defence used by the nurse. Splitting refers to breaking up all the work needed for patients into several distinct tasks. Instead of providing holistic care for a few patients, each nurse is assigned to a particular task (e.g. dressings, medication, observations), which must be done for all patients on the ward. This method of working prevents the nurse from dealing with the complete reality of any one patient (in the form of holistic care) and thus provides protection from the potential anxiety inherent in getting closer to any particular patient. Further, the 'skilling' of nurses to conduct routine chores where there is only one acceptable way of doing a task discourages their use of initiative and discretion.

This task-oriented style of nursing work which focuses on the paperwork and the 'running of the clinic', and hides behind the professional status, insignia of the uniform, and technical equipment, enables nurses to prevent themselves from opening up to the illness experience and the human needs of the person (van der Walt & Swartz, 2002, p.1006).

These features relate to the second defence identified by Menzies (1960, p.101), namely **depersonalisation**, categorisation and denial of the significance of the individual**.** For example, the nurses' uniform serves both to create regimentation and exchangeability amongst nurses, and to distance nurses from patients:

"The nurses' uniforms are a symbol of an expected inner and behavioural uniformity; a nurse becomes a kind of agglomeration of nursing skills, without individuality; each is thus perfectly interchangeable" (Menzies, 1960, p.102).

Menzies (1960, p.102-103) identified **detachment and denial** of feelings as the third organisational defence in nursing. The buffer provided by task orientation is bolstered by other mechanisms, which restrict full personal contact between nurse and patient. Van der Walt and Swartz (1999, p.486) point to the emphasis in nursing training that all patients be treated similarly; the reinforcing of professional detachment by spurning nurses who display their emotions, requiring them to 'pull themselves together'. Clearly this cultivates a nursing culture which denies feelings, training nurses away from involvement with emotional issues.

Van der Walt quotes a nurse who had become a TB patient:

> *"Nurses do not want to expose themselves to a patient who could possibly be emotionally unstable. They prefer to avoid involvement with the patient. I don't think it is because of the germs. I think that they lack the emotional strength to provide the support that patients need. They are not prepared to acknowledge the person behind the folder. They prefer to deal with the disease rather than with the human being"* (Van der Walt, 1998, p.124).

Anton Obholzer while Chief Executive of the Tavistock and Portman Clinics, London, Consultant Psychiatrist and practising psychoanalyst (1994, p.177) made the same point. He refers to the defensive tendency in the health service to push patients and what they so painfully stand for aside and comments that it is far easier to deal with diseased organs than with a person who is struggling with a health-related life crisis.

In 'Health Workers for Change' workshops in South Africa, where there was collective reflection on their own attitudes, nurses described themselves as uncaring, insensitive and rude. They acknowledged that they treated clients selectively, showing more respect for men and discriminating against poor and illiterate women. They attributed these attitudes to their socialisation in a context stratified by gender, race and class (Fonn et al., 1998). We see social relations penetrating the defence mechanism of detachment and denial, to determine who gets more or less caring engagement from nurses.

In keeping with this, Vetten reported some patients' experience of nurses with reference to nurses' capacity to be of assistance in relation to IPV. Their comments reveal a primary barrier to nursing care for IPV in the PHC context (Vetten, 2003):

"I don't think that I would talk to the nurses about that problem because ... they are not helpful and so how can you speak about that with a person who is unhelpful like that? You will not be able to approach that kind of a person."

"If you were talking to them about that they would tell you to go to the social worker. Their work has to do with health. It is not their work."

The attempt to eliminate decisions by **ritual task-performance** is the fourth social defence mechanism identified by Menzies (1960, p.104-105) and refers to a practical strategy to eliminate the anxiety caused by the responsibility of making decisions. Firstly, nurses are trained to perform their task-lists in a ritualistic manner. Precise instructions regarding the nature, order and timing of the tasks must be adhered to even though such exact instructions may not necessarily be desirable. Where there are a few effective alternatives, much time and effort is spent on standardising nursing procedures. By inference, the student nurse is actively discouraged from using her own discretion and initiative to plan her work appropriately. This has direct implications for my findings and links clearly with issues relating to complexity theory regarding zones of high versus low certainty.

Menzies (1960, p.104) describes how the psychological burden of anxiety caused by the responsibility of making decisions is diffused by the common practice of checking and **re-checking decisions** (fifth defence) for validity and postponing action as long as possible. This standard practice prevails even when the implications of the decision are of negligible consequence. Sandenbergh et al. (2002, p.6) found that a difficulty facility managers expressed was their experience of frontline nursing staff refusing to take any responsibilities. They explained that the staff had the expectation that the facility managers would solve all their problems for them.

4.7.3 Relationships of nurses in their working context

The psychoanalytic framework is of benefit for understanding the dynamics in relationships between health care providers and patients and could arguably be extended to nurses' intrapersonal and interpersonal relationships throughout their working context.

Stokes argues that it is vital to acknowledge the complex emotions and frequent ambivalence pertaining to the activities of curing and caring. Similar to the argument made by Obholzer (1994, p.169) about the poison of denying and repressing unconscious factors at work in

organisations under section 4.6.4 above, Stokes cautions that unless this ambivalence is acknowledged and managed, and worked with rather than denied, the danger of significant cruelty in the care system exists (1994, p.123). Indeed, Menzies observed that nursing students suffered severe emotional strain and frequently complained that senior staff neither understand them nor made any effort to help them. If the emotional stress arose from the nurse having made a mistake, she was punitively reprimanded rather than helped. However, in personal conversation with Menzies and her team, the seniors demonstrated understanding of the students' trauma but lacked confidence in their ability to deal with emotional stress in any way other than by repressive techniques:

> *"Kindly, sympathetic handling of emotional stress between staff and student nurses is, in any case, inconsistent with traditional nursing roles and relationships, which require repression, discipline, and reprimand from senior to junior"* (Menzies, 1960, p.103).

A local action research project which provided care for caregivers in a local PHC district of the Cape Metropole (Sandenbergh, Benjamin & van Wyk, 2002) found that facility managers felt unsupported by upper management, which they perceived to be intimidating, authoritarian, critical and distant. Upper management was slow to acknowledge good work done by any facility. Since upper management was mostly absent from the service sites and therefore unaware of the day-to-day challenges that facilities were dealing with, their expectations and demands of frontline staff and services were experienced as impossible to achieve (2002, p.8).

We can pull together strands from the concept of internalised oppression and from the defence mechanisms described by Menzies (in particular strategies of emotional detachment and the denial of feelings) in examining a further problem that characterises the predominantly female nursing context. Writing on "Women's Inhumanity to Women", Chesler (2001) provides evidence that women are masters of indirect aggression towards each other: we tend to judge each other harshly, hold grudges, gossip about, exclude and disconnect from other women. Indeed, Chesler's argument implies that women envy and compete against each other far more than we do against men and many of us hold sexist beliefs. Chesler argues that since women depend upon each other for emotional intimacy and bonding, the power to create cliques and to shun each other functions to enforce female conformity and to discourage female independence and psychological growth (Chesler, 2001). These dynamics are

extremely prevalent in South African nursing environments and pose significant obstacles to appropriate, comprehensive care for IPV within the PHC.

Jewkes (2001) comments that health care providers who experience violence in their own lives find it very difficult to sustain work with abused women unless they have the necessary support to work through their personal experience of abuse first. Jewkes concludes that establishing an effective health sector response to gender-based violence necessitates a more caring approach within the health sector towards its own staff including the recognition of IPV as an issue in their lives and assistance to deal with it. Defensive strategies such as emotional detachment and the denial of feeling, and the Taylorist ideal of a rational organisational machine with no place for messy human feelings – which are therefore pushed underground just as the experiences of IPV likely are – will mediate against supporting battered nurses to work through their own abuse.

This section has explored certain psychodynamic factors relevant to the individuals within the PHC system, and to the PHC system itself and to the relationship between individual and organisational functioning. All of these factors speak to the viability of IPV care in the PHC sector of the Western Cape. In Chapter Seven we see how organisational defence mechanisms were implicated in the response to our research project – but we also see signs of hope for the potential for change when feminist understandings and ways of working broke through the defences to create new work relations.

4.7 Conclusion

After some meta-theoretical notes, this chapter opened by tracing the historical overthrow of mostly female holistic healers by mainly male doctors in Europe and the United States with the establishment of the bio-medical tradition. It then looked at similar processes in the Cape Colony, bringing us to the early 20th century and the modern era of nursing in the Nightingale mode. Theoretical frameworks unpacking gender oppression, the maintenance of relations of dominance, and internalised oppression were used to examine the position and role of nursing in the modern health system, interpolated by broader social relations. Specifically South African dynamics were examined. The manifestation of such oppressive relations in nursing, in bio-medical patriarchal cultures of control, impacts on the ability of the PHC system to provide effective IPV care.

An examination of management theories helped explain the emergence of 'cultures of control' and the organisation of the health system and structuring of nurses' work that reinforces oppressive relations and is not conducive to empowering nurses to act with initiative and informed engagement in responding to IPV. Having noted that unconscious factors at work in organisations, and the people creating them, can sabotage the stated project of the organisation (such as the vision for holistic PHC in South Africa), the lens of psychoanalytic theory was turned on the health system in South Africa. This was particularly helpful in bringing to light mechanisms employed within nursing as defences against anxieties provoked by the very role nurses are called to play, with its unmanageable demands and cognitive dissonance. The impact of these defences upon relationships between healthcare providers was examined, pulling in threads from the other theoretical frameworks previously discussed. Such defences will need to be acknowledged and transformed to a mature level to bring about meaningful change in the health care system.

In embarking on action research which ultimately seeks to catalyse changes in IPV care by changing attitudes and practices in nursing within a PHC context, we would do well to heed lessons from a study done on introducing a psychological skills training programme in the Soweto Community Health Centre System (Seedat & Nell, 1992, pp.187-188). It found that the programme was both enabled and hindered by medical hegemony, state ideology, personal perceptions and professional interests. They argue that within PHC, a coalition is established that suits both state and health care providers:

> *"Under the guise of primary health care, nurses assist in entrenching curative health services, which in turn enhance the state's political credibility ... In return for professional autonomy, nurses and other health professionals serve to entrench the 'official' western biomedical approach by adopting an alienating stance toward patients, ignoring community needs, and belittling the many indigenous paradigms of illness and healing"* (Seedat & Nell, 1992, 187-188).

This chapter has highlighted the complexity of the challenges facing PHC, particularly in regard to IPV and the role of nurses. The tough truth is that IPV is a chronic health problem and the unsatisfactory status of nurses also has a chronic element that silences, subordinates and marginalizes the feminine. If nurses are to play the role policy assigns to us, we need to empower ourselves.

Currently nursing in South Africa may be too compromised to be the major driver of a programme to deal with IPV. The various discourses touched on in this chapter are essential tools to lay bare this problematic reality. In particular, it is my argument that understandings and practices drawn from feminist theory and methods will be crucial in exposing the gender relations giving rise to IPV and subordinating nurses within the health system, in helping nurses to recognise and work to cast off their own and IPV survivors' internalised oppression and defence mechanisms, and in creating supportive networks and alternative options to challenge oppressive features of the organisation of the health system and the bio-medical approach. Feminism and feminists are sorely absent from the South African nursing context, which poses particular problems when aiming to provide care for IPV. But at a deeper level, in my view, this absence is a powerful demonstration of how effectively nurses have internalised oppressive elements of the patriarchal bio-medical context. It seems in the main, nurses are unable to conceptualise and inhabit a transcendent realm where nurses systematically support and empower each other as individual professionals and in relation to the hierarchies which surround us.

A feminist project thus informed the research proposal for this thesis, and shaped the way in which the research was tackled. This had to be cognisant of the issues thrown up by the theoretical frameworks covered in this chapter. This leads us to the next chapter, which first tracks the evolution of the research proposal and features thereof, before describing the different methods used to investigate the study objectives.

CHAPTER FIVE

METHODOLOGY: MAKING META-METHODOLOGY REAL

5.1 Introduction

This chapter serves as a pivot between the theoretical underpinnings of the study and its findings. Coming out of the theoretical work in the previous chapters, where Chapter Two outlined the meta-methodological aspects of the study, Chapter Three reviewed literature relating to IPV and problematised it as a social product of gender relations, and Chapter Four examined theoretical understandings of the health care system and working within it, I now turn to concretising the research study and describing the research design, process and methods which gave expression to the research goals outlined in Chapter One.

This study implemented a recently developed South African protocol for the screening and holistic management of IPV in women in order to test its feasibility and to adapt it for use in the primary health care sector of the Western Cape. It also aimed to identify the current nature of care offered to female survivors of IPV. Thirdly, it aimed to learn from the process of training and supporting (nurse) researchers who were new to the action research paradigm and methodology.

The chapter starts by reflecting on the process of developing the research proposal including working with a reference group, and locates the study in the modelling phase of a complex health intervention, according to the British Medical Research Council's staging. I briefly describe the study setting, and explain how and why the five study sites were selected, to inform our understanding of the constraints provided by the context, as will be seen in later chapters. I then examine the research methods and techniques chosen as appropriate to advance each research goal, using the steps of assignment, assessment, and analysis as hooks to hang the explication on, and with particular attention to ethical aspects of the study design in each case. As foregrounded in Chapter Two section 2.2 'Ethical considerations', technical adherence to ethical study design features does not guarantee that one can avert all negative consequences for IPV survivors nor researchers.

Methods that could equally well serve the agendas of the interpretive-hermeneutic and empirical-analytic methodological frameworks were harnessed within the overarching action research approach of an emancipatory-critical paradigm. This can be seen when research

approaches used in screening women for IPV experiences are described (section 5.6), in modelling the protocol with these participants (section 5.7), and in analysing their medical records where available in order to establish the pre-existing standard of IPV care as a baseline (section 5.8), and in the utilisation of key informants to broaden and deepen the perspectives brought to bear on the study (section 5.9). However, threaded throughout the research process were aims and approaches that could only be applied within the action research framework, and these are underlined in the chapter's conclusion. Centrally this involved the establishment of an action research co-operative inquiry group of co-researchers.

Fig 1: Flow chart of research methodology

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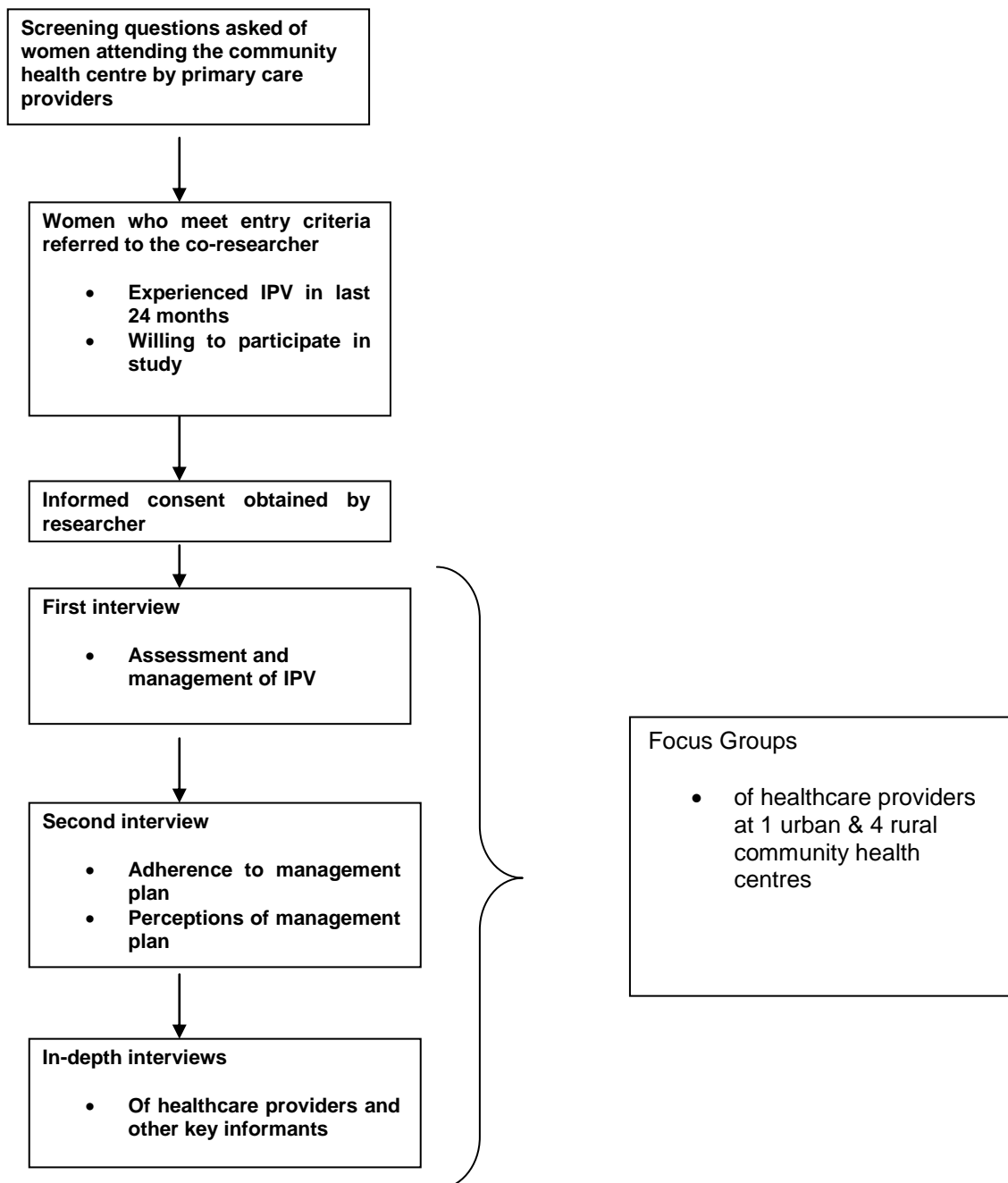
5.2 Development of the research proposal

The nature of this project as a doctoral study, impacted significantly on the action research focus. For example, the first phase of planning was dictated by the requirement of registering a satisfactory protocol at the University of Stellenbosch before beginning the project. Therefore the principal investigator and her supervisor worked intensively to plan the research design in advance of recruiting the professional action research team. The methodological challenges of the planning process as a whole are reflected upon in Chapter Eight.

During this period, a reference group was constituted consisting of colleagues with research interests in IPV:

- Helene Combrinck, Senior Gender Researcher, Community Law Centre, University of the Western Cape.
- Diana Gibson, Associate Professor, Anthropology, University of the Western Cape.
- Lorna Martin, Professor of Forensic Medicine and Toxicology, University of Cape Town.
- Gubela Mji, Head of the School of Rehabilitation, Stellenbosch University.
- Lilly Artz, Director; Kelly Moult and Dee Sm,ythe , researchers at Gender, Health and Justice Unit, University of Cape Town each attended one meeting.

Despite the grandeur of its name, note that this group met only three times during the pre-data collection phase, to brainstorm the project. Some of these members had been actively involved in the Consortium on Violence Against Women, and in the production of the very protocol that this doctoral study implemented. It was challenging to strive for collaboration amongst colleagues who were potential competitors. Fortunately, since we share deep feminist commitments, the priority of developing an effective research project that could engage practically with the PHC sector, created a coherent focus during the few times we met. Helpful ideas, such as the value of working with both a rural and urban sample, emerged. However, there came a point where the impetus and cohesiveness dissolved resulting in the reference group process being aborted 21 months into the process.

Thus the development of my intellectual property to produce this study was most influenced by deep, extensive supervisory involvement, as well as the superior methodology of the co-operative inquiry group. In the light of that, the reference group's relatively minor role was to provide food for thought at the inception phase.

5.3 Overall study design

5.3.1 The study as the modelling phase of a complex health intervention

The introduction of a new screening and management protocol for IPV at the primary care level can be framed as a complex health intervention. A complex health intervention consists of multiple components that may act independently and inter-dependently and may include a number of different behaviours, offered at different frequencies and times and with different techniques of organisation and delivery. Successfully implementing and evaluating a complex health intervention in the current South African primary health care scenario presented a considerable challenge. A flexible methodology enabling real engagement with, and a creative response to, the issues as they emerged, was required. Guided by the British Medical Research Council's framework for development and evaluation of randomised controlled trials for complex interventions to improve health (Figure 1) (Medical Research Council United Kingdom, 2000, p.3), this study was positioned within the modelling phase.
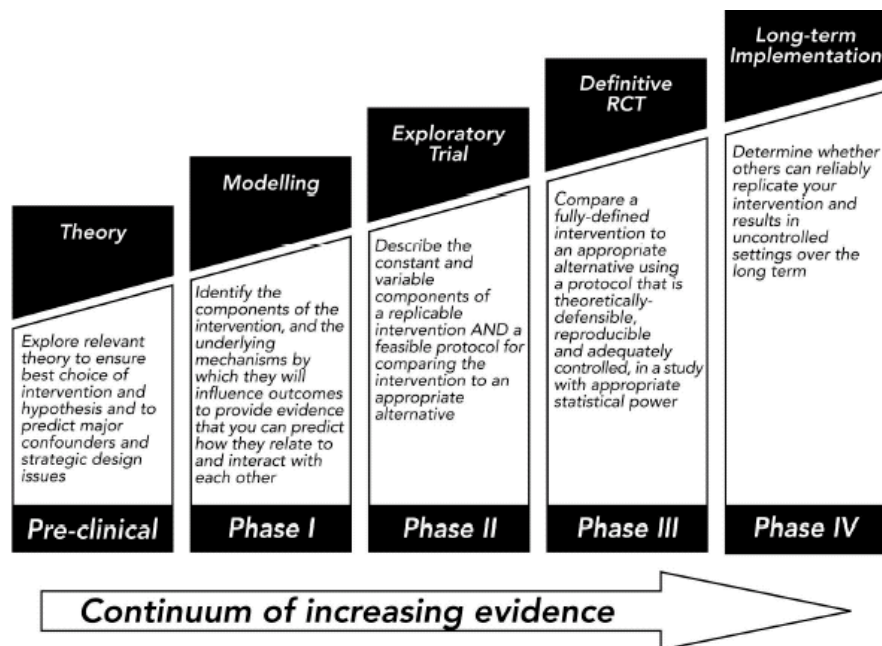
Figure 2: Framework for development and evaluation of randomised controlled trials for complex interventions

The first pre-clinical or theoretical step was the development by the Cape Town based Consortium on Violence Against Women of the protocol (Martin & Jacobs, 2003), which the study implemented (see 5.7). The modelling phase of a complex health intervention intends to develop a more in-depth understanding of the intervention itself. The different components of the intervention can be experienced and reflected on in terms of how feasible they are, how they interrelate, how acceptable they are in the context and how they may relate to surrogate or final outcomes.

As discussed in Chapter Two, professional action research offers multiple reflective possibilities and opportunities for effective engagement with central issues and challenges within a work-related context. Since the project dealt with the modelling phase, and included both quantitative and qualitative techniques, professional action research was chosen as the overarching method.

5.3.2 Prior development, adaptation and description of the protocol

The Consortium on Violence Against Women was formed in Cape Town in 2000 to co-ordinate work and think around addressing the crisis of gender-based violence in South Africa. Lorna Martin, Tanja Jacobs and Rachel Jewkes among others, were subsequently hosted by South African women in Canada, for a week of intensive exposure to domestic violence facilities and resources in Toronto. Professor Martin collected extensive reference material and returned to write up a policy and management framework for the South African health sector in terms of screening for IPV. Her criteria for relevance were the socio-economic circumstances of IPV survivors regarding accessibility of services and resources in our impoverished setting. She also wrestled with the complex issue of safety within the IPV survivors' home environment (L Martin, personal communication, May 20, 2009). As a forensic pathologist, guided by the Canadian material, she formulated a comprehensive medico-legal questionnaire, entitled Report on Domestic Violence Examination (Martin & Jacobs, 2003, pp.19-29).

5.4 Study setting

During the study period, the Metro District Health Services in the Cape Town Metropolitan district operated 49 urban and peri-urban Community Health Centres. The Provincial Administration for the Boland-Overberg district operated 74 rural community health centres and clinics. The community health centres in both areas offered ambulatory primary care in the public sector, which primarily served poor and historically disadvantaged communities. These communities were predominantly coloured Afrikaans-speaking communities and black Xhosa-speaking communities. The demographics of the female population in the Cape Metropole and the Witzenberg and Breede Valley, formerly Boland-Overberg regions were (Census 2001):

- coloured: 1 478 2221
- black: 668 514
- white: 483 288

- Indian / Asian: 23 436

Since the study was positioned within the PHC system, it excluded affluent communities, which use the private health care system. At all sites, people earning up to approximately R4000 per month are entitled to free treatment and medication within the current primary health care system.

The setting of the study in the South African PHC sector, and the implications thereof, were raised in Chapter Three section 3.5.2 'The South African primary health care context', and will be explored in greater depth in Chapter Seven section 7.1.1 'The context: primary health care in transition', and section 7.3 'Structural barriers affecting care for IPV in health care setting.'

5.5 Selection and characteristics of study sites

5.5.1 Site selection

Study sites were purposefully selected on the basis of the following characteristics:
- representative of other community health centres in the same region;
- reasonable standard of mental health service offered;
- sufficient workload to ensure enrolment of the required sample sizes over relevant periods;
- sufficient space for a separate private room for the co- researcher; and
- comprehensive enough service to fulfil all the requirements of the intervention, e.g. X-rays, HIV testing and counselling.

The acting medical superintendent of the Cape Metropole District Health Services demonstrated his support for the project by selecting two sites from specifications given to him. It was specified that one site should serve a predominantly black community, the other a predominantly coloured community. He was mindful of the size of the facility, the requirements specified above, and the number of patients attending daily for optimal chances of achieving the proposed sample size. The doctor in charge of the facility in the black community, Site A, felt that this study would address a significant need, and with his support, the logistics of utilising this site were straightforward.

The facility manager of the other potential site subsequently refused to accommodate the study on the grounds of insufficient space for the co-researcher due to restructuring of the

facility. My supervisor, Professor Mash, referred me to Site B, which has historic links with Stellenbosch University, and the facility manager agreed to accommodate the study for six weeks of data collection.

The possibility of orchestrating the rural component was solved when an ex-student residing in the small rural town of Sites D and E agreed to participate as a co-researcher and was allocated a bursary for her Master's degree. As Site C was 50 kilometres away from the town, she conducted the first interviews there.

5.5.2 Site characteristics

Site A is situated in a part of Cape Town formerly designated as a 'black group area' and Site B is situated in a former 'coloured group area'. Both comprise predominantly lower socio-economic residents who are reliant on the health services provided by the community health centre. Servicing approximately 400 patients per day, in each community health centre, all general primary health care services are provided by a team of health care providers, a social worker and a psychiatric nurse. Both sites offer preventative services in the form of Family Planning, Immunisation, Voluntary Counselling and Testing for HIV and Tuberculosis clinics. After hours services comprise the trauma unit at Site A and the adjacent maternity facility at Site B.

Site C is situated in the main town of the former Boland-Overberg district adjacent to a provincial hospital. Situated in the former 'coloured group area', the community health centre serves the town and surrounding farming district. This community health centre is unusual in that dedicated practice teams offer continuity of care, family-oriented care and the integration of chronic and acute patients. The practice teams depend on effective collaboration between the clinical nurse practitioners and doctors (Mash et al., 2008).

Sites D and E are community health centres that lie just outside of a rural town in the Witzenberg district. Agriculture, predominantly fruit farming, is the main local industry and consequently many of the study participants were farm workers. Site D is in a formerly designated 'coloured group area' and Site E is in a formerly designated 'black group area'. Both have a distinct 'township-feel': under-serviced islands away from the hub, designed to supply labour for town residents and farmers alike.

5.6 Screening women for IPV

5.6.1 Assignment: Selection and training of health care providers

Prior to data collection at each site, as principal investigator, I introduced the study to the health care providers of each community health centre with a presentation emphasising the gravity of IPV in South Africa (Jewkes, Levin & Penn-Kekana, 2002; Matthews et al., 2004). Having thus implied an ethical imperative, the health care providers were introduced to how the study would work. Thereafter the session was opened for questions and discussion.

All health care providers were provided with a laminated page of possible screening questions (Martin & Jacobs, 2003) (Appendix A) and were requested to ask one question of every female patient over eighteen years of age. Interestingly, judging by the requests for more of the question paper, and by the amount of photocopies made, many health care providers rapidly lost this tool. The patients identified as experiencing IPV and consenting to participate in the study were referred to the co-researcher present at the site during the data collection period.

5.6.2 Assessment: Focus groups of health care providers

At the end of each data collection period, a focus group was conducted with the primary care providers who had screened patients and referred participants to the researchers. A combined focus group for Sites A and B met. At Site C, where data had been collected for eight weeks (double the period of other sites), there were two focus groups: one for those health care providers who had asked screening questions and referred patients, and one for those who had not. One focus group was offered for Sites D and E. The aim was to explore the nurses' and doctors' experience of asking the screening questions. If they had not screened patients, it was necessary to understand why.

The focus group approach allows for an extensive exploration of the area under discussion. It enables participants to collectively explore different experiences and views, put forward ideas, and debate and compare their ideas with those of other group members (Gerbert et al., 2000). Each of these groups was guided by a facilitator, who was a member of the research team. The sessions lasted approximately 60 minutes. A semi-structured guide encouraged the facilitators to follow specific topics and open new avenues of inquiry when appropriate (see Appendix I).

Comments and input by health care providers from these focus groups are reflected in the findings in Chapter Seven, particularly sections 7.3.2 'Role, workload and working conditions of nurses within PHC', 7.3.3 'Morale amongst health care providers', 7.3.6 'Desensitisation to emotional labour', 7.4.1 'IPV in health care providers' lives', 7.4.2 'The hegemony of biomedical discourse and the "righting reflex"', and 7.4.3 'Case finding for IPV in a health system in transition.'

5.6.3 Assignment of participants for intervention

Following the training of health care providers in the screening procedure (described above) eligible women wishing to participate in the study were referred to the co-researcher on site.

Inclusion criteria: All females over eighteen, and all females over the age of sixteen if legally married, who admitted to having difficulties in their intimate relationship and experienced IPV in last 24 months.

Exclusion criteria: Due to ethical constraints specified by the University, all unmarried women under eighteen years of age were excluded. All males were excluded.

✦ Analysis: Qualitative Data Analysis

For initial analysis, I conducted multiple readings of transcripts of six co-operative inquiry groups, six focus groups, fifteen key informant interviews and five sets of field notes to identify prominent themes. The transcripts were coded and themes were analysed using the framework method (Ritchie & Spencer, 1993) described below and triangulated to create an in-depth picture of:

1) how the screening and management protocol was experienced by participants, health workers, and researchers; and

2) how a holistic intervention for IPV could be integrated into the local, contemporary primary health care system.

This process involved working through the following stages:

Familiarisation. I immersed myself in the raw data by listening to data, reading transcripts, studying all researchers' field notes in order to list key issues and recurrent themes. I focused on being aware of my reactions, prior assumptions and prejudices that bias perspectives and

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interrogated these issues regularly with Professor Mash in supervision, and in my own psychoanalysis. I endeavoured to remain open, neutral and curious in my reading of the data.

Identifying a thematic framework. I identified all the key themes and specific issues under each theme by which the data was examined and referenced. The end product of this stage was detailed indexes of the themes and sub-issues specific to each research goal.

Indexing. The thematic framework was applied by systematically indexing all the data in textual form by annotating all transcripts in the margin.

Charting. A chart for each theme with columns for the different issues was formed. Each category of transcripts formed a row in the chart. The data was rearranged by cutting and pasting the actual text into the chart and entering a reference to the page and line numbers; this created charts that brought together all the viewpoints and statements made on a specific issue under a specific theme. The charting process thus involved a considerable amount of abstraction and synthesis.

Mapping and interpretation. The charts were used to make sense of and interpret the data to extrapolate meaning at deep, essential levels. A range of opinions on diverse topics and multiple connections between different issues and themes and how they might influence each other were observed and reflected upon. Contradictory information provided further pause for deeper insight and understanding. In one case, further interviews were conducted to explore a specific area of interest and to attain a better understanding.

5.6.4 Ethical issues: Written informed consent

Permission was obtained from the Regional Director of the Boland-Overberg Region in 2004 and from the Acting Medical Superintendent of the Cape Metropole in 2005. The Faculty of Arts and Social Sciences, approved and registered this doctoral project in July 2005. Ethical approval was initially granted by the Committee for Human Research at the Faculty of Health Sciences, Stellenbosch University on 1 September 2004 and updated on 5 February 2007.

By agreeing to participate in this action research project, the co-researchers consented to participate in the co-operative inquiry group meetings, and to provide field notes for analysis of the findings. All key informants gave verbal consent, which was recorded at the beginning of each interview.

However, a deeper ethical tension exists within health systems research because the procedures required are so hierarchical, that gaining consent for the participation of health care providers is not as free as it should be. I provide an example from the rural Site C, although the same procedure applied for the sites in the urban region. Original permission was obtained in writing from the regional director of the Boland-Overberg Region in April 2004. This was ratified at a meeting in February 2006 with various key members of the Boland-Overberg management team where Professor Mash and I presented the study to them at the Regional Head Office. When we were ready to begin data collection, I directly approached the relevant facility managers, who thoroughly approved of the study. We were given a training slot at the beginning of February 2007 in order to present the project to the health care providers immediately before data collection was to begin. None of the health care providers voiced opposition to the proposed period for data collection, nor were there any queries as to how it might impact on them.

Since the research team had decided that we should have two focus groups at Site C, one for those who screened and one for those who did not, I faxed the facility manager specifying who should be in each focus group. In retrospect, I have interrogated how meaningful informed consent is in such a context. This is a clear example of how little autonomy the health care providers had to choose to participate.

These issues led to discussions with other researchers who encouraged me to consider how many people who have a study explained to them via the informed consent procedure **really listen** carefully and think clearly about what is being asked of them? And how many simply sign on the dotted line? Therefore, what do those tidy pieces of paper really mean?

5.7 Modelling the protocol

5.7.1 Formation of the action research team

The action research team was co-ordinated by me as principal investigator. At each site a nurse researcher was required to implement the protocol because of the clinical component. A detailed discussion of the process of establishing the team is provided in 8.3.

5.7.2 The IPV management protocol

We adapted the protocol for use in our study (Martin & Jacobs, 2003). For example, from the outset Professor Mash and I recognised that the emotional care provision within the protocol

was inadequate as it allowed only four lines to address 'Emotional Status' with no provision for a diagnostic assessment of the participant's mental health. The World Health Organisation toolkit for the recognition, diagnosis and treatment of mental disorders in primary care has been adapted by the Department of Family Medicine and Primary Care of Stellenbosch University, for the South African context (Mash, 2002). This was used for each participant, within the history taking and medical treatment plan, since the study was committed to responsible management of clinical issues that arose. Referral resources were investigated and utilised.

A co-researcher introduced the study to the participants and obtained written informed consent prior to proceeding with the IPV protocol (Appendices, B, C, & D). Comprehensive assessment and management was performed according to the protocol we had originally modified to include mental health assessment (Martin & Jacobs, 2003) (Appendix A). In summary this involved:

- o a supportive participant-researcher relationship
- o systematic history of abuse, including the patient's prior attempts to enlist assistance from police, legal service providers or courts
- o forensic documentation when necessary
- o referral and reporting of the abuse to the local police under the Domestic Violence Act together with the completion of the J88 (Appendix J) when necessary
- o the participant's verbal report of previous results of voluntary counselling and testing for HIV were recorded at baseline, and if testing occurred, later at follow-up
- o case-finding for sexually transmitted infections and treatment as per national syndromic management guidelines
- o case-finding for pregnancy
- o other special investigations as appropriate
- o safety assessment and discussion of safety plan
- o case-finding for mental disorders such as depression, suicidality, anxiety, post traumatic stress disorder and substance abuse
- o counselling
- o supplying a list of local resources
- o making referrals as necessary to local health services and other agencies
- o making a follow-up appointment for the second interview

During our planning phase we modified this for implementation as our first interview instrument in the urban data collection phase. Thereafter, via the co-operative inquiry group process, we modified it three times, see 5.7.7.

5.7.3 Training

Urban training course

A three-day training course was conducted immediately prior to the urban data collection phase. Topics for the first day included:

- the purpose of the study
- a brief overview of IPV literature and the study design
- an introduction to action research
- the adapted protocol (first interview tool, Appendix K)
- forensic evidence collection and
- how to complete the J88, which is the official medico-legal document for police purposes (Appendix J)

The second day focused on:

- coding medical records according to the International Classification for Primary Care
- the Domestic Violence Act of 1998
- role plays in order to learn how to use the mental health assessment guides

Day three focused on:

- interviewing techniques
- participant observation and
- follow-up interview tool.

Rural training course

A refresher training course was held the day before the rural data collection began. It was co-ordinated by myself, as principal investigator, and attended by the rural researcher who had attended the first course, five months before, and three potential follow-up researchers. After introducing the study, all research instruments for both interviews were reviewed. Training on forensic documentation and how to complete the J88 effectively was repeated.

5.7.4 Action – how the protocol was implemented

Health care providers referred participants to the co-researcher at the site who conducted the protocol (Appendix A or K) as a bio-psycho-social and forensic intervention. After comprehensively attending to the participant, referral letters were written to accompany referrals and where possible, referral appointments were made. A follow-up date was set with the participant, and subsequently confirmed telephonically or by mail. A different co-researcher conducted the follow-up interview which was a research intervention to assess how useful the participant had found the protocol.

5.7.5 Observation: field notes; patient records; follow-up interviews

Each member of the research team kept a research journal to record their experiences with participants and health care providers in narrative format as well as their personal thoughts, emotions and reactions. This journal was intended to be used by each person to document her unique journey with the research. It also was the repository of field notes that were relayed to me on a weekly basis during data collection for later analysis and interpretation.

Co-researchers conducted follow-up interviews using a semi-structured questionnaire, which had been formulated by the research team, to explore the patient's adherence to, and perceptions of, the care planned during each participant's first interview (Appendices L & M). The interviewer also sought to understand whether the initial intervention had been helpful for each patient and if so, in what particular ways. In most cases, the follow-up interviewer was not the same person as the one who did the intervention.

Site	Time Frame	Co-Researcher
B	6 October – 24 November 2006	LLR
A	23 October – 4 December 2006	KJ (PI)
C	2 March – 7 March 2007	IS
C	16 March – 24 April 2007	KT
D& E	4 May – 18 May 2007	MA and KT

The evaluation by IPV survivor participants of how the protocol intervention (first interview) and referrals impacted upon her situation and emotional wellbeing, as reflected by her in the follow-up interview, is captured in Chapter Seven, qualitatively in section 7.2

'Participants' experience of intervention' which uses the 'stages of change' model, and quantitatively in Table 7 'Usefulness of protocol intervention' which grades her emotional state following the intervention, and Table 8 'Usefulness of interventions' which rates the referral interventions and other practical actions. Table 9 'Adherence of women to plans made by 1-month follow up' provides a quantitative measure of the extent to which change in the women's lives was embodied in actions taken according to the plans they had intended to undertake in the first interview.

5.7.6 Reflection – how the action researchers and the co-operative inquiry group reflected on the experience and constructed new ideas / questions

A co-operative inquiry group comprising the research team (Mash & Meulenberg-Buskens, 2001) was created to plan, observe, document and reflect on the implementation of the protocol. Professor Mash facilitated the three and a half hour meetings since he was not actively involved with the data collection so that I could better inhabit the space of researcher and use the opportunity to reflect on the research process. The facilitator and I were present at every meeting, and whichever researchers were currently working on the project attended meetings in that period. Six cycles of action-reflection were completed in three phases. The first comprised two meetings during urban data collection in 2006. The first co-operative inquiry group was two weeks into the data collection period and the second was at its end, two weeks later. The second phase comprised monthly meetings during the three months of rural data collection. The final meeting was preceded by six months of reflection and assimilation, which culminated in the final meeting to finalise the options regarding proposed models.

DATE	TEAM MEMBERS PRESENT
18 September 2006	BM, KJ, NB, MA, EM
2 October 2006	BM, KJ, NB
23 February 2007	BM, KJ, MA
19 March 2007	BM, KJ, MA, KT
20 April 2007	BM, KJ, MA, KT
22 October 2007	BM, KJ, MA, KT

Reflections from the research team informed the qualitative findings about the usefulness and effectiveness of the referral resources deployed in the intervention. This is captured in Chapter Seven section 7.5, which also drew on the key informant interviews detailed below. Section 7.6 'Evaluation of the safety assessment and plan encapsulated in the protocol' represents a critique of these aspects of the protocol based on co-researcher input.

5.7.7 Planning – how the action researchers as co-operative inquiry group planned changes to the use of the protocol

Through this interactive process, our intention was to explore the possibility of universal screening, which Martin and Jacobs (2003) propose, and to plan changes which could modify the protocol for effective use. In retrospect, this aspect of the cycle was the weakest area of our study, since we were still too contaminated by the empirical-analytical mindset to really trust the action research possibilities for innovating and implementing change in the moment.

At the second co-operative inquiry group meeting, the two urban researchers altered the order of the protocol to better fit the flow of the interview. The forensic component was reduced and removed to an appendix for use only when necessary.

Prior to rural data collection, co-researchers reviewed the original follow-up tool (Appendix L) and made certain changes which are visible in Appendix M. The final co-operative group was an intensive four hour discussion to reach consensus about all the final modifications and policy recommendations for Chapter Nine.

5.7.8 Ethical issues: Averting negative consequences

During the first interview participants were requested to supply contact details for research staff to remind them of their appointment for the follow up interview or to reach the participant if the appointment was missed. Participants were reassured that only discreet messages (not mentioning the study at all) would be left at any of these numbers / contacts. Reminder calls were made or letters sent out before follow-up appointments. Participants were provided with a cash reimbursement of R50 to cover their travel and refreshment costs for each follow-up visit.

During the research process regular debriefing and co-operative inquiry group meetings enabled the research team to discuss the challenges and feelings raised. Consultations with a psychologist were also made available if wanted. This accorded with the ethical responsibility to reduce work stress and avert negative consequences.

5.8 Standard of care

5.8.1 Assignment: Selection of patients' records

Participants' medical records from the past 24 months were copied. In one third of the sample, the record was missing, or participants had presented for the first time. Furthermore, the lack of co-operation from health care providers to screen participants, prompted the rural co-researcher to use her initiative and contact services outside of the community health centre to recruit participants. In the final analysis, the sample was 114 medical records.

5.8.2 Assessment: Use of the International Classification of Primary Care

The International Classification of Primary Care (International Classification Committee, 1998) was used to code all reasons for each encounter with participants and the diagnoses made during the previous 24 months. Where intimate partner violence had been diagnosed by the health care provider, coding included the management provided. For the urban phase of the research, co-researchers completed the coding. For assessment of inter-rater reliability, a sample of their coding was sent to an expert in International Classification coding, Dr Yogeswaran, principal family physician of Family Medicine at Walter Sisulu University. She found that the coding of the reason for the visit and diagnosis were generally consistent, but that in some cases more attention should have been paid to coding all the reasons for the visit in each of the consultations. Coding was then completed for the rural sample. I checked every record/coding sheet and corrected any errors or absences.

5.8.3 Analysis: Rigorous coding allows of statistical analysis by computer

The coding was collated into an SPSS spreadsheet and analysed by the Centre for Statistical Consultation, Department of Statistics and Actuarial Science, Stellenbosch University. The data was categorical in nature and was analysed by means of simple frequencies and contingency tables to identify the commonest reasons for encounter and diagnoses made in these women known to be suffering from IPV. For those who had been previously identified with IPV the International Classification coding was analysed to determine the current standard of care.

5.8.4 Ethical issues: Patient anonymity

The medical records were analysed and reported in a way that conceals the identity of participants concerned.

5.9 Further consolidation of learning by principal investigator

5.9.1 Key informant interviews

I conducted key informant interviews between March and September 2007 with a variety of specialists in areas related to IPV. The purpose of these interviews was to become informed by their differing perspectives on what potential models for addressing IPV could work within the PHC system. This data has contributed significantly to the findings for the second research objective, presented in Chapter Seven. Key informants included

- Managers of the facilities in which the research team worked;
- Former acting medical superintendent of the Cape Metropole District Health Services;
- Professor of Forensic Medicine and Toxicology who is first author on the protocol the research team implemented;
- Head of Chronic Care for the Western Cape Metropole, now promoted to Head of Chronic Care for the Province;
- Psychologist intern for the Boland-Overberg Region; and
- Co-ordinator of the Rape Forum for the Boland-Overberg Region.

Within the NPO sector informants included

- Director of the Saartjie Baartman Centre for Women and Children. This is a centre for women and children who have experienced violence. It has formed a partnership with fourteen other on-site non-governmental organisations that provide services at no cost to the clients. These include counselling, life and job skills training, legal aid and residential (shelter) facilities.
- Domestic violence specialist for the Legal Advice and Training Project.

Research methods specialists:

- Both domestic violence specialists in the Gender and Health Unit of Medical Research Council, Cape Town;
- Senior lecturer in Medical Anthropology, University of the Western Cape;
- Retired public health and health systems nurse researcher; and

- Senior researcher, gender project, Community Law Centre, University of the Western Cape.

⟡ Triangulation of all quantitative and qualitative data

The following quantitative data was extracted from the first interview as recorded in the protocol's 'examination form' and analysed to give a profile of the women and their management plans. The profile of the women includes data on:

o different types of abuse experienced as defined by the protocol;

o perpetrator of the abuse, relationship to participant;

o participant's mental health status: presence of depression, anxiety, including post traumatic stress disorder symptomatology, and alcohol abuse;

o injuries present;

o need for special investigations (X-rays, HIV, sexually transmitted diseases and pregnancy testing);

o results of safety assessment questions and ratings;

o prior and current use of police services i.e. criminal charges; and

o prior and current use of the Domestic Violence Act i.e. protection order.

The data on the management plan includes:

o need for specific treatment (injuries, emergency contraception, syndromic management of sexually transmitted infections, post-exposure prophylaxis for HIV); and

o management plan (safety plan, referrals made or recommended, resource list supplied).

The data from the follow-up interview quantifies:

o participants' satisfaction with different components of the initial visit according to a four point Likert scale from 'very useful' to "unhelpful"; and

o participants' adherence to recorded components of the management plan.

This statistical data provides insight into the main health-related needs of women presenting in the community health centres. This analysis is discussed in Chapter Six and includes which treatments and services were most needed, valued and accessed by the patient.

5.9.2 Ethical issues: Key informants' permission

Verbal consent was given by all key informants at the beginning of each interview, which was a formality as each interviewee had already agreed to meet with me for interview.

5.10 Exploring the methodological process

5.10.1 Interviews with all researchers

I interviewed each co-researcher about their experience and perceptions of action research, and was in turn interviewed by Professor Mash. The third research goal, "what did we learn from the process of training and supporting researchers who are new to the action research paradigm?" is essentially retrospective. Analysis of transcripts of interviews described above, all field notes / research journals as well as the transcripts of the co-operative inquiry group material was written up to form Chapter Eight. In addition, as principal investigator, I was new to action research and wrote a reflexive piece about my own methodological journey.

5.10.2 Analysis of all qualitative material pertaining to methodological issues

The method of qualitative data analysis used in this study is described in detail in 5.5

5.10.3 Ethical issues: Commitment of co-researchers

All researchers interviewed gave their verbal consent to be interviewed and participated with commitment.

5.11 Conclusion

This chapter sought to address the concrete methods and approaches applied in order to achieve the research goals and the underlying feminist activist mission of this thesis. Having explored the development of the research proposal, our study was located in the modelling phase of a complex health intervention according to the British Medical Research Council's research categorisation. The intervention modelled was the implementation of the protocol for IPV screening and treatment, adapted from a protocol developed by the Consortium on Violence Against Women and previously published (Martin & Jacobs, 2003). Initially, BM and I adapted the protocol to cater for mental health issues in greater depth. It is of interest to note that institutional requirements at the outset diluted a purist action research methodology, in that the research proposal and design were necessarily presented as a *fait accompli* to co-researchers. The setting for the study was briefly described, and how and why the five study

sites were chosen was explained. The chapter then connected the methodological approaches used to each of the research goals.

For the second research goal, which aimed to determine the feasibility of implementing a published South African protocol for screening and management of IPV within local primary healthcare settings, we identified and trained health care providers from the five study sites, who then used any one of a set of questions provided to screen all women patients over 18 years old for IPV experiences. Identified IPV survivors were referred to a co-researcher on site, who implemented the biopsychosocial and forensic protocol in a baseline interview and intervention. A follow-up interview was conducted a month later, to ascertain each IPV survivor's evaluation of the impact of the protocol intervention and referrals on her situation and state of mind, and whether she had in fact implemented plans she had made with the researcher in the first interview. Measurable results from the interviews were tabulated and numerically analysed, to triangulate with the qualitative findings. Key informants were interviewed to gain other perspectives and greater understanding of issues surrounding IPV and the protocol implementation in the South African PHC context. For research goal 1, which aimed to identify the current nature of care offered to survivors of IPV in the primary health care sector of the Western Cape, we pulled the extant medical records of IPV survivor participants, coded their diagnoses and treatments according to the International Classification of Primary Care, and statistically analysed the results on computer.

All of the above methodological techniques can be placed within the interpretive-hermeneutic and empirical-analytic methodological frameworks, discussed in Chapter Two. What locates our study firmly within the emancipatory-critical paradigm are the following action research approaches:

- the intention of producing outcomes that could potentially change health care practice in the South African PHC sector;
- the feminist commitment to making a real, constructive difference in the consciousness and lives of participating IPV survivors and health care providers;
- focus groups of the health care providers, held after the screening period at the sites, allowed them to reflect on their experiences and learnings;
- the principal investigator and co-researchers establishing an action research co-operative inquiry group under independent facilitation, which kept journals and met regularly to reflect on our experiences and the research process, and which amended the research design (specifically the protocol) during the course of the study;

- the framing of research goal 3 of 'learning from the process of training and supporting researchers who are new to the action research paradigm and methodology', which is only made possible by the overarching action research methodology; and

- the intensive and comprehensive process whereby the principal investigator internalised, analysed and mapped the volumes of interview transcripts, records of group meetings, field notes from co-researchers and my own journal, to distil themes – including contradictions – which informed and organised the research findings.

With a theoretical roadmap in hand from previous chapters, and understanding the extent and limitations of the research design from this chapter, let us now proceed over the following three chapters to discover those findings in terms of the three research goals.

CHAPTER SIX

STANDARD OF CARE FOR IPV

6.1 Introduction

One hundred and sixty-eight women were referred to the study with a history of IPV. In 54 cases the medical records were missing or the patient was attending the health centre for the first time. Therefore 114 medical records were entered into the final analysis. Only 9.6% of participants had been previously identified, although this was no guarantee of effective assistance. Yet all participants had asked for help when it was offered, suggesting that the problem was serious enough to need intervention from their perspective and therefore may have benefited from earlier intervention.

Complex issues surround the identification of IPV and the potentially concomitant role of health care providers. Operant inequities between men and women common to most societies tend to also be reflected in the health sector (Garcia-Moreno, 2002b). Aspects of the medical model and its institutions stifle much potential for responding to women experiencing violence. International specialists emphasise the need for structural transformation of documents and protocols as crucial for the evolution of an effective health service response to women in abusive situations. This change is seen to be vital for health settings where violence against women is common (Warshaw, 1993).

Key themes that emerged when exploring these participants' medical records were:

1. The standard of documentation was unacceptably low and revealed a serious deficit of IPV-related skills.
2. Assistance both at time of identification and subsequent care was inadequate, particularly in comparison with parallel contexts in the health systems of the developed world and in comparison with interventions for other health-related problems in SA.

In order to get deeper and more sensitive insight into the lives of the women represented in the statistics presented later in the chapter, we start with the analysis of six case studies. My critical analysis of their medical records, juxtaposed with the participants' stories, follows deconstructionist lines. A key aim of deconstruction is to ascertain what is marginal, absent or excluded from a text. This resonates with work covered in Chapter Three section 3.2.2 where

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feminist hermeneutics were used to uncover ways of (not) talking about and shaping the understanding of IPV. Indeed the boundaries separating texts from social contexts provide fertile ground for critical endeavour. Ideologies predictably surface at the borders of all discourses including medicine (Waitzkin, 1991). Significantly, ideology also presents itself by means of a lack of open discussion about alternatives to the status quo, by a de-emphasis on contextual difficulties, or by a lack of critical attention to such problems. Eagleton, a Marxist critic influenced by deconstruction, states this powerfully (Eagleton, 1978, pp.69 & 89):

> *"Ideology, rather, so produces and constructs the real as to cast the shadow of its absence over the perception of its presence ... These absences – the 'not-said', of the work – are precisely what bind it to this ideological problematic: ideology is present in the text in the form of its eloquent silences."*

Thus the dominance of biomedical ideology in the contemporary South African health system can be seen to state itself distinctly at certain times and pervasively also via unspoken or marginalized themes. The key themes here are the full humanity of female South African citizens, and the protection of our right to humane health care.

Services by health care providers that give patients a sense that they are being cared about has been termed 'emotional labour'. This relates to the element of work that is involved in smiling and being courteous and empathic. If emotional labour is unrecognised in health care systems it may be that it does not easily fit the biomedical organisational culture and context for it must be given freely if it is of value (Small, 1995). Further, 'care' and 'emotion' are concepts that have strong cultural associations within the 'private' sphere of love and feelings, rather than the 'public' world of work. In Chapter Four section 4.5.1 'Cultures of care versus cultures of control' I explored how nurses are emotionally separated from their patients and are unable to do the emotional labour needed for effective IPV care, through internalised notions of status in the context of being oppressed and socialisation into an authoritarian, biomedical system.

6.2 Case studies

In the case studies below, the full extent of IPV-related content for each medical record is included. On careful reading it will quickly become evident that in each case health care providers omitted obtaining a psychosocial history, failed to ask about a history of sexual or physical abuse and failed to address the women's safety. By not addressing these issues, the

health care provider missed the opportunity to attend to the underlying cause of the patient's medical condition. Failure to acknowledge the woman's abusive experience is often psychologically damaging in itself (Warshaw, 1989). There is evidence that 'disconfirmation' of abuse by a care-giver is a contributing factor to the development of subsequent psychopathology (Randall, 1990). Even if a woman does not choose to pursue interventions, a clinician's support is an act that may in the long run contribute to her being able to change her situation (Hegarty et al., 2008).

Scant documentation of issues pertaining to a patient's abuse is an international phenomenon (Buel, 2002). Sadly, medical records may comprise the sole documentation of the patient's injuries and thus should contain all key facts, including identification of perpetrator, use of weapons, and whether injuries arose from their use or threatened use. In the second tier of our modified protocol (9.2.2), we provide the J88, which is the medico-legal document health care providers' should use in South Africa. Buel (2002, S41) recommends that health care providers record the patient's own words relating to her physical and/or mental condition instead of recording a clinical interpretation. For example, "Mrs Jim says that she was frightened her husband would kill her when he held a gun to her head." Body maps are valuable: one can be used for new injuries and another for old ones. Health care providers should also document any incongruities between possible causes of the injuries and patients' explanations, which don't fit. The diagnosis and opinions, which may confirm abuse should also be documented; for example, "Patient's trauma is consistent with being hit with a blunt instrument on the back." According to IPV care standards in the developed world, patients should be offered the chance to have any visible injuries photographed for medical and forensic purposes (Buel, 2002, S41). Given how under-resourced the contemporary South African primary health sector is, this would not be possible here, yet.

In our sample of medical records of IPV survivors, the only mention of IPV-related injuries is of the most reductionist kind. For example, "c/o:- Allegedly assaulted with hammer – now swollen and tender." Note no mention is made of the affected body part. The treatment provided was an X-ray, which proved that there were no fractures. Analgesia was provided. The entry totalled thirteen words, representing the cursory manner in which the patient was handled and/or the overloaded nature of the health provider's caseload leaving little time for making comprehensive notes. In the representation within the medical record, the patient herself is invisible – the only reference to her bodily integrity is that somewhere her tissue is

"swollen and tender", an indication of physical pain. In such cases, the psychic pain is usually far more intense, yet there is no mention of that either.

This neglect is all the more concerning since primary health care providers tend to be the clinicians who see the IPV survivor and her perpetrator and children. Central principles for management of the family, drawn from an expert consensus panel, are the safety and confidentiality – within legal limits – of family members who may self-harm and also harm others in the family (Taft, Hegarty & Feder, 2006). The quotations in the following case studies were taken from their medical records, first and follow-up interview tools. The co-researchers' based their notes on the participants' words.

6.2.1 Case Study (VM)

According to a note made on 07.02.06, this participant had an injury that merited *"advice about the disability grant application procedure"* from the health care provider, "…*injury due to domestic violence"* ends the brief entry. No offer of assistance or referral in this regard was recorded.

The next relevant entry appears on an Accident and Emergency form, dated 15.09.06: "...*patient allegedly fell and injured right arm yesterday."* A crepe bandage, anti-inflammatory and analgesic medication were prescribed. No reference was made to the previous incident, nor to the fact that this patient screened positive for our study and was seen by a co-researcher at this point. One wonders how many other pertinent details were not recorded, thereby leaving the patient without a prompt reference for future care.

In our study, she revealed herself to be a 43 year-old mother of one son, married with an ante-nuptual contract, although since separated. Her story was that they married in 1999. Thereafter he started attacking her with metal weapons all over her body when under the influence of alcohol and/or drugs. He also hit and kicked her, called her names and controlled all financial decisions. For example, despite their poverty, he felt so entitled to absolute control that he framed this abuse as punishment for her disobeying his wish for her not to work. He burnt her clothes, identity document, and all certificates including her son's birth certificate. The following week he tried to burn down the shack while both she and her son were inside it. She pursued charges against him in 2002 and the case appeared at the Moantsane Magistrate's Court. On informing the Court that she was leaving for Cape Town, the charges were promptly dropped even though she only ultimately left her husband in 2003.

Lacunae rather than substance dominate her medical record. As with the other case studies, when juxtaposed with our comprehensive assessment, it reads like a spider web with huge empty spaces. In our investigation, she had symptoms suggestive of depression, anxiety and post-traumatic stress requiring further assessment and treatment, although there is no mention of any of this in her medical record.

Furthermore, when still with her husband in the Eastern Cape, there was an incident following her husband's diagnosis as HIV+. Her status had tested negative. When they got home from the hospital, he beat her up because he said she was talking / gossiping with doctors and nurses because she had admitted that he wasn't condomising. Here we see that even while he was culpable of potential manslaughter, he physically and emotionally abused her for trying to protect herself from the HIV infection caused by his infidelity to her during their marriage.

She explained that she found the safety assessment helpful because it showed her that she, *"no longer has that fear."* She felt that she *"can stand on her own."* She expressed that she had already successfully accomplished her own escape from a dangerous husband who damaged her hand so badly that she had finally been awarded a disability grant. She was to start receiving the grant in the month of the interview. She was keen to start attending a support group.

In answer to how useful she found our intervention, she said, *"After I've met her I was so relieved. When I was talking was feeling very hurt and bad about what my husband has done to me, but after that day I felt different."* In response to what had changed, if anything, *"Yes, the following week I came for check-up and I dressed up nicely. I used to not want to wear clothes, I felt so dull ... Now I always have a hope that things can be right for me – ideas about the future. Before it was just darkness."*

Here VM provided a florid example of how pervasively abuse impacts on the mental health of a client, doing damage even after the relationship has ended (Bergman & Brisman, 1991; Campbell, 2002; Cascardi, 1999; Coid et al., 2003; Golding, 1999; Orava et al., 1996). Findings confirm that co-morbid major depressive disorder and post- traumatic stress disorder are common amongst IPV survivors (Cascardi, 1999; Nixon et al., 2004). Indeed, psychiatric disorders are the most persistent and disabling conditions resulting from IPV, particularly depression, post-traumatic stress disorders, chronic anxiety and substance misuse (Golding,

1999). In a study investigating the associations of adult mental health measures with childhood sexual abuse, sexual assault in adulthood and domestic violence, the latter showed the strongest associations with most mental health measures (Coid et al., 2003). These findings support the importance of mental health clinicians (Danielson et al., 1998) and primary care providers screening for IPV and treating survivors and perpetrators proactively.

6.2.2 Case Study (NA)

The following case study illustrates a more complex scenario in that the participant had a history of a major depressive disorder with psychotic features and previous suicide attempts. She was a 39 year-old mother of four, who related her story well despite her depressed affect. At the time of our first interview she was eighteen weeks pregnant. The entries in her medical record raised ethical issues about the management of this IPV patient, since it was clear that a more constructive approach could have at least prevented this unwanted pregnancy, in addition to protecting this client and her four children better. Specific dates are included to elucidate the delays in provision of care.

The first record of a session with a psychologist was on 23.02.06 (although referral was noted on 04.08.05, almost seven months prior). The patient presented with depressed mood and suicidal ideation. A no-suicide contract was signed, and the contact number for Lifeline was given. The only other point noted was, "*referred to social worker for assistance – she wants to initiate divorce proceedings but is scared her husband will kill her.*"

On 23.02.06 the health care provider noted that, according to the patient, the husband became violent when under the influence of liquor. Referral was made to FAMSA, the Family and Marriage Society of South Africa, *"... regarding her contemplation of divorce and the relationship problem and also the contravention of the marital contract. To see social worker in due course."* However there is no further evidence of her seeing a social worker. Indeed the last management plan recorded in her folder on 05.09.06 is for "… *urgent social work referral.*"

Psychologist's notes from the second session on 23.03.06 record "… *patient's mood has improved drastically. She says that her husband has not returned so she is feeling better.*" The rest of the psychologist's entry focuses on the patient's current capacity for employment and prevention of suicide attempts.

The third session with the psychologist is undated. A note is made that the patient complained of high blood pressure whilst saying that her husband would be returning at the end of the month. The psychologist records advice given to patient as follows, "… *explained that she needs to be pro-active, she needs to break cycle of abuse. Advised her to contact NICRO, National Institute of Crime Prevention and Rehabilitation of Offenders. She needs to protect herself and children. If husband will not stop drinking and abuse, then she needs to make the choice.*"

Here we have a clear example of what Limandri (1987, p.11) terms an "inhibitive helper response". Implicit is an undertone of blame (she needs to break the cycle of abuse; that is, it is her fault that this has not already been achieved) and a directing style that advises the client to leave the abuser. By contrast, a 'facilitative helper response' would acknowledge the seriousness of abuse and that she did not deserve it. Active and empathic listening should also have been combined with assisting the woman to assess her internal strengths and to consider the full range of available options (Limandri, 1987). Motivational interviewing terms this a guiding style (Miller et al., 2008).

In May 2006, the triage nurse records "*sleep disturbance and nausea*" and refers her to a medical officer for further medication. The nurse also states that, "*social problems were looked at and counselled*". Unhelpfully, in South Africa with the exception of psychiatry, most nurses are trained to counsel clients by giving advice. **Furthermore, why was practical and insightful assistance, in the form of contraception, not provided at this point?**

The next entry made by a doctor at Site A on 29.06.05 is for referral to the psychiatric emergency unit at a nearby academic hospital and includes a diagnosis of abusive husband, separation thrice previously. Although the medical officer / doctor states that patient has been seen on a weekly basis, and provided weekly with medication and contracting regarding suicidality, there is no evidence of any of this in the medical record "*... she seems to be deteriorating and last night attempted to take overdose in spite of contract. Has a history of three previous suicide attempts: overdose; hanging; drinking car battery water*".

On 08.08.06, NA's record reveals: "*Husband is physically abusing her again. He is abusing alcohol as well. Seen in trauma by medical officer and was given lorazepam 1mg po x 5/7. She went to police but was not attended. Worried again because she has not menstruated for*

three months. Not using contraception ... had suicidal thoughts after assault by husband. Daughter took all the tablets ... (Plan) – counselling done – refer social worker".

On 05.09.06 NA was seen by a nurse and the matter discussed with a doctor. "*Contacted Saartjie Baartman Centre for alternative placement ... client not keen to divorce husband. Letter written to court as per client's request. Patient to be seen soon.*" No copy of the letter is included in her folder.

At this point the client was referred to our study. Her first interview revealed that her husband hit her, called her names, shouted at her, restricted her contact with family / friends, controlled her activities and all financial decisions. She explained, *"Verbal abuse is worse – he uses strong words, always blaming me. That makes me feel worthless, stupid. I don't like myself. I hate myself most of the time, I hate marriage, I hate my husband, and if, if I may have the power and means, I can kill him while sleeping but at the end I am not cruel so I don't have the guts to do so."* Instead she had tried to kill herself several times because she did not see the value of living since she felt she was always seen as a bad person by her husband.

The following details could seriously confuse and/or demotivate health care providers who lack insight into the dynamics of IPV. The patient stated that she was not interested in leaving her husband because she still loved him. This contradicted her desire to divorce him noted in the first entry of 23.02.06, but may be explained by the fact that she was now halfway through her fifth pregnancy with his child and consequently her entrapment is that much deeper (Ludsin & Vetten, 2005). Here she was trapped also in ambivalent thoughts and emotions that paralysed her. She identified that being kept at home all the time made her feel isolated and depressed since her husband did not allow her to meet other people, not even her neighbours. She did not have friends and was not working.

Symptoms of agoraphobia were evident in that she was scared of social gatherings and crowds of people. Sometimes she felt as if *"the walls are suffocating"* her and her *"head feels like it is going to burst"*. Her medical folder revealed no effort to assist her with this disabling anxiety disorder other than the problematic prescription of lorazepam as required.

On follow up this patient admitted to finding our intervention *"...very useful"* because since their discussion, she felt strong inside. She explained that the co-researcher had tried to convince her that, *"in this world I need to be strong and that I must always believe in myself.*

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Now inside me is different. Also, he has been in jail since two days before the first interview – now I feel free." She explained how she was recovering her strength and spirit. He was to reappear in court in October 2006 for sentencing.

Encouragingly, she had been to the Philippi Court for a protection order and had found the family court there helpful. She had been reassured when they told her that if he hurt her again they would arrest him – which they did just before she was seen by our project. She was granted a final protection order on the strength of the social worker's letter, which explained her history of abuse, so it seems that she was eventually seen by the social worker. She became tearful when explaining that her children were so scared when he was drunk, and that now they were scared that when he came out of jail he was going to kill her, because he had threatened to do so.

Qualitative studies reveal that women in abusive relationships are at different points in a cycle of change (pre-contemplation, contemplation, decision, action, maintenance or relapse) in relation to the abuse (Zink, Elder, Jacobson & Klostermann, 2004). In this context, the stages of change theory argues that IPV survivors who are at the pre-contemplation stage need brief messages suggesting a possible connection between symptoms and their experience of abuse. At the contemplation stage, the clinician helps the patient to resolve ambivalence by sensitively exploring the possibilities of change. Those at the planning stage need resources and support to be explored properly; and at the action stage the theory focuses on the documentation of injury or referral to another resource (Zink et al., 2004). This integrated process allows for brainstorming of options and the selection of specific practical actions and goals, all of which mirror the motivational interviewing paradigm.

I would insist though that every stage, and not only the action stage, requires thorough, accurate documentation of injuries, since this should be done whenever women present with injuries, so as to build evidence within the medico-legal folder. Furthermore, at all stages IPV survivors may appreciate appropriate referrals, even if only to bear in mind for later. A systematic review of qualitative studies revealed that at all stages women experiencing IPV want recognition and continuing support from clinicians, without pressure for a specific course of action (Feder, Hutson, Ramsay & Taket, 2006).

6.2.3 Case Study (CA)

This patient was referred on 06.05.06 to the psychiatric nurse at Site B after an attempted overdose with 16 paracetamol. The multi-axial diagnosis made on 10.05.06 specified,"... h*usband – psychological abuse ..."* on Axis 4 and following an Axis 1 diagnosis of major depressive disorder with anxiety component, antidepressants were prescribed.

On 05.07.06, the psychiatric nurse noted, "*...husband still violent and abusing,"* and planned to continue medication and refer the patient to both a psychologist and marriage counsellor.

On 02.08.06 the patient presented with insomnia and depressed mood and the psychiatric nurse noted that her husband expected sexual activities from her, which she found unacceptable. He also noted that she, "*...wants to visit her sick sister but her husband forbids her... manipulates her +++ and breaks her down emotionally".*
The psychiatric nurse's plan read: "*1) meds 2) social worker for advice re ?divorce 3) follow-up on 31.08.06".* She was seen by the social worker at Site B on 02.08.06, who referred her to a community service, Communicare, from where she was removed to a 'place of safety'.

CA was a 45 year-old mother of two teenage daughters, married in community of property. Her husband controlled her activities, particularly by restricting her contact with family and friends. He also hit and pushed her around, and had used a weapon. He shouted and swore at her and she also suspected him of infidelity.

On interview, the most recent abuse had started on her return from the shelter two weeks before. Since then he had been accusing her of having an affair and refusing to allow her to visit her sisters. She explained that she had gone to the shelter when sent by Communicare because she was feeling so battered by the horrible things he was saying, for example that all her family were whores, that she herself was a whore and that the relationships he had with other women were much better than with her. He threw water, milk or whatever in her face and worst of all, he spat in her face. She described him as mean and cruel, particularly regarding her sister who is mentally disturbed and whom she loved and really wanted to visit. He controlled her with his moods and if she ignored him he picked at her and so she found swearing the most effective way to silence him. They also have had major sexual problems and there was a lack of respect, no greetings. Whenever she came to him with a problem he

always saw it in a negative way. In her estimation, during the past two years he had been rude and unpleasant 90% of the time.

Although CA only scored 2 on the safety assessment scale, which placed her in the lower risk caution category, in this case, severe and ongoing verbal abuse seems to have triggered a suicide attempt. This revealed a faultline in the safety assessments internationally, since none assess suicide risk. On follow up CA revealed that she was feeling "…*weak and scared to make decisions*". However, on the day prior to the follow-up interview, she had been to an organisation that deals with divorces and had filled in the forms. She told her husband but he thought it was a joke. She was scared of what he would do if he realised that she was serious.

In terms of whether anything had changed within herself or her circumstances in the intervening month since the first interview, she said she had felt boosted after the interview with the co-researcher. She wanted to be able to make decisions and to not feel so scared all the time. Her mental state clearly reflected the oppressive difficulties of her circumstances. In the previous week he had hit her so that she needed to be booked off work by her doctor. He followed her so that she couldn't go anywhere. She claimed that he was a good father, but their daughters were also scared of him. She seemed to have made no progress with getting a protection order.

She said that she had been in many shelters, but because she missed her children she returned to the home and marriage. She felt she would have to go to a shelter if she divorced him. She also said that both the psychiatric nurse and the social worker of her facility had said to her, *"… dat sy moet eers besluit neem en man skei voor sy terug gaan…", ("… that she first must take a decision and divorce her husband before coming back to see them …"*). Here we have another blatant example of an inhibitive helper response in its refusal of help until she had left the abuser. Not only is this inappropriately directing, but it also demonstrates that the health providers have internalised and perpetuated the misguided 'separation assumption' of dominant discourse. That is the assumption that separation from the partner will resolve all of her problems and is the only solution.

The disabling fear of the abuser is palpable in most of these narratives and health care providers need to grasp the underlying power and control issues that are key to the violence of battering (Worcester, 1992, pp.4-5):

"For the woman being abused, physical violence is but one of the tools that her abuser uses to have power and control over many, or all, aspects of her life. Many formerly battered women who have even suffered life-threatening injuries say that physical violence was nothing compared to the psychological and emotional abuse they endured."

CA provides an example of someone paralysed by fear and disempowered by the social and economic factors that constrain her capacity to find a way to a better life for herself. A study focusing on female primary care patients in Sweden who suffered from biomedically undefined musculoskeletal pain disorders, found that 50% had been victimised by a former or current partner. They emphasised that the pervasive fear caused by threats of violence was as hard to survive as the violence itself; they described always being on guard (Hamberg, Johansson & Lindgren, 1999).

6.2.4 Case study (TM)

On 11.01.05 this patient with epilepsy and with a history of alcohol dependence since 2003, was referred to Site A by a general practitioner. She was first seen by the psychiatric nurse at Site A on 18.01.05. On 24.05.06 the psychiatric nurse notes for first time that the patient complained of "*... lots of social problems ... stressors:*
 1) marriage problems 2) lost sister ...". The entry dated 06.06.06 states, "*... wants to divorce – married 8 years. Housewife ... verbal abuse, financial irregularities, no support from husband recently".* TM was referred to the social worker at this point.

TM was a 39 year-old mother of three, married in community of property. She came alone and explained that her husband was unfaithful, withheld money and controlled all financial decisions, also restricting her contact with family and friends. He pushed her around and shouted insults at her.

Her description of the most recent incident of abuse was on the 11.09.06 in the evening when he asked the children why the dishes were not washed. Without getting an answer he turned to her and said she did not have discipline, why were the kids not cleaning? Not able to do anything? He said that she was useless and used vulgar language and he pushed her, continuing to shout. After that he went away and did not sleep at their house. He went to his parental home.

TM complained that his parents poisoned him against her. Every time he came from his parental home he fought with her. Things were becoming worse because he shouted everyday, so before she slept she knew he was going to hurt her feelings verbally. He did not even want her to have friends or meet with other people. If she was with other people he became restless and would ask her what she was saying to those people. TM admitted knowing that he had girlfriends and did not condomise.

When describing the nature of past abuse, she said he had started to shout at her once they were married. After three years she had had enough, particularly since she had recently lost her sister suddenly and understood that her sister's death was caused by IPV. However, like NA, she did not want to divorce. She stated that she still loved him. The only problem was his family because he believed what they said about her and came back from them to abuse her spiritually and emotionally. She used to like going to church but now she was losing interest because his family attended the same church.

On follow up, TM explained that she had found our intervention useful, "*… to have advice from someone else, just to open my heart in a different way …*". TM said the co-researcher had helped her by informing her that when her husband started to abuse her she could go to police and social workers or counsellors from non-governmental organisations and speak to someone.

Responding to whether anything had changed within herself or within her circumstances since the first interview, *"Ja, there is something changed. Before I met the researcher, I always felt alone. Secondly when I'm talking to my kids I'm always fighting because I always think I am somebody useless. After I talk with her I do not fight so much. I try not to be aggressive. I try to sit down and talk with my children. At least they listen to me – they appreciate me being kind. Also, I have stopped shouting at my baby, now 18 months, because I love her so much and show her that in a kind way ... the last three weeks I feel more normal, like myself."*

However, concerning the current state of the relationship, TM reported that he still shouted at her and hurt her feelings on a daily basis, but now she said, "*… no man, stop …*" and at least sometimes he did. When asked if she wanted to take the legal route, TM said that for now, she didn't want to because she just wanted to try and speak to her husband. If he didn't stop then she would take further steps. Note the parallel between NA and TM's approach at this critical 'window of opportunity'. Both were compromised by mental illnesses, and both had a number

of children with their husbands. These are usually factors that health care providers find prohibitive to exploring how to assist such an IPV survivor and are explored in sections 7.3.6, 7.3.7, 7.3.8, and 7.4.2. Yet compassionate and constructive attention from our clinical researcher impacted positively on their mental health and is consistent with international findings (Bauer & Rodriguez, 1995).

Here TM provides a parallel to NA, for both opt to stay with their husbands and indeed even express fondness for him while recounting abuse that one would expect to eliminate such feelings. During a co-operative inquiry group meeting the researcher from this site referred to these contradictory discourses and ambivalent feelings as common. The participants were also fearful of attending referral appointments because they felt it could be perceived as disloyal. The conflation of love with abuse is sadly a distinct strand within contemporary local discourse (Wood & Jewkes, 1997).

6.2.5 Case Study (MP)

MP had a history of epilepsy, depression with psychotic features and treatment at Valkenberg, a local psychiatric hospital. The patient was managed primarily with medication from 18.02.05 until 13.09.06. There was an exception on 02.04.06 when a nurse made a note to fax the social worker at *Diakonale Dienste* the client's information, but there is no further reference to this process.

At this point MP was referred to our study and to a group session facilitated by a psychologist. In the interim, a health care provider had noted pertaining to the state of her marriage, "*... husband unemployed, not financially supportive, very controlling ...*" "*... husband unfaithful ...*" "*... marriage problems, got another girlfriend, poor financial status – husband not supportive ...*" "*... husband very abusive – wants to rule her life – verbally abusive ...*" "*... husband abusing alcohol ...*" and finally "*... patient wants to kill her husband but admits to no specific plan ...*".

MP was the 27 year-old foster mother of an eighteen month-old baby boy. She was married in community of property. The following forms of abuse characterised her husband's behaviour towards her: verbal abuse, shouting, restricting contact with family and friends, threats, controlling her activities, unwanted touching, infidelity, forced intercourse, withholding money, taking money, controlling all financial decisions.

MP hid all her money with the help of two neighbours otherwise he stole it for drink. He even stole her cigarettes. Although he got a grant because he was in an accident and also sold beer, dagga and ice cream, he never gave her money for food, electricity or water. But he complained if there was nothing to eat. He only once gave her R200.00 for Christmas in 2005, nothing before or since. They married in March 2005.

MP provided more detail. Her husband accused her of having sex with other men. He was rude to her in front of neighbours, accusing her of having sex with men wherever she has gone. Then he demanded sex and forced it on her. He was so rude, chasing any potential friends away. She left work because of the depression her life with him had caused.

Sometimes when she was resting in the afternoon he came home and wanted to know why she was sleeping? Did she sleep with other men? Her neighbour gave them a plate of food, which she gave to him and he threw it in her face so MP called the police and used an interim protection order to get him locked away. They were still to appear at Family Court for the finalisation of a protection order at the time of the first interview.

MP reported that after her depression had stabilised sufficiently for her to be discharged from Valkenberg, her husband was sweet for three weeks and then everything went back to normal, *"… rude and raping me every day. Sometimes he wants to have sex three to four times per day."* Her husband called her *"a slut"* and she asked the researcher, *"what must people think of me?"* When she was asked routinely about sexually transmitted infections she informed, *"… my whole vagina is sore – inside, outside it is sore. Even if I have my period he wants sex. No foreplay, he just shoves it in and goes on and then leaves me lying there. I feel nothing."*

On danger assessment, responding to whether he had threatened her with physical violence, MP said that he threatened to kill her if she didn't give him sex. She had activated her own safety plan since she had obtained help from the police at the Family Violence Court. This was encouraging since she seemed to have been well assisted by the psychiatric nurse at Site B and a social worker at a nearby community health centre.

At the follow-up meeting MP said that the protocol had really helped her and she wouldn't change anything. Normally she can't talk it out so holds everything in. She appreciated the researcher's empathy. Also she appreciated the referral to the Legal Advice Office at Saartjie Baartman Women's Centre as well as the counselling and support she had received for herself

and baby at the Trauma Centre. After talking to them she was so emotionally drained that she slept for four hours while they looked after her foster toddler. When she woke up, they made her tea, all of which she greatly appreciated.

In terms of how things were going in her relationship a month after the interview, at the follow- up meeting, she said that nothing had changed. After time with the researcher she had been waiting at home for her court date to get the interdict finalised. He had tried to make up, said he was sorry and when she had said he always lied he had started to cry. Later she decided that she had to continue with her plan to get a final protection order.

6.2.6 Case study (SVD)

The patient was managed for medical problems from 27.01.05 until 08.01.07 over fourteen visits. On 08.01.07 she presented with insomnia, dizziness and tension headaches and was referred to the psychiatric nurse where it was noted that she had a problem with her cohabiting ex-husband in terms of a history of physical and sexual abuse. At this point she was referred to a social worker for further management and subsequently to our study.

SVD was 39 years old, and although divorced, was currently cohabiting with her ex-husband. They had five children. Hitting, kicking, use of a weapon, pushing, name calling, shouting, restricting contact with family and friends, threats, forced intercourse, withholding money, controlling all financial decisions were the forms of abuse that had characterised their marriage. During the period that they were separated, he was seen sleeping in a field, and their children were so ashamed that she *"… took him in again".* In response to her kindness, he demanded sex three to four times per night. He was extremely verbally abusive and if she didn't give sex then he said she was bad. He had often tramped on and kicked her with safety boots. He also pulled her hair. Describing the most recent abuse she explained that he wanted to have sex with her without her consent. Later she gave in.

According to her safety assessment, this participant was in a high-risk category, answering "yes" to the following:

- Has he threatened you with physical violence?
- Has he threatened to kill you?
- Does the patient think he is capable of killing her?
- Were alcohol and / or drugs consumed prior to the last incident of abuse?
- Was intervention from the South African Police Services necessary?

- Is he presently in the home?

Sadly, she did not return for her follow-up interview even though her symptomatology indicated that she needed care for depression and post-traumatic stress disorder. Hopefully she attended the referral appointment to the psychiatric nurse.

6.3 Psychic atmosphere and lived reality of IPV sample

In South African health systems as elsewhere, battering tends to be a hidden phenomenon, remaining undisclosed to clinicians due to varying cultural and internalised constructs about its significance. Yet in Table 1 below we see how dangerous IPV is, as measured by the safety assessment of the protocol. Even setting aside the danger to the woman herself, fully 54% of the participants in this project admitted that their partners had threatened to kill their children. The fact that 46% believed that he was capable of killing indicates the psychic atmosphere of fear that pervaded the households. Unsurprisingly 52% of respondents were at high risk, and a further 16% at severe risk, indicating that 68% of the sample was, by international standards, in significant danger. In Chapter Seven section 7.6.1 'Critique of the safety assessment' some critiques of the protocol's safety assessment and some recommendations for improvements are made. Notwithstanding any criticisms, the use of the safety assessment revealed that most IPV survivors in our sample (and by implication their children) were in significant danger, a finding that surely should spur action particularly since it is borne out by both quantitative and qualitative data. The neglect of IPV as a crucial health concern is legitimised by a biomedical framework that sanctions de-contextualised health care, which this thesis contends leads to unethical practice.

Table 1: Safety assessment score

	n = 168	%
Safety assessment score		
Not done	3	1.8
Caution (0–3)	50	29.8
High risk (4–7)	87	51.8
Severe risk (8–11)	27	16.1
Safety assessment fields		
Threatened with physical violence?	125	74.4
Threatened children with violence?	109	64.9
Firearm in house?	102	60.7
Made a death threat?	92	54.8
Threatened to kill children?	91	54.2
Capable of killing?	77	45.8
Substance use prior to last abuse?	62	36.9
Police intervention necessary?	54	32.1
Is he in the house?	41	24.4
Has abuse escalated in severity?	35	20.8
Received medical treatment for injuries?	33	19.6

The fact that only 19.6% of the sample had received medical treatment for injuries implies that 80.4% will be missed if injuries are the only way of identifying IPV. The high incidence of firearm possession by perpetrator, at 60.7%, is a mirror to how normative violence is in South Africa. The high levels of unemployment are also indicated by the fact that 24.4% of partners were at home during the working week.

In Table 2 below the levels of emotional and psychological abuse are revealed to be seriously high. It must be remembered that the categories are not mutually exclusive, and so one woman is experiencing multiple forms of abuse. Since 168 respondents reported 1 315 incidences of types of abuse, each women is on average bearing the brunt of about 8 forms of abuse, over extended periods. It is a wonder they have any resilience left.

In terms of emotional abuse, 83% of women admitted to being shouted at, and exactly half the sample lacked autonomy to live their adult lives because their partner restricted their contact with family and / or friends. Even tighter control by the perpetrator of the participants' freedom to pursue activities of her choice was exerted in 38% of sample. A fusion of sexual

and emotional abuse was evident since while 11% of the sample was accused by their partners of sexual infidelity, 43% of the participants suspected their partners were having affairs.

Physical abuse came a close second to emotional abuse, with 68.5% of the sample admitting to beatings. Almost 50% admitted to being kicked, and alarmingly almost 34% had been choked. Strangulation poses a serious threat of intimate femicide, since death is quick and too easy (Martin, 1999).

Table 2: Prevalence of different types of abuse

Abuse behaviour	n = 168	%
Emotional		
Shouting	139	82.7
Name calling	136	81.0
Threatening	94	56.0
Restricting contact	84	50.0
Controlling activities	63	37.5
Accusations	19	11.3
Other	16	9.5
Physical		
Hit	115	68.5
Pushed	90	53.6
Kicked	82	48.8
Use of weapon	69	41.1
Choked	57	33.9
Burnt	8	4.8
Hair pulled	2	1.2
Sexual		
Infidelity	72	42.9
Sexual coercion	55	32.7
Unwanted touching	41	24.4
Sexually transmitted infections	41	24.4
Other	6	3.6
Financial		
Withholding money	72	42.9
Controlling decisions	25	14.9
Taking money	23	13.7
Other	6	3.6
Total reports of an incidence of abuse	**1 315**	

With regard to estimated frequency of abuse, 57% of participants had been abused more than twenty times in the past two years and 27% had been abused ten or less times. The remaining 16% estimated that they had been abused between 11 and 20 times in the previous two years.

6.4 Recognition of women affected by IPV

From the medical records 1697 RFE (presenting complaints) were documented and 710 diagnoses made during the preceding 24 months, when these women were experiencing IPV and attended the health centre. As explained in section 5.8, the reasons and diagnoses were coded according to the International Classification of Primary Care, which then allowed for numerical analysis. The top 15 RFE and diagnoses are presented in Table 3 and Table 4 respectively and represent 53.1% and 59.4% of the total RFE and diagnoses.

Table 3: Reasons for encounter (N=1697) in women experiencing IPV

	Reason for encounter	n	%
1	Follow up for hypertension or heart problem	218	12.8
2	Headache	72	4.2
3	Request for psychiatric medication	66	3.9
4	Backache	64	3.8
5	Follow up for diabetes	47	2.8
6	Sleep disturbance	42	2.5
7	Request for contraception	36	2.1
8	Dizziness, feeling faint, loss of balance	28	1.6
	Throat complaint	28	1.6
9	Cough	27	1.6
	Assault	27	1.6
10	Fatigue	23	1.4
	Feeling anxious / nervous / tense	23	1.4
	Follow up for psychiatric problem	23	1.4
	Pap smear	23	1.4
11	Nausea	21	1.2
	Feeling depressed	21	1.2
	Psychological symptom	21	1.2
	Bladder symptom / complaint	21	1.2
12	Request for anti-retroviral medication	19	1.1
13	Abdominal pain	18	1.1
14	Painful respiration	17	1.0
15	Vaginal discharge	16	0.9

Table 4: Diagnoses (N=710) made in women experiencing IPV

		n	%
1	Depressive disorder	63	8.8
2	Uncomplicated hypertension	39	5.5
3	Sexually transmitted infections	27	3.8
4	Acute bronchitis	18	2.5
	Tuberculosis	18	2.5
5	Cystitis/urinary tract infection	17	2.4
	Asthma	17	2.4
6	Acute upper respiratory infection	16	2.3
	HIV/AIDS	16	2.3
7	Pregnancy	15	2.1
8	Assault	14	2.0
	Acute / chronic sinusitis	14	2.0
9	Vomiting	13	1.8
	Type 2 diabetes	13	1.8
10	Partner behavior problem	11	1.5
11	Streptococcal sore throat	9	1.3
12	Gastroenteritis, presumed infection	8	1.1
12	Muscle pain	8	1.1
13	Tension headache	7	1.0
	Allergic rhinitis	7	1.0
	Anxiety disorder/state	7	1.0
	Boil/carbuncle	7	1.0
14	Constipation	6	0.8
	Vaginal discharge	6	0.8
	Syphilis	6	0.8
15	Bruise	5	0.7
	Suicide attempt	5	0.7
	Conjunctivitis, allergic	5	0.7
	Relationship problem	5	0.7
	Feeling nervous/tense	5	0.7
	Osteoarthrosis, other	5	0.7
	Allergy/allergic reaction NOS	5	0.7
	Headache	5	0.7

No-one said they came because of abuse. The reasons for encounter and diagnoses when compared to similar data from the general female population give clues to better recognition of these patients. Cough is almost always the commonest reason for encounter in primary care (Mash, 2006) and yet in this group of women it is tenth and is preceded by headache, psychiatric medication, sleep disturbance and dizziness. These are all clues to emotional difficulties / mental illness and clearly suggest that IPV should be specifically asked about whenever a mental problem is likely. Fatigue, feeling anxious, depressed and other psychological symptoms also occur in the top twenty reasons for encounter and strengthen the case that clues for mental problems should prompt a specific enquiry about IPV. Furthermore, those already on psychiatric medication or diagnosed with a mental problem should be asked about IPV.

Various complaints of pain: headache, backache, epigastric, abdominal, pelvic or genital pain and painful respiration were within the top 28 reasons for encounter. Both Flitcraft and Warshaw have found that health care providers circumvent the issue of abuse by prescribing pain medication. In this way they discharge their medical obligations, but don't square with the implications of what or why they are medicating (Randall, 1990). This supports my argument that the application of a biomedical approach is counterproductive in the treatment of a psychosocial problem. Pain is also a common presentation for mental problems.

Perhaps the prevalence of psychiatric medication in our sample is indicative of a similar biomedical pattern in response to emotional complaints, since Table 5 below reports very high levels of mental health symptomatology in our sample. Certainly it has been suggested that health care providers' prescription of analgesia or mild tranquilisers for IPV survivors is contraindicated because abuse victims are at risk for suicide and drug or alcohol abuse (Kurz & Stark, 1990). In this way, battering and its subtext of other destructive problems tends to escalate when health care providers do not diagnose and address abuse. In support of this argument, a recent Dutch study analysed 42 months of the electronic medical records of IPV survivors and compared them to the average female population of the Second Dutch National Survey in General Practice 2001. Pain, in all its manifestations, was revealed to be the most frequently presented health problem. In all age categories, IPV survivors consulted their family doctor nearly twice as often, and received three to seven times more pain medication (Lo Fong Wong et al., 2007).

Family planning visits for contraception may also offer a vital juncture for IPV screening, since they provide an ideal opportunity to discuss aspects related to the patient's intimate relationships. Moreover, this thesis contends that it is ethical practice to ensure that only wanted babies are brought into such a compromised family environment. Therefore termination of pregnancy where applicable (in first trimester), and / or sterilisation should be offered and discussed.

All patients who live with chronic diseases should also be screened. These include HIV, hypertension, diabetus mellitus, congestive cardiac failure and inflammatory bowel disease. Psychosocial issues, adherence to chronic treatment and control of chronic illness also present crucial opportunities for discussion about underlying issues / concerns.

Similar patterns of ailments are seen in the diagnoses of women affected by IPV during the previous two years in Table 4 below, showing a congruence between the reasons why women present and the diagnosed complaints they are then treated for, without much digging for underlying causes by the health care provider.

Table 4 shows that health care providers did diagnose depression but in most cases omitted to identify the cause and also didn't seem to recognise other mental problems. Yet as Table 6 reveals, when specifically asked about mental symptoms, participants identified a wide range of mental distress.

As described in Chapter Five, at the outset of the study we amended the protocol to take greater account of mental health issues. To this end we added a screening tool for mental problems to the protocol, the questions of which can be seen in Table 5 below, together with the numbers and percentages of responses to each question. The overwhelming majority of respondents experience one or multiple forms of mental problems illustrating the enormity of the mental health problems in women affected by IPV.

Table 5: Responses to mental problems screening tool

Issue	n = 168	%
Are you thinking too much / worrying?	137	81.5
Sleep problems	125	74.4
Feeling more tired than normal	124	73.8
Feeling sad or crying	120	71.4
Feeling anxious	96	57.1
Loss of interest or enjoyment	95	56.5
Experienced traumatic event	77	45.8
Suspected alcohol problem	31	18.5

6.5 Management of IPV survivors

Only 11 of the 114 medical records (9.6%) revealed that the patients' difficulties with their intimate partners had been identified by a health care provider in the 24 months prior to their identification and consent to participate in our study. Internationally, rates of inquiry into IPV by health care providers vary, although a systematic review shows the range to be between 13–20% of consultations (Hegarty, Taft & Feder, 2008).

The recorded management of these 11 patients is presented in Table 6. Although the management was relatively insubstantial, social issues were addressed in 7 patients, legal issues in 1 patient, psychological issues in 7 patients and clinical issues in 2 patients.

Table 6: Management of patients (n=11) previously identified with IPV

Management plan	Total											
	N	1	2	3	4	5	6	7	8	9	10	11
Social issues												
Referral to social worker	7	X	X	X	X		X	X				X
Referral to shelter	2	X	X									
Referral to Family and Marriage Society of South Africa	1		X									
Administrative procedure e.g. grant, referral letter	3							X	X			X
Legal issues												
Referral to Domestic Violence Court for Protection Order	2		X		X							

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Referral to police	1				X						
Psychological issues											
Referral to psychiatric nurse	1		*		X		*	*			*	*
Referral to psychologist/psychiatrist/ psychotherapeutic group	3	X						X			X	
Admission to psychiatric hospital	1						X					
Referral to marriage counsellor	1	X										
Psychiatric medication	7	X	#		X		#	X			#	#
Clinical issues											
Referral to medical officer	1								X			
Suture and dressing	1									X		
Medication prescribed e.g. analgesics	1									X		
Total number of items in management plan		5	5	1	5	0	3	4	2	2	2	3

*Already being seen by psychiatric nurse

Already on routine psychiatric medication

Recognition of women experiencing IPV is very low in primary care. Of the 9.6% who had been identified, scanty documentation in their medical records revealed inadequate management, primarily in the form of referrals. Recognition of the underlying issue of IPV was alluded to vaguely as "stress at home" or "social problem".

Women presented with a variety of RFE that should raise the index of suspicion for IPV: assault, headache, request for psychiatric medication, sleep disturbance, dizziness, fatigue, feeling anxious, depressed and other psychological symptoms. None of the women presented the problem of IPV directly. Altogether 14.6% of the RFE listed above were suggestive of mental problems, indicating that IPV should be specifically asked about in patients presenting with psychological cues. Furthermore, those already on psychiatric medication or diagnosed with a mental problem should be asked about IPV. Depression was the commonest diagnosis, but even in these patients IPV was not identified as an important trigger. Many studies have shown a strong link between depression and IPV (Duxbury, 2006; Campbell et al., 1997). No diagnoses of anxiety disorders were made, although the literature suggests that these should be common and the RFE suggest that anxiety was present (e.g. feeling anxious, dizziness, sleep problems) (Coid et al., 2003; Herman, 1992). Low back pain and backache are also associated with psychosocial stress, especially when chronic (Lo Fo Wong et al., 2007).

It is also clear from the RFE and diagnoses that women experiencing IPV are frequently attending the CHC with other chronic diseases such as hypertension, asthma and diabetes. HIV/AIDS was in the top 20 diagnoses and evidence suggests that women who experience IPV are at increased risk of HIV (Jewkes et al., 2010). Increased psychosocial stress from IPV may negatively impact on adherence to medication, self-care and control of chronic disorders. Other sexually transmitted infections were also in the top diagnoses. Opportunities for identification of women with IPV were evident in requests for contraception and pregnancy-related consultations. Interestingly injuries were 1.6% of RFE, although this would be the most obvious prompt to asking about IPV.

Clinical and legal issues were the most neglected aspects of care. Clinically, health workers should manage any immediate medical problems, and then pro-actively consider the possibility of STIs, HIV, pregnancy or the need for family planning. Health workers may lack a structured approach to the clinical issues in a woman with IPV. Health workers appeared ill-equipped to address the legal issues, despite evidence that women find this advice worthwhile (Joyner et al., 2007). Although many of the women identified were referred to social workers and psychiatric nurses the notes revealed that they frequently waited weeks and sometimes months to be seen.

The low referral rate to other sectors shows poor connectivity which is a term complexity theory has coined to describe lack of communication and interaction, here between the health care providers, community health centres and local psychosocial resources. Such ineffective collaboration between health care providers and other potentially beneficial resources is symptomatic of a lack of complex adaptive systems in the contemporary South African organisation of health. Yet the high rate of suspected depression and post-traumatic stress disorder in this sample as a whole highlights the need for effective psychosocial interventions during the critical window period. Psychosocial support has also been shown to be crucial to the improved health of traumatised individuals (Farrell, 1996; Sullivan, 1992) as a lack of post-trauma social support has consistently been shown to be a predictor of post-traumatic stress disorder and its symptoms (Ozer, Best, Lipsey & Weiss, 2003).

Inadequate referrals to existing government and non-governmental services prevents liaison between health care providers and the legal and crime prevention sectors regarding the implementation of the Domestic Violence Act (Parenzee et al., 2001). Significantly, it has been suggested that the lack of agency networking presents a major obstacle to the treatment

of IPV survivors in South Africa and that work pressure is often used as a defence because liaison would reveal the shortcomings of practice (Padayachee & Manjoo, 1996). Clearly, in the absence of policies, education and implementation, to support intervention, the response received by an IPV survivor is based on the idiosyncratic knowledge of the treating health care provider.

Here is a clear indication of the effects of the multiple barriers this thesis discussed at length in Chapters Three and Four (Henderson, 2001; Loring & Smith, 1994; Sugg & Inui, 1992; Sullivan, 1991). Survivors of abuse often report being victimised twice – by their abusers, and then by the health care providers at the facility where they seek help. Medical history is replete with IPV victims' experience of self-blame and the isolation of their victimization (Hoff, 1991). Indeed, the absolute lack of historical data on human abuse in social science and health literature speaks to its historical interpretation as a private rather than a public issue.

6.6 Conclusion

This chapter serves the first research goal of identifying the current nature of care offered to survivors of IPV in the primary health care sector of the Western Cape, and found a dismal state of affairs by analysing the thin pickings in extant medical records of IPV survivors who participated in the study, plus what they reported about their IPV experiences and prior treatment and actions in the initial interview, and subsequently in the follow-up interview. While 168 women with a history of IPV were identified, only 114 medical records were analysed because either the women had no recorded medical history at the site as they were coming for the first time, or their medical records were missing. Even within the 114 records, only 9.6% of participants had previously been identified as IPV survivors and the record-keeping of abuse was scanty and obfuscatory. Assistance both at time of identification and subsequent care was inadequate.

It is in this chapter that IPV survivors who participated in our study spoke most directly to us of their own experiences and feelings, through six cases studies selected for their illustrative value (section 6.2). Through our case studies we found how pervasively IPV impacts on the mental health of a survivor, potentially continuing to do harm even after the abusive relationship has ended (as seen in VM), and confronted the paradox of women remaining loyal and committed to abusive partners (very clear with NA and TM). This is the contradiction that so often confounds and frustrates health care providers, who tend to subscribe to the 'separation assumption' (seen in the case of CA) that separation of the

woman from the abusing partner is the only solution to IPV and will resolve all of the survivor's problems. We saw a difference in the prior treatment of these women as evinced by their medical records displaying suspected 'inhibitive helper responses' (see for example NA's records), contrasted with the 'facilitative helper responses' we utilised in our protocolintervention taken from the framework of motivational interviewing. Compassionate and constructive attention from our researcher impacted positively on survivors' mental health (in at least the case of TM). I drew on the stages of change theory whereby IPV survivors could be at pre-contemplation, contemplation, decision or action stages in a cycle of change in relation to the abuse. At all stages women experiencing IPV want recognition and ongoing support from health care providers, without pressure for a specific course of action. In this light, the case studies illustrated whether anything had changed within herself or within her circumstances since the first interview: all the case study women expressed a positive benefit from the protocol intervention if only at the pre/contemplation stages, while MP who was at the decision/action stage appreciated the concrete support and referrals – except sadly for a high-risk survivor SVD who did not return for the follow-up interview to reflect on the intervention's impact. The case of CA revealed another kind of risk, that of suicide, which was not assessed as part of the safety/danger assessment in the protocol.

In Section 6.3 we approached the lived reality of IPV survivors who participated in our study from a largely quantitative angle, and the results were displayed and interrogated in Table 1 'Safety assessment score' and Table 2 'Prevalence of different types of abuse'. The prevalence of a range of emotional, physical and sexual abuse experiences were revealed to be seriously high, and 68% of the sample were assessed as being in significant danger.

Turning to the screening and treatment of IPV survivors in sections 6.4 and 6.5, we again adopted quantitative methods in analysing the past 24 months of medical care: interrogating the reason recorded for why women had presented at the clinic (Table 3) and what their diagnoses had been (Table 4), and adding an extra dimension of mental health that was not present in the original protocol (Table 5). Bearing in mind that all the women in our sample were IPV survivors, health care providers at the sites had previously only identified 9.6% and these women had received care that was less than ideal, as quantified in Table 6 'Management provided for IPV when identified', including a low rate of referrals to other psychosocial agencies and resources (reflecting poor connectivity, to use terminology drawn from complexity theory).

From the quantitative and qualitative analyses used in this chapter, and juxtaposing the high prevalence of IPV and the serious health impacts and high risks experienced by IPV survivors which render it a major health issue, with the low-grade response of the PHC sector to IPV embodied in the low rate of recognition and poor quality of care found in our study, I conclude that such pervasive neglect of IPV care is tantamount to unethical health practice. This provides both a clarion call for the need for an IPV protocol intervention and a baseline standard of care to measure its impact against, the subject of Chapter Seven – which also builds on the theory of Chapters 3 and 4 in explaining why the state of affairs should be as sorry as it is.

CHAPTER SEVEN

PUTTING THE IPV PROTOCOL INTO PRACTICE

"When Kate first came I said to myself, she'll get a lot of pressure."

"I thought so too."

"I also thought so"

"I also thought so."

(Participants in focus group at end of urban data collection phase, November 2006)

7.1 Introduction

Moving from Chapter Six which presented and discussed the current standard of care for IPV survivors in the study sites (the first research objective), this chapter focuses on the second research objective: to determine the feasibility of implementing a published South African protocol for screening and management of IPV within local primary health care settings. This also involved looking at how the protocol should be modified to make it more feasible to implement in the local context of the Western Cape study sites, and providing the rationale for suggested changes. In order to address this objective, the chapter incorporates an appraisal of the South African primary health care context at a particular cusp in its transformation, that is, the nine months leading up to the inception of the Occupational Specific Dispensation in July 2007. In presenting the findings in this chapter, some results are presented quantitatively. However, it is the voices of participants, key informants, health care providers and the research team that dominate. The evidence I put forward is thus largely qualitative and provides a very different perspective to that provided by Wathen and Macmillan's "scientific review" (2003).

After an introductory look at the shifts within primary health care during the research period, findings related to the IPV survivors' experience of the interventions are analysed in section 7.2. I reflect on participant responses to whether they experienced positive benefits from the intervention in terms of being listened to; personal transformation; communication in the relationship with their partner; helpful information and referrals; diagnostic and medical value; and even if there was no change in their circumstances (sections 7.2.1 to 7.2.6), drawing on the stages of change model and motivational interviewing. Comments from participants who experienced no change after our intervention, and declared it "not that

helpful" or "not useful" are discussed (section 7.2.7). Participants' input on improving the protocol are considered (section 7.2.8), which besides problems with the length of the protocol interviews mainly had less to do with the protocol itself than with the need for ongoing support and other kinds of interventions. Participants' reflections on the safety assessment and plan that was worked out with each woman at first interview are discussed (sections 7.2.9 and 7.2.10). Besides drawing on participants' feedback comments, results are also presented quantitatively in this section. The change wrought in participants is measured by the extent to which by one month later they had carried out their own stated intended plans to improve their situations.

Having tried to establish whether implementing the research protocol is worth it in terms of the impact on IPV survivors, in sections 7.3 and 7.4 the chapter turns to look at how well it worked within the health care setting – which speaks to the feasibility of implementing it. In section 7.5 we examine how feasible and effective the protocol's referral section proved to be in the local context, and in section 7.6 we critique the safety assessment and plan part of the protocol.

The facility managers and upper echelons of the local district health system clearly supported our project, but we encountered significant resistance from health care providers to participating in the research study. In section 7.3 we look at structural or systemic barriers to providing effective care for IPV survivors within our research context and settings, which this thesis argues directly affected the feasibility of protocol implementation. A functioning comprehensive and holistic primary health care system such as that envisaged in South African policy, particularly the Health Care Plan 2010, is a prerequisite for addressing IPV effectively. But the South African health care system displays many features which are less than ideal, not least of which are underlying inequitous gender relations and sexism, also internalised by mainly female nurses, which lead to IPV being normalised and yet simultaneously stigmatised. The evidence is analysed within the following systemic categories: mechanistic organisations or living systems; role, workload and working conditions of nurses within PHC; morale amongst health care providers; racial tensions; lack of support and internalised oppression; desensitisation to emotional labour; normalisation of IPV; and stigma and prejudices surrounding IPV. Biomedical elements come to the fore in sections 7.3.1, 7.3.2, 7.3.5 and 7.3.6.

In section 7.4 we analyse the largely psychosocial factors explaining why health care providers proved resistant to participating in the study and to screening for cases of IPV as required by the protocol. In 7.4.1 the impact of IPV in health care providers' own lives and (in section 7.4.2) of biomedical discourse are scrutinised. IPV appears to be rather prevalent in health care providers' lives, and as much as any survivor if not even more, health care workers resist opening up about psychosocial problems they may have. Because unresolved IPV is then 'too close for comfort', they avoid identifying the issue among patients. In contrast, this thesis contends that those health care providers that work to resolve their own experiences of IPV are better equipped to help other survivors.

The goal of fixing what is wrong is a major element of the biomedical approach that pervades South African health care, which also accepts only physical and action change as real change. The 'righting reflex' of health care providers steeped in biomedical discourse gets in the way of identifying IPV and thus being drawn into trying to 'fix' an issue that is not amenable to a quick, one-off solution, where the patient seems to be stuck in an unchanging loop. In section 7.4.3 we probe reasons offered by health care providers for why they resisted getting involved in the research project, or avoided uncovering cases of IPV. Issues of time constraints, work overload, privacy issues in small communities, the nature of the patient/provider relationship and expected roles, and fear for personal safety are interrogated.

Going beyond the boundaries of the research sites, section 7.5 reflects the researchers' evaluation of the efficacy of the local referral resources harnessed as a result of prompting by the protocol (the IPV survivor participants' evaluation having been reported in section 7.2 above). Table 9 summarises quantitative data of the referral needs and actions undertaken for and by survivors as a result of the protocol interventions. We then examine the role that various referral resources can play in assisting the PHC sector to address IPV care, and limitations of these resources, all of which are under-supplied (particularly in rural areas) and over-stretched, and in some cases unavailable or dysfunctional. In this way we look at psychiatric nurses, psychologists, social workers, lay counsellors, alcohol and substance abuse services, battered women's shelters and NPO women's centres, forensic services, the police, Victim Empowerment Programme units, and the Legal Advice and Training Project. Some limitations of the Domestic Violence Act and of IPV survivors' utilisation of protection orders under the Act are discussed. While faith-based organisations could potentially be a referral resource, some ambivalence about this is expressed. Two innovative proposals are made: to use the Sarah Baartman Women's Centre in the Cape as a training placement for

student nurses, and the expansion of multi-sectoral rape forums to include IPV at sub-district level where all the role players from the private sector, NPOs, health, education, social services and justice work together.

Section 7.6 critiques the safety assessment and safety plan components of the protocol. Assumptions underpinning the protocol's safety assessment do not accord with the researchers' experiences, there are weaknesses in how accurately the tool measures the risk, the alignment between the motivation for doing the assessment and which questions are asked is probed, and problems with transposing the assessment into the South African context are raised. Some recommendations for improvements are made. While the concept of a safety plan, a few ideas within it, and especially the idea of a service to mutually work out such a plan with the IPV survivor, were very valuable, it is difficult to transpose a First World safety plan to the South African context and individual women's specific situations.

7.1.1 The context: primary health care in transition

The data collection started in August 2006 was mainly complete by July 2007, and so fell squarely within a deep and protracted period of organisational transformation within the primary health care sector of the Western Cape. Policy such as the 2010 Comprehensive Health Care Plan indicates that the development of primary care (district health system) is a long term process of transformation. Occurring within the active phase of implementing the 2010 plan, the challenge facing our project was that the feasibility of future IPV care depends to a large extent on how effectively the health system functions and how motivated and confident the personnel are to deal with IPV.

Key systemic changes within post-apartheid South Africa, which have caused a sharp increase in patient load, have characterised the context:

- Services, including medication, for all citizens earning up to R4 000 per month became free in the post-apartheid government. Therefore more people took advantage of the health system than might otherwise have done so, a welcome extension of health services.

- PHC used to be for minor ailments, but now is for extremely ill patients too. This is because its gatekeeper role has been insisted upon whereas previously people went directly to hospitals. Ninety percent of services were reallocated and "blended" at PHC level, 8% were allocated to secondary and 2% to tertiary services which, prior to 1994, had the lion's share of resources within South African health systems. A key

informant noted that these formerly privileged specialists are accused of failing to bring their expertise to the PHC level.

- Simultaneously, between 1994 and 2007, the South African health system lost many qualified nursing and medical staff to better salaries overseas.

So within the first 15 years of post-apartheid government, as patient numbers increased, so the staff component decreased. It was observed that the constant influx of patients needing care tires staff out and that the shortage of staff exacerbates the emotional strain of dealing with tragic cases:

> *"It's a bit like Alice in Wonderland – they have to run faster and faster just to stay in the same spot and after a while it just becomes too much" (Key informant interview, 2007).*

7.2 Participants' experience of intervention

An authentic sense of the value of the protocol is provided by the participants, and precedes a fine-grained analysis of the contemporary primary health context of the Western Cape. Quotes are made from the follow up interviews with IPV survivors a month after the intervention.

In total, 168 IPV survivors were interviewed at five rural and urban sites by the research team. In the protocol intervention, we discussed various plans and options with each woman, and recorded their intentions to take various actions. Where agreed with participants, we wrote referral letters to hospitals, social workers, psychiatric nurses, and NPOs. One month later, the same women were interviewed by different researchers. Participants were asked to reflect on how helpful they had found the protocol intervention, how they felt about their IPV situation now, how useful the various referrals had been, and whether they had acted upon their intended plans. The qualitative results discussed below, the quotations and the tabulated quantitative data, come from those follow-up interviews.

This section highlights the types of change that women experienced in terms of the stages of change model and motivational interviewing. Note how women shifted from contemplation to preparation, from preparation to taking action. On the one hand this section speaks qualitatively to the effect of the intervention and on the other hand to understanding the reasons for this effect. Here the inner personal transformation in the woman is understood to link to the external actions that she took.

Sections 7.2.1 to 7.2.10 collate the comments of IPV survivors about the protocol intervention by the research team, as recorded by different researchers using follow-up tools. The quotations are the researchers' formulation, when recording what the participants said. The section headings reflect the range of themes that emerged. If a participant indicated that she had found the protocol intervention helpful, she was then asked in which of the ways, reported in sections 7.2.1 to 7.2.6, she had found it helpful. Section 7.2.7 reflects comments from participants who did not find the protocol intervention helpful. Participants' contributions on how the protocol could be improved are given under section 7.2.8. Sections 7.2.9 and 7.2.10 are participants' reflections on the assessment of the safety of each woman and a proposed safety plan that was worked out with her based on the assessment.

7.2.1 Caring listening released bottled-up feelings

Certain communication styles / skills were found to be helpful. Being encouraged to tell their story and being listened to with genuine interest and care emerged as key features of the interview which participants valued. This echoes studies cited under section 3.4 in Chapter Three, which speak of IPV survivors' need for compassionate, uninterrupted listening (Limandri, 1987; Bauer & Rodriguez, 1995), and Chescheir's (1996, p.766) contention that a clear indication to patients that violence is not a taboo subject is in itself a vital therapeutic component of any intervention.

A common follow-up theme was well expressed by a participant who explained that she:

"found it very helpful to talk especially because she has been keeping it in for so long and it makes her feel helpless sometimes. Everything was much better afterwards and she even stopped being irritable with her child."

Some participants articulated that they never had the courage to talk to someone before, and be honest. Others described that it was the first time a health care provider had helped them with handling IPV situations better.

Many participants described the cathartic effects of having been able to pour their hearts out and be listened to, supported and understood:

> *"The protocol helped a lot. She felt that she could talk and cry and express how she really felt. She has been to social workers before but it is not the same."*

Another reported that she could not talk to anyone before and now she could unload with KJ. She felt she didn't have anything to hide because KJ was someone who actually cared. Follow-up researchers captured participants' descriptions of how good it felt to be understood and well advised, for example:

> *"[It was] especially useful to talk about painful experiences that she had kept inside for a long time."*

The opportunity to talk through difficulties and gain a different perspective was frequently lifted out as valuable. One explained that she is not someone who can normally talk, and would not have expected to be honest about her drinking problem, but she actually felt very relieved, like a burden had been lifted. Another stated that the first interview had made her think about her circumstances and she realised that for her daughter's sake, as well as her own, she should get divorced.

7.2.2 Personal transformation

The protocol intervention was found useful because it opened up awareness, enabling participants to see the discrepancies of their life and explore ways to achieve alignment with more hopeful solutions. Several participants expressed that the questions opened up a new world. One had not been aware that there were people who could help her. Another found it good to know that she can do something to change her circumstances.

Others describe feeling motivated to change their own behaviour. Motivational interviewing theory explains that the intervention led to increased readiness to change (importance and confidence) through empathic listening, reflection, and the provision of relevant information. Examples of participants' perceptions follow:

> *"... learned a lot, now knows how to handle her husband, no longer reacts when he fights with her ..."*

> *"... trying to drink less, now a week without alcohol – husband calmer too ..."*

"... could also talk about her future and it enabled her to stop drinking ..."

"... useful in motivating her to leave her boyfriend ..."

"... feels good about protocol – learnt that ... wrong to take her own life ..."

"... She had been an aggressive person in the past, but decided that aggressive acts like these were not worth it. They seemed a solution because she felt bad about herself. Now she is better able to withdraw and ignore him ..."

Participants described coming back for the second interview because the first had inspired them with hope and strength. They spoke of feeling stronger inside, having gained a positive attitude. Although the protocol was experienced as being too long for some, it was nevertheless judged resoundingly successful because being listened to by a caring, constructive health care provider enabled a great shift within themselves, as identified by participants.

Participants reflected that they appreciated being made to feel special:

"... long time since anyone looked after her so nicely and listened to her health problems in such a way ..."

"... good that sister examined everything so thoroughly ..."

"... thought at first that sister would discuss her drinking problem but discovered that sister was interested in her as a woman as a whole ..."

On follow-up, participants reported having taken action to improve the quality of their lives. For example one decided to terminate her pregnancy, another made the choice to be sterilised and another went to court and asked that her partner be put out of the house.

One participant experienced the protocol intervention as having affirmed her human rights as a woman:

> *"It was difficult and embarrassing to talk about bedroom matters in detail, but MA told her it is not necessary for her to be put through these things [abusive behaviours by partner], and she opened up to her and could then be honest."*

Another participant informed that the researcher had helped her understand that she has rights, before that she had felt lost.

7.2.3 Opened up communication in the relationship

For some women the intervention enabled them to communicate more openly with their partner about the problem of IPV. In some cases this led to a change for the better:

> *"... the situation at home has improved very much, the husband is even working in garden and helping the children with homework – never before ..."*

> *"... felt it was time everything was brought into the open so a solution could be found – he needs to be helped ..."*

Other women described that their partners had changed their behaviour, for example, as a result of a letter from one of our researchers, one woman's partner did not isolate her from her friends anymore. Another noted changed behaviour in response to a protection order.

However, one rural participant stated that while she had found the protocol intervention useful, she has tried to implement the advice but can't get her husband to change, and she feels it is not worth trying to fix a marriage if only one person is trying.

7.2.4 Gained helpful information and referrals

Women described finding it useful to learn about all the different people who could help them. Many voiced relief to have learnt about how to apply for protection orders at the Family Violence Courts and some found it helpful to realise that when their husband hurts her again she can go to the social worker or police.

Some participants had found their referral appointments very constructive. Some mentioned that the referral letter had helped significantly. One stated that, *"before Philippi court had refused to help her, but with letter they gave her a protection order, now she feels happy.*

One participant explained that although there was no real change in her situation, but she is approaching it more positively and now knows where to find help if she needs it.

7.2.5 Diagnostic and medical value

A number of participants appreciated having their health as women being taken seriously, particularly since many aspects were examined which are not usually dealt with. One valued having her anxiety condition diagnosed, another was impressed to get a follow-up appointment at Tygerberg because her local community health centre had been trying for long to get her a hospital appointment without success. Many felt relieved to have testing for sexually transmitted infections and HIV attended to, and to know their status.

7.2.6 Useful even though no change in circumstances

A number of participants reported that the protocol had been useful even though there was no change in his behaviour, nor in her circumstances. Another stated that she valued being part of the project since although there was no apparent change, she was motivated to enlist her children's help in finding solutions. This suggests a shift in their self efficacy and from being stuck or ambivalent to looking for ways to change the situation. It seems their readiness to change had shifted. Perhaps this is also part of personal transformation resulting in increased motivation to change or look for a solution?

Overwhelmingly, participants experienced the protocol intervention in itself as useful, with 76.8% of them reporting they were "feeling much better" (63.2%) or "a little better" (13.6%) after the intervention.

Table 7: Usefulness of protocol intervention

Participants' response to intervention	%	N
Feeling much better	63.2	79
Little better	13.6	17
No change	20.8	26
Not applicable	2.4	3
Total	100	125

Next I look at comments from participants who reported experiencing no positive benefits from the protocol interview.

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7.2.7 Not really that helpful, not useful

The following are examples of participants' negative experiences of the intervention. One participant stated that it had helped a little but she still gets no money from her husband and he still drinks. She was referred to three places, but had not gone to any yet. Similarly a participant had not got herself to referral appointments at the Saartjie Baartman Women's Centre, describing herself as too weak and scared to make decisions. Another said she was happy when she left the interview but the next day everything was the same. Digging up the past had upset another. One complained that she felt very frightened after the interview and is silent on the issue. Perhaps this is the best course of action for her anyway, in order to conserve energy, and at best, strategise?

7.2.8 What would have made the protocol better?

Some participants wanted their partner to be seen by the IPV specialist too, so that it doesn't appear that only women need help. Some felt disloyal discussing partners behind their back and requested couple counselling. Many wanted this facility to be available at their clinic in an ongoing way, particularly since many complained that they had waited very long for their turn and that the protocol (first interview) was too long. Others identified needing help with filling out the protection order application form.

Mostly however, the women didn't find the interview too long when they were in their own interview, where they appreciated the focused and comprehensive attention. The problem was the long wait before their own interview.

Participants at Site A were keen for a support group and one woman in particular was willing to facilitate it. At other sites participants emphasised that they would appreciate being able to talk with other IPV survivors. Perhaps the co-researchers commitment to working proactively with the participants had catalysed a collective response which runs counter to the norm of patriarchal domination. One could also interpret their desire for a support group as the need for affirmation and exploration of a liberating matrix of values to inform a new humane standard / code for behaviour. Thus the research process had elicited the following dialectical tension: these women had been immersed in a socio-cultural context where IPV is normative. However, now that their consciousness had been raised, they no longer found that acceptable.

Participants at sites C, D and E expressed that they would like to be able to talk to other women who have been through the same situations, to make friends and learn from them. They wanted a network of support groups to be set up in their area too.

7.2.9 Safety assessment

The safety assessment was useful for the following range of reasons:

- made her feel better after hearing that it was wrong to be forced to have sex;

- opened her eyes as she learnt that he should not hurt her like that;

- confirmed her experience of him as a dangerous person;

- saw how dangerous her situation was and decided to get help (an interdict);

- made her aware of her own faults as well;

- after this she felt she could make a case, or get help; and

- she went to get an interdict.

Thus it seems the safety assessment provides feedback on how one's situation is perceived relative to a different norm. This enhances the discrepancy between what is normal and one's current situation, which can increase motivation to change.

7.2.10 Safety plan

The safety plan sets out everything that should be taken if the participant has to leave home in a hurry. It also enables her to plan ahead to protect her safety and that of her children. Participants cited many reasons why they found the safety plan useful, the range of which is best represented by the following selection of quotes from researchers' transcriptions of follow-up interviews*:*

- *"She is very afraid as feels he could kill her. Good to discuss what to do and make a plan – not tell him anything and just leave."*

- *"Told her things she did not know. She did what was discussed. Now feels reassured and knows she can find all her important documents in an emergency."*

- *"In the past always had to scramble around and look for things in an emergency but now all her things are in one place."*

- *"Interdict, which was part of her safety plan, helped as he spent a week in jail and now he leaves her alone."*

- *"Got emergency numbers from researcher and is now able to think and plan ahead."*

- *"Never realised how important it was to plan ahead and had never considered her safety in such ways."*

- *"Made aware of House of Hope – a happy discovery".* (House of Hope is a shelter for battered women).

- *"Gave her confidence and courage to seek help and now she keeps the documents with her."*

- *"Useful to discuss her safety. Alone in a large house and neighbours far away so trying to get a phone installed."*

- *"Learnt a lot and did what is suggested."*

- *"Good to gain all that information – has taught her children so they can be aware too."*

- *"Felt the safety plan was an opportunity to make a decision about changing her situation."*

An intervention plan with actions specific to each participant had been worked out at first interview. Participants were asked whether they had found each intervention action helpful, on a scale from "very helpful" to "harmful", and catering for "don't know". No-one found any intervention actively harmful and remarkably high percentages of participants found the actions "very helpful" or "helpful", the lowest being 57.2% of 7 participants referred to an NPO for legal advice found that useful, to the highest being 93.8% of those 16 that did find it useful to lay a criminal charge. See Table 8 below.

Table 8: Usefulness of interventions

Intervention	N	Very helpful		Helpful		Unhelpful		Harmful		Don't know	
		n	%	n	%	n	%	n	%	n	%
Safety assessment	106	31	29.2	54	50.9	6	5.7	0	0.0	15	14.2
Safety plan	102	33	32.4	44	43.1	9	8.8	0	0.0	16	15.7
Protection order	28	14	50.0	9	32.1	4	14.3	0	0.0	1	3.6
Going to NPO for legal advice	7	2	28.6	2	28.6	1	14.3	0	0.0	2	28.6
Going to NPO for counselling	12	5	41.7	4	33.3	1	8.3	0	0.0	2	16.7

Going to psychiatric nurse	28	13	46.4	13	46.4	2	7.1	0	0.0	0	0.0
Going to social worker	23	6	26.1	10	43.5	3	13.0	0	0.0	4	17.4
Laying criminal charge	16	5	31.3	10	62.5	1	6.3	0	0.0	0	0.0

Thus, the total percentage of participants who found the intervention "Helpful" plus "Very helpful" were:

Safety assessment	**80.1%**
Safety plan	75.5%
Protection order	**82.1%**
Laying a criminal charge	**93.8%**
Going to NPO for legal advice	57.2%
Going to NPO for counselling	75.0%
Going to psychiatric nurse	**92.8%**
Going to social worker	69.6%

Women described finding it useful to learn about all the available services and resources. Many voiced relief to have learnt about how to apply for a protection order at the Family Violence Courts, some having gone ahead and got one between their first and follow-up interviews. Also some found it helpful to realise that when her husband hurts her again she can go to the social worker or police.

Some participants had found their referral appointments very constructive and mentioned that the referral letter had helped significantly, for example:

> *"before [the] Philippi court had refused to help her, but with [the] letter they gave her [for] a protection order, now she feels happy".*

Another explained that although there was no real change in her situation, she is approaching it more positively and now knows where to find help if she needs it.

Table 9: Adherence of women to plans made by 1-month follow up					
	Intention at first interview		**Reported action taken at 1 month**		**Percentage taking planned action**
	N	**%**	**n**	**%**	**%**
Wants HIV test	56	45.2	31	25.0	55.4
Wants rapid plasma reagin test	25	20.2	10	8.1	40.0
Wants pregnancy test	6	4.8	10	8.1	100.0
Intends to obtain a protection order	28	22.6	28	22.6	100.0
Intends to lay a charge	19	15.3	16	12.9	84.2
Went to NPO for legal support	15	12.1	7	5.6	46.7
Went to NPO counselling	32	25.8	12	9.7	37.5
Went to psychiatric nurse	58	46.8	28	22.6	48.3
Went to social worker	24	19.4	23	18.5	95.8

Remarkably, 100% of participants who articulated intending to get a protection order, had made the application by the time of follow-up interview. Similarly notable is the fact that 84.2% went ahead with their intention to lay a charge while 95.8% went to the social worker.

It was equally of importance that 100% of those who had intended to have a pregnancy test, did so. In fact, an additional number of women had a pregnancy test in the intervening month suggesting that their discussion with co-researcher at first interview had alerted them to the risk of unwanted pregnancy. This may indicate that the intervention had reminded them of their capacity to retain control, by taking responsibility for this aspect of their quality of life.

7.3 Structural barriers affecting care for IPV in health care setting

Patriarchal themes which are pervasive in diverse socio-cultural contexts are prevalent in the personal and professional worlds of health care providers and patients alike. In Chapter Three section 3.4.2 we examined literature on barriers for IPV care. Here we reflect what emerged in the course of our research about structural and systemic constraints preventing effective care for IPV survivors.

In *Spiral of Entrapment*, South African authors and activists, Ludsin and Vetten (2005, p.45) point out that the optimal set of conditions needed to assist women to either stop the violence or successfully leave their partner include:

- a social environment that does not tolerate abuse;

- an efficient criminal justice system which promptly protects battered women's safety;

- service providers who query the cause of battered women's injuries and/or emotional distress;

- access to a range of services – particularly in emergency situations;

- access to alternative accommodation;

- independent means and economic resources or, where these do not exist, government social security schemes;

- supportive family, friends and work colleagues; and

- service providers always intolerant of abusive conduct.

They conclude (as we are about to see) that *"the happy coincidence of all these factors in individual women's lives is anything but guaranteed"* (Ludsin & Vetten, 2005, p.46).

7.3.1 Mechanistic organisations or living systems?

A functioning comprehensive and holistic primary health care system such as that envisaged in South African policy is a prerequisite for addressing IPV effectively. But the South African health care system employs management and human resource approaches that treat people as cogs within a delivery machine, which will mitigate against recruiting, retaining, training and supporting staff to provide the holistic and comprehensive primary health care envisaged in the Health Care Plan 2010.

Conceptualising organisations as living systems or as machines is valuable when one is contemplating how to initiate change within them. Such concepts provide alternative grids against which the health system can be evaluated. Complexity theory is promising since individual potential for initiative and autonomy is viewed as both a strength and inherent component of the system. Complexity theory helps us to understand how unpredictable change and innovation are in an organisational system by giving us the theoretical matrix to address alternative modes of functioning.

Importantly, not all mechanistic structures are completely dysfunctional. They work well for the functioning of routine chores, or of things that need to be controlled in a very routine way. But in the health system, mechanistic structures are over-emphasised and used for the wrong purpose. If you want innovation, creativity, change, adaptation, flexibility, it can't be achieved by imposing a machine-like approach on the organisation. In any case living systems are there, just hiding out.

One example of a mechanistic managerial approach is provided by the relatively new Staff Performance Management System, a source of much dissatisfaction amongst health care providers. The Staff Performance Management System requires annual categorisation of 60% of staff as average, 20% above average, for which they receive a linked salary increase, while the facility managers must rate 20% of staff as performing below average. Many find it inherently unfair, particularly since they are coping with excessive workloads and feel deserving of reward, yet only 20% can be lifted out, and 20% are humiliated by being found below par. The facility manager explained that she finds it impossible to do this assessment fairly. Many staff members are resentful and she noted the marked stress and interpersonal tension annually at appraisal time, making her task as manager, striving for a functional health team, even more challenging. Arguably, the mechanistic nature of the Staff Performance Management System, demoralises health care providers, rather than motivating and encouraging staff.

A key informant discussing the Health Care Plan 2010 voiced concern about two points, firstly, "*to use the same ... human resources that we're having at the moment ... it's going to need a total switch of their understanding of how it can work*" and secondly, *"they [policymakers] think there is going to be a magic wand and then everything will fall into place! ... things should really start getting into place already."*

When challenged by the concern that nurses are very scarce and are already handling many tasks the health system manager responded that this was:

> *"... obviously a challenge that will have to be dealt with – the recruitment, training and retention of the workforce. There is a whole human resources plan that goes with it. The human resources, infrastructure and finance plans are the flesh on the Health Care Plan 2010's bones."*

Here is evidence of the concerns raised in the literature review, namely that in South Africa, policies look good, but implementation thereof disappoints. This thesis argues that the layout of the comprehensive service and human resources plan is unhelpfully mechanistic since it conceptualises staff, skills required, and training needs as components or cogs within the primary health service delivery machine. The data collection phase was completed just before a wave of nursing strike action of unprecedented proportions which culminated in the dismissal of striking nurses. Shortly thereafter, the Minister of Health announced major salary increases for clinical nurse practitioners. Chapter Four investigated the punitive nature of the nursing environment, which this national drama demonstrated. In sections 7.3.2 to 7.3.6 below we look at what emerged in the course of our research about the impact of the nature of the health care and particularly nursing environment on the capacity of the system to provide adequate IPV care.

7.3.2 Role, workload and working conditions of nurses within PHC

A fundamental premise of the Health Care Plan 2010 is that every patient who presents at the PHC sector will be seen by a clinical nurse practitioner. Difficult cases will be referred to doctors. A barrier to overcome is that IPV survivors, in England at least, identified *doctors* as the individuals they would most like to talk to about their situation (Rodriguez et al., 1999; Gerbert et al., 2000). This may reflect the relative actual and perceived status of nurses and doctors within the health care system and society more broadly.

A senior manager within the Cape Town Metro District Health System commented:

> *"The challenge is to break down the traditional doctor/nurse stereotype completely. In primary health care the nurse is the most important person: she is responsible for managing facilities, for implementing programmes and for the hands-on-work of diagnosing, treating and following patients up. The doctors' role is now to train and support nurses."*

This senior manager's idealism seems undercut by views of key informants who find management's expectations of nurses unrealistic:

> "W*e are asking generalist nurses to be specialists in everything and we don't have enough nurses to start with."*

> *"Nurses are required to take on a lot of responsibilities that earlier would have fallen outside their scope of practice ... furthermore, they are expected to address psychosocial issues which previously would have been quite acceptable for them not to address. Therefore, they are supposed to approach patients holistically, but they don't have the wherewithal."*

A key informant local medical anthropologist points to the nub of the matter:

> *"Nursing and medical staff are trained more and more to be sensitive to the patients' needs and things like that, but the moment they get into the reality, it becomes untenable for them because how empathetic can you be if you spend seven minutes with the patient? Then it is just the disease or symptom that is sitting in front of you and that is what you deal with."*

This is a vital point underlining the argument made about the hegemony of biomedical care in section 4.5.2 of Chapter Four. Training and subsequent practice has remained so task- and result-oriented that clinical nurse practitioners are struggling to provide a patient-centered integrated care approach – which has significant implications for the provision of IPV care. Effective care for IPV necessitates a humane and holistic response. If you are asking health care providers to be responsible, aware and ethical they also need to be treated like that within their working environment. This is highly relevant in the field of health where the archetype of the wounded healer predominates. Personal growth is a key matrix for developing healthy staff.

An emerging theme during the doctoral process was an awareness of the irony that the IPV survivor's relation to her perpetrator mirrored at a number of levels, the plight of the health care provider, especially nurses, in relation to their working environment. Chapter Four dealt with this issue in some depth. A sophisticated understanding of internalised oppression can thus be used to explain why health care providers resist assisting IPV survivors. Trapped within the health care system, nurses' powerlessness mirrors that of the IPV survivor. They may wish to leave and work in an organisation that is more caring and supportive, but like many of the IPV participants they are also financially dependent on the abuser. Another parallel is that health management imposes huge workloads on nurses and tends to be constantly negative about their performance.

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The extent and variety of social problems, and how they impact on human health, can be very draining for perceptive health care providers. Focus group participants at Sites C, D and E noted that compassion fatigue contributes to secondary victimisation of IPV survivors. A family physician commented:

> *"One must understand that health care providers work very long hours into the night, and when they see another drunk person that has been assaulted, it is very difficult ... often theatre staffs' reaction was ... 'Are you stupid to stay in this relationship?'"*

Clearly the Health Care Plan 2010 envisages a role and workload for nurses that neither their biomedical training nor the overstretched and understaffed PHC system can realistically cater for. As we see next, this cannot but add to the prevailing morale problems.

7.3.3 Morale amongst health care providers

This study provides a snapshot of a particular period of the district health system, namely August 2006 to July 2007. Morale was at its lowest ebb. As the study ended, the exploitative dynamic described above was transformed by the inception of the Occupational Specific Dispensation (OSD) in July 2007 which significantly boosted pay structures for clinical nurse practitioners. In fact, the total change of scene, from data collection to write up, graphically depicts the transformative milieu outlined in 7.1.

The programme manager of Women's Health for the Boland/Overberg district had this to say on the subject of morale:

> *"No-one is trying to make a secret of it. Morale is low, terribly, terribly low ... much more so in the case of nursing staff ... the big issue is that everyone thinks that nurses are underpaid ... money is a big, big problem ... A nurse has to be multi-skilled. She is responsible for ... a large proportion of the doctors' work and they [nurses] are not compensated for it."*

> *"With such a shortage of nurses, they say they will pay you extra if you go and work on such and such a shift. So at the end of the day, they are so exhausted and burnt out ... morale is very low – all the nurses."*

A disgruntled entry in my field notes of 13 July 2007 speaks to my perception of other nurses' lack of pride in their professional identity:

> *"We had to run after the nurses to fetch them for a training session that had taken months to organise and was to assist them with knowledge about referral resources. Then, straggling in 15 minutes late, they just sat at the back in a huddle and didn't ask any questions. I wondered whether all the effort necessary to coordinate this event had been worth it. Once again felt let down and betrayed by my colleagues, ashamed at some level of being a nurse."*

It also speaks of my own struggles with morale.

In sum, over the research period, morale was at an all-time low among nurses, which may not be fully ameliorated by the pay increases implemented in July 2007. Demoralised nurses cannot rise to the challenge of IPV care, which is perceived as yet another unreasonable demand.

7.3.4 Racial tensions

In this post-apartheid 'rainbow nation', our working context is typified by multiple racial issues and dynamics. The theme of interracial mistrust was submerged for the most part, but surfaced powerfully during the following key informant interview. Her views were all the more astonishing for their inaccuracy, given how directly they contradicted our experience of recruitment at her community health centre:

> *"Only black doctors can probe into a black person's problem ... they would make time because they understand the patient's language and customs. They understand everything ... you know, black to black."*

Her response to my query therefore about the very low screening rate by doctors at her facility was that it wasn't because they didn't want to. It's because of racism and the situation that they are working in:

> *"Black doctors are disadvantaged in this manner that they will ever be inferior ... no, it was not a happy working unit, as it is not now."*

This unhappy emotional climate seems to be reflected in the physical environment. The co-researcher for this site described it as:

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> *"… neglected, smelling, with blood in the passages, especially over weekends. The patients' toilets were filthy, with flies all over."*

With regard to staff / patient racial dynamics, in a focus group at Site C, when asked whether health care providers detect that patients are struggling with abuse problems, a midwife responded:

> *"It's there, but with most of the patients … firstly I am a white woman and what have I got to do with anything? So alcohol and domestic violence go hand in hand. So she is bruised, she is in labour – most probably because of the violence! If I ask, "who hit you like this" she says nothing."*

Here the health care provider's indifference, as well as her assumptions and stereotypes produced by a racialised society, present a dramatic barrier to the potential for this nurse to provide beneficial attention to such IPV patients.

Hence we find the manifestation of racism among health care providers affects the quality of care received by black IPV survivors, and racialises perceptions of which providers are suitable to treat whom.

7.3.5 Lack of support and internalised oppression

A senior specialist for gender-based violence research at the Medical Research Council speaks to her own origins as a nurse:

> *"The work environment for nurses is not very encouraging, doesn't have the support, doesn't encourage you to be better at what you are doing – that is why we all left."*

Other key informants raised a number of concerns such as the high levels of criticism observed towards nurses, noting that nurses get very little emotional support for the things they have to deal with. The programme manager for Women's Health in the former Boland-Overberg district speaks from her own experience:

> *"Work satisfaction as a nurse is tenuous because one doesn't feel recognised. There is a lot of neglect."*

Neglect produces neediness. An intern psychologist working in the former Boland-Overberg district commented that a lot of nurses have emotional problems to deal with and request referral. She also noticed that nurses tend to be their own worst enemies. Instead of supporting each other, they frequently undermine each other. This is a blatant manifestation of internalised oppression (Chesler, 2001).

A facility manager commented that although the staff support each other in times of crisis, with regard to their own IPV problems:

> *"Nurses don't talk to colleagues because they fear a breach of confidentiality ... Nurses can't trust each other to be genuinely supportive."*

Another facility manager made the same point:

> *"Personnel are not as professional as they are supposed to be. So the minute you say something, you are afraid that ... it's going to spread through the facility."*

When asked about her view on the culture of nursing, a key informant from the NPO sector said she had observed many nurses breaching client confidentiality, for example shouting to each other about patients' HIV status. These disturbing reports are substantiated by participants' articulated fear of disclosure lest confidentiality is breached.

This seeming inability to provide genuine support substantiates arguments made in Chapter Four about internalised oppression in nursing. A glimmer of this at managerial level was evident when a nurse facility manager was very keen for psychology and social work students to work in her rural community health centres, but would not entertain a similar placement for advanced psychiatric nursing students, whom she appeared to undervalue. Yet, the area she was responsible for servicing was a drastically under-resourced rural area where psychiatric nurses were in short supply. Perhaps she did not feel up to the time and effort for supervision they would require from her as senior nurse manager in the district?

As explored in Chapter Four, what the nurses' working environment does encourage is Foucauldean self-surveillance (Foucault, 1973):

> *"Nurses police themselves more than any other profession I have ever seen. And I think it probably has a lot to do with the training and experience they have as they go through the system."*

Overloaded and distressed nurses receive little recognition and affirmation, and offer each other little support, if not actively undermining each other. They are then hardly in a position to offer holistic caring to others, as would be required to deal with IPV issues.

7.3.6 Desensitisation to emotional labour

In Chapter Four section 4.5.1 'Cultures of care versus cultures of control' we explored the concept of emotional labour and its relative absence from health care work worldwide. We encountered the same lack in doing the research for this thesis.

The historical lack of mentoring within South African nursing reflects a mechanistic management style but also, a lack of aptitude for authentic emotional engagement. The nurses who arrive in the profession with this ability are hard-pressed to retain it, and certainly there is minimal scope for developing it:

> *"From training days onwards, nurses are warned against becoming emotionally involved with patients. Subtle messages are sent out that there is absolute danger there … in caring too much you are exposing yourself. You are not going to be strong enough to cope"* (Key informant interview).

Another key informant explained that local medical students are merely told in the first year that they must be debriefed to cope with the emotional effects of their work, and that is the end of any such debriefing or emotional containment thereafter. This is particularly concerning given the range of traumatic scenarios that health care providers continually deal with. In a focus group, a family medicine specialist raised how the staff shortage exacerbates the emotional strain of tragic cases:

> *"A while ago we (doctors and medical students) walked into the local district hospital children's ward and there was a little girl sitting with her head against the cot. She was sobbing. She had been raped the previous night. And in the next cot was a neglected little boy who had been admitted for a place of safety and further on there was another little boy whose parents had not come to fetch him for the past five days*

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since discharge. Next bed a boy assaulted ... so I just wonder how the young students cope?"

Not only is emotional labour not claimed as part of the work expected of a health care provider within a biomedical approach, the message conveyed is to shut one's emotional responses down and no help is offered for the inevitable emotional traumas providers must encounter in the course of their work. To add insult to injury, signs of distress are perceived as weakness, or "not coping". They would thus distance themselves from empathy with IPV survivors and resist engaging with an emotionally uncomfortable arena.

7.3.7 Normalisation of IPV

As a product of patriarchal consciousness, IPV seems to have become largely normalised within South African society. Speaking from her own experience from within Xhosa community, the nurse researcher who did first interviews at Site A explains:

> *"With Xhosa people ... they see it as a normal thing to be beaten by a husband or shouted at ... or for a husband to demand sex anytime, anyhow, without a condom. And for a husband to tell her – 'I have got another girlfriend. I am going to that girlfriend now.' And for a husband to disappear for the whole weekend or week and come back again without apologising."*

The only health care provider from Site A to participate in the focus group that followed the data collection period, contributed as follows:

> *"In (Site A) you mostly see the assaults – women stabbed – especially on weekends. But the problem is, those women don't want to disclose, and (the nurses) don't have time because they are working in trauma ... Then if you've got that little time, and you ask what is happening, yes, this woman will tell you, my husband stabs me for money or what. The problem is, this woman is depending on this man, so she doesn't want to take the case further. Because the fear ... she is going back home to stay with this husband. So it's really difficult for them. And the husbands are also very alcoholic. Weekends ... it's a disease. You can't say anything."*

As key informant, the facility manager of Site A picks up on a sinister dimension of how this affects patients' need for health services and the service they get:

"Our custom is like that – if the boyfriend is hitting the girlfriend it shows love – it is an old thing."

She asserted that in the face of this commonly believed myth, health care providers give up. A psychiatric nurse speaking to his experience with patients at Site B, provides an example of her point:

"They don't see it as abuse. And for me, having to see all these people and explain it – it's very tiring ... because for some people, having a 'klap' [smack] from a husband now and again is quite normal ... It's strange, but some people will come and complain that their husband stopped hitting them. Something must be wrong!"

A domestic violence specialist working in the NPO sector, elaborates on the apathy displayed by service providers towards IPV:

"The same complaints that abused women have around nurses, same with police, legal system, businesses, employers – there is just this whole attitude of 'well, it happens'."

Internationally but particularly in South Africa, violence characterises and is constructed as part of normal male/female relations, to the extent that IPV is even offered as evidence of the perpetrator's depth of feeling. So why would health care providers try to recognise and intervene in a problem that viewed by many not as a problem but as 'normal'?

7.3.8 Stigma and prejudices surrounding IPV

Despite the paradoxical relationship between stigma and normalisation of IPV, surprisingly, they are not mutually exclusive. Deacon explains that the process of stigmatisation fosters an illusion of control and immunity from danger at both individual and group levels, as it distances people emotionally from risk (Deacon, Stephney & Prosalendis, 2005, p.23). Such socially constructed representations lead to discrimination and the reproduction of other structural inequalities by those empowered to do so:

"The powerful nature of dominant group 'othering' in a society can override other representations and even cause widespread self-stigmatisation."

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Thus stigma should be understood as a social process embedded in social power relations (Deacon, 2006, p.421). Symbolic stigma which refers to the process of othering, blaming, shaming, is relevant to IPV.

Operating unconsciously, there seems to be an aspect of personal blame, particularly since not all women experience IPV, so survivors are especially to blame. A facility manager comments on the "definite stigma" linked to IPV:

> *"Many times people are not honest and open about it because abuse draws shame on a person."*

Indeed many health care providers reported that *"patients don't raise the matter".* In fact, it transpired that communities tend to be unsupportive towards women experiencing IPV. On follow-up, participants described being sabotaged and undermined by their husband's family, demonized by churchgoers, judged, disrespected and badly treated by those who could be supportive. In the rural communities, participants expressed fear of exposure since the state of people's marriages is top of the gossip list. Inevitably, this leads to secrecy and silence as a defence against the shame, and resultant pain, of exposure.

The extensive stigma around IPV seems inextricably interconnected to the secondary victimisation that many IPV survivors experience. An NPO social worker asked why a woman victimised by a car accident is treated more seriously then if she has been cut open by her husband:

> *"Is that how you pass judgment on how the woman got her injuries? ... how does that explain the so-called medical approach?"*

Certain health care providers expressed finding this a delicate, difficult issue because it is so private and personal. Some admitted to discomfort around asking the screening question, "How are things going in your relationship?" Where the assault had caused obvious physical trauma, they found it easier to ask.

Health care providers voiced fears that their intervention would open a can of worms they felt unable to cope with and did not want to feel responsible for (akin to the 'Pandora's box'

problem referred to in Chapter Three section 3.4.2. Some anticipated that the intervention would produce a homeless mother and children. Here we have a clear blend of conscious concerns and unconscious projections that did not match our experience of the participants in the study. In reality, only two of 168 women fled their home as a consequence of our intervention.

Note the deep-seated prejudice revealed in the following comment made by a health care provider during a focus group. It reveals a cruel twist for materially privileged women in abusive relationships accentuating their social isolation:

> *"When you look at her you will never say that she has got these problems at home ...*
> *looks like a well-off person."*

The stigma linked to IPV work tends to permeate the culture of health care provision. In the US, physicians expressed that treating IPV was "not respected" by their peers, nor was it "the way to get ahead in the profession", nor was it the source of prestigious research awards and other support:

"In telling and often poignant ways, health care providers [committed to providing care to IPV survivors] identified their own marginalisation among their professional peers with the way in which family violence victims were being marginalised as patients" (Cohen, De Vos & Newberger, 1997, p.S24).

Although supposedly part of the 'normal' fabric of women's lives, paradoxically IPV survivors are also stigmatised: it is shameful to experience IPV, blame attaches to the survivor, and various prejudices about IPV survivors abound, leading health care providers to avoid raising or dealing with IPV.

The systemic barriers to effective IPV care set out above came into play in trying to conduct our study, emerging partly as a resistance against implementing the research protocol. In section 7.4 we examine psychosocial factors which we identified as coming into play in this resistance by health care providers to using the IPV protocol and so possibly identifying cases of IPV which would then need their attention.

7.4 Factors limiting health care provider recognition of IPV for the study

Resistance proved to be a major phenomenon throughout the data collection process, as evidenced by the difficulties recruiting co-researchers as well as participants, which in turn resulted from most health care providers avoiding involvement in our research process. Our experience throughout was that while health care providers were almost daily reminded and motivated to screen, only some health care providers remembered to screen and refer some of the time.

7.4.1 IPV in health care providers' lives

In Chapter Three section 3.4.2 'Barriers to providing care for IPV' I reviewed international literature which looks at the prevalence and impact of personal experience of IPV on health care providers' ability to identify IPV and provide adequate care for survivors. Rodriguez et al. (1999, p.470) report that 12% of physicians surveyed in California had experienced physical abuse from an intimate partner or feared for their safety as an adult. This did not vary by physicians' specialty, but twice as many female than male physicians reported experience of IPV. This phenomenon is clearly far more prevalent than the international community has been aware of (Keeping it Secret, 2007). Key informants for this thesis, facility managers, explained that a significant percentage of their staff live with IPV-related problems in their own lives.

As Chapter Four discussed, nurses tend to be distanced from their own emotional needs and their own inner life, and this extends to denial of IPV and its impact in their own lives:

> *"As nurses you are taught to focus on others' needs and forget about your own ... sometimes health care providers have this problem of being abused but they are quiet about it. They don't know how ..."*

A key informant (medical anthropologist) spoke of her experience with a study on domestic violence at another community health centre in the Cape Metropole:

> *"The medical staff would refer to counsellor or social worker and make an appointment for patient. The nursing staff didn't really want to talk about it because they felt it is not really their place to talk about ... for them it was very very very close to home and they felt this is a very private thing ... they did not want to raise it."*

A positive feature of this example is that it provides an example of an optimal biomedical model extending into its potential for psychosocial care, since doctors did at least refer the patient for social work or psychological services.

A facility manager comments on his staff's reactions to their own difficulties:

> *"It's the shame – how will I come and work here again? Embarrassed ... people mustn't know. Too private ... if it's psychosocial issues nurses don't want to be patients because of stigma attached."*

His assessment was that such dynamics would prevent health care providers from using local resources to address difficulties in their own lives.

Hester van der Walt (1998) developed the thesis "*too close for comfort*" in relation to health care providers' difficulty with addressing the emotional needs of patients who in some unnerving way mirrored their own issues. For the purposes of providing IPV care, this speaks to how their own experiences of IPV may render them unavailable to attend effectively to those of others. I think that it depends on the degree to which the health care providers have been empowered in their own lives to deal with their personal experience of IPV. A key informant from the NPO / research sector who has experience with training nurses to integrate IPV care in their work, insisted that first and foremost, nurses need to deal with their own experiences of violence. She stressed that unless health systems management acknowledges this and provides adequate support for staff, it will be a continuous barrier. This endorses and extends the call made by Vetten and Liebowitz-Levy (2003) that any training about IPV care needs to explore nurses' own experiences of IPV and their willingness to engage with IPV at work, cited in section 3.4.3 'The quest for quality psychosocial care: IPV training and other interventions to change care.'

In summary, a fundamental barrier to providing care for IPV is health care providers' unresolved personal experience of IPV, either as victim or perpetrator and possibly also growing up in a home with IPV (Keeping it Secret, 2007). Paradoxically though, despite fears that being open about one's own IPV would lead to shame and marginalisation, in the doctoral study we found that where health care providers and/or researchers had dealt, or were dealing with their own IPV-related issues, they could work optimally with IPV survivors.

7.4.2 The hegemony of biomedical discourse and the "righting reflex"

Biomedicine accepts only physical and action change as real change, and creates or attracts a desire in practitioners to fix what ails patients. Since IPV seldom responds to one quick-fix intervention, health care providers are reluctant to identify IPV and thus be called to embark on a potentially longer term process of psychosocial care often with little discernable results to reward the provider for their intervention.

A recurrent theme during the co-operative inquiry groups was that historically within our health system, IPV has been framed as a social problem, thereby absolving health care providers of responsibility since they deal with biomedically defined health problems (Petersen, 1998). We wondered whether beneath their distaste for social problems lurked their perception of their own impotence. Deeper perhaps was their shared sense of hopelessness about this disturbing problem.

An ex-nurse, now senior research specialist in gender-based violence, explained:

> *"if you are trying to think about why it is that ... health care providers respond the way they do around responding to women ... (it is because their) training didn't inform them that violence is part of a health problem."*

Another constraint on the development of an effective IPV service within the PHC system was raised by a family physician who stated that in the public sector, care is so episodic that health care providers don't take time to fully write up a sensitive case history in the folder.

A psychiatric nurse in a focus group commented that the majority of patients at Site B suffer from some form of stress and that the health care providers don't want to admit that. Biomedical discourse precludes the kind of multi-dimensional approach to health that prioritises psychosocial care and the subjectivity of the patient's illness experience. A key informant's narrow definition of a health care provider's job description is revealing:

> *"A big problem then is that the doctors and nurses are so few and far between ... such a shortage of staff. So they can only do their jobs – they can't counsel. They don't still have time for counselling because someone is waiting in casualty or emergency or somewhere."*

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Contributing to the focus group we held after data collection at Sites A, B and C, health care providers displayed the biomedical mindset as follows:

> *"It's not that we don't want to do it – it's something new ... [we are] so used to examine, diagnose, medicate ... and it opens up an area that is not easy to deal with ... often an area that people struggle with: stress, psychosocial issues, messy ..."*

> *"To start off with something is sometimes very difficult. Something new is a challenge, it's also very intimidating."*

The second quote speaks of the automated mentality produced by a mechanistic job dominated by routine chores.

A facility manager commented on how health care providers are demotivated by non-compliant patients, who also come with their own biomedical mindset. Patients expect medication to fix everything and often it doesn't. She added:

> *"At Community Health Centres, health care providers are more inclined to focus on the physical ... and don't feel comfortable with the emotional side of things ... should have more time to explore those things and put people into groups where they can talk about those issues."*

The internationally noted fear of opening 'Pandora's box' is clear (Sugg & Inui, 1992). A key concern of the health care providers was what the research project would do to prevent the woman from going back into the relationship where the cycle would just repeat itself again? They wanted to know what had happened to the participants? Had action been taken? Have the police apprehended the perpetrator? What happens when he comes back again? And when the man and woman are divorced, financially, what is going to happen to the woman?

Here we see the presence of the "righting reflex", arguably a key feature of biomedically oriented practice. Expanding on the impatience health care provider's display in relation to patients' processes, a member of the co-operative inquiry group noted:

> *"People operating within a medical paradigm have a 'fix-it' mentality ... don't really want to understand the situation, or its complexity, or help the person think through*

what they can do and might want to do. They just basically want to fix it ... but in this situation you can't give penicillin ... [so they] want to now give one simple and straightforward thing that you can prescribe that will sort it out. And it seems like the most obvious answer from the health care provider's perspective is that she must just leave him. And then their whole frustration of course when their simple solution is rejected."

Indeed, this "righting reflex" appeared in various guises throughout the process of the research. In focus groups health care providers voiced significant concern about the following points:

"It's a whole anthill you are disturbing and maybe there are a lot of them who have had advice and help, but they just didn't want to help themselves."

"I think if you have opened something up it should immediately be dealt with."

"We have to help the patients find a solution. The patient is going back to the same circumstances. She is going to get another beating at home."

In terms of the stages of change model this shows an over-emphasis on action as the only stage that matters. A facility manager commented that the doctors in his facility were afraid to get involved because as family medicine practitioners they did not want to only screen. This argument was presented on the grounds that holism is a key principle of family medicine. Perhaps the hidden motive is that identifying IPV in their patients would require them to invest more time and effort in that patient (with the potential added frustration that this will in any case likely not lead to any biomedically perceived outcome). This reluctance is picked up on by a key informant:

"The other reluctance could be, how much do you want to know about this patient? Because the more you know, the longer it's going to take you to get through your work."

A key informant encapsulated a number of key aspects well:

"A theoretically interesting point is that one of the critiques has always been that biomedical care fragments [the patient] and now we are trying to bring the person together but in a system where they cannot actually deal with it. And we are expecting them to take on a lot of responsibilities that earlier would have fallen outside their scope of practice ... and philosophically and ethically speaking that is correct, but the resources are so few and the time constraints so large that this is highly problematic because what PHC is actually doing is turning them back into body mechanics again."

This links to a key critique within the thesis, namely the expectations of policy mismatching what happens at ground level.

7.4.3 Case Finding for IPV in a health system in transition

We probe reasons offered by health care providers for why they resisted getting involved in the research project, or avoid uncovering cases of IPV. Issues of time constraints, work overload, privacy issues in small communities, other issues relating to the nature of the patient/provider relationship and expected roles, and fear for one's own safety are interrogated. One factor leading to a lower rate of IPV survivors being willing to participate is noted.

At a conscious level, key practicalities were articulated as the reason for not getting involved in the research project. Health care providers felt overburdened, lacking time for extra tasks. Many administrative tasks land in nursing staff's lap too. Judging by focus group data, our request was perceived as a burden:

"At the beginning I was kind of annoyed with KJ because I felt now she is dumping her survey on us. Making us responsible for screening her patients for her."

"I think we all felt the way Sister X felt – that they dumped the research on us. We must do the work for her. At the end of the day, when she started working on this, I found that it was actually a great help."

One doctor argued that it was not just a matter of asking a screening question and referring. When he got a positive response the potential participant started crying and he didn't feel comfortable to refer her immediately so she kept him busy for "*a good extra 15 minutes*".

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From then on he was careful not to start something that he didn't feel able to follow through. He did admit however that he saw her a week later again and "S*he looked completely different. She looked like she had a lot of self-confidence*". So he felt positive about the project, but emphasised that he didn't have the time to participate. His facility manager later explained that the doctors had discussed at a recent meeting that they want to screen for the study but don't have the time because they also have other duties.

> *"All of us felt really positive about the project – but the most important thing was that there wasn't enough time to really ask these types of questions of the patients. We felt if you were going to do it for an extra 5 – 10 women per day …it would take close to an extra hour…many days we walk out of here at 18.30 so an extra hour is too much."*

He specified that to provide a more comprehensive (mental health including IPV) service they need more human resources at Site C.

Our rural nurse researcher on the project was a strong voice within the co-operative inquiry groups on the side of the stressed and busy health care providers. Having worked at grassroots level in this region as a clinical nurse practitioner, she specified how many times she hoped the patient wouldn't mention another problem because there isn't time to treat the patient holistically.

An experienced nurse researcher honed in on the delicacy of the boundaries. She pointed out that requiring health care providers to ask a screening question of each female patient over 18, may be asking them to break privacy between them and the patient, *"The smaller the community, the fewer the boundaries"*. She suggested that in rural areas nurses may fear being earmarked as carrying stories. This view is borne out by a comment made by our rural nurse researcher, *"sisters don't want to screen because they know patients"*.

Service provision is clearly more difficult in small rural communities where the clinics are sometimes extremely short-staffed and under-resourced, yet a vital paradox emerged. At Site D, for example, the researcher found one clinical nurse practitioner coping alone with extremely sick patients. At this site many patients are infected with TB and/or HIV. This nurse started work at 07.30 without even a clerk to assist her with drawing folders. She was alone with some extremely sick patients until 09.00 when the HIV counsellor arrived. This scenario reveals a clear fault line in health systems policy and practice. Systems for rural

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clinics are mechanistically designed for a full complement of staff whereas in real life staff become ill, pregnant, take leave or go on training. This seems not to have been factored into the original equation / algorithm. The clinical nurse practitioner working alone at Site D had to cope with all the patients, manage the clinic, complete the statistics and write the reports.

Yet to her credit, her commitment to IPV motivated her to develop a strategy so that she could successfully recruit patients for our study. Significantly, this sister was the only one of three clinical nurse practitioners to attend both our focus groups in her town. Here she expressed that she is keen to provide an IPV service if the recommendations we make in Chapter 9 are implemented. Note further, that this sister was the only white clinical nurse practitioner I encountered during our involvement in that rural region (February – June 2007) which provides further evidence for Van der Walt's thesis "too close for comfort" discussed earlier (Van der Walt, 1998). The latter suggests that such a nurse would indeed be best placed to provide IPV care in this region since her social context and consequent living environment affords the distance necessary to protect her own psychological and material well-being (Petersen, 1998; Petersen, 2000b). In other words, because she was not from the same community as her patients, her boundaries were more intact and so she was better able to give of herself.

As always in the focus groups, a variety of views emerged. A doctor, who was studying for a MMed in Family Medicine, articulated the crux of the matter:

> *"At first I ... felt uncomfortable to ask the question, not knowing what is going to come back at me and what I'm going to do about it.. But as I asked more and more I felt confident."*

Another doctor felt it was easier to ask patients with whom she already had an established relationship, although this was contradicted by others. It was clear that most doctors found it altogether too delicate to raise. They argued that it was off the point of their consultation. Quite a few admitted that they had forgotten to ask as it wasn't part of their routine. They also complained that patients don't disclose when asked. Clearly, these health care providers have not grasped the social determinants of health, revealing their lack of training in psychosocial management (Tannenbaum & McGillivray, 1996). Yet if their problem-focused approach manages to incorporate routine questioning about other lifestyle / social issues such as cigarette and alcohol habits, then why could IPV not also be part of their routine enquiry?

At Site A doctors only referred physical assaults. This is disappointing as doctors are well positioned for greater insight regarding IPV's deleterious health consequences. Indeed, our nurse researcher at Site A struggled constantly with the fact that the doctors were not screening. She excused them as being busy, but also noted that patients rebuke health care providers for taking excessive time over lunch and tea.

A health care provider commented that the patients are very surprised that, all of a sudden, somebody would be interested in what their relationship with their partner is like and they clam up. Another health care provider from Sites D and E commented that she noticed some patients had difficulty trusting the researcher because she was a stranger. They also noted the patients' ambivalence: both receptive to and suspicious of what the researcher could potentially offer them. In fact, questions may get different reactions depending on the underlying nature of the relationship and spirit of the interaction. Note the mindset / relationship within which you ask the question may be as important as the question itself.

Another factor that impacted on recruitment was the patients' resistance to waiting for an additional appointment. Many come to a community health centre on their way to work wanting to be seen quickly so that they can still earn the day's wage. Also, some community health centres are oversupplied with research projects which can frustrate patients who feel "overused".

Health care providers' fear of retribution by the perpetrator surfaced during a focus group at Site C, where a health care provider expressed that she had worried about her own safety after "interfering" in the relationship. She was concerned that the patient's husband would harass her and others at the community health centre but he never did.

7.5 Referral resources

The provision of comprehensive primary care in South Africa is extremely challenged by the lack of community-based resources. A legal specialist in gender-related research in the Cape Metropole emphasised the deficit of domestic violence resources in townships. Indeed the urgent need for more shelters for black and rural women surfaced regularly during the project.

Furthermore, health care providers in the rural areas pointed out that most IPV happens over the weekends when nothing apart from the trauma unit at the hospital and the (often hostile or

apathetic) police station, is open. Public transport is also minimal on weekends. Therefore support services tend to be unavailable in such emergencies.

In a focus group, health care providers admitted that they are so occupied with what they have to do in the clinic that they tend to forget about outside resources. A co-operative inquiry group member confirmed that in her experience the health system markedly under utilises the NPO sector (Joyner et al., 2007). In focus groups, health care providers admitted to ignorance about alternative local resources, and hence the over-use of already skeletal psychosocial resources. Health care providers expressed frustration that patients have to wait months for a referral appointment if they are lucky enough to get one. Health care providers expressed that this demotivated them for IPV-related work.

In the follow-up focus group for this thesis at sites D and E, health care providers commented that since the study finished they are back to minimal resources again with totally overloaded psychologists and social workers. Clearly, our project had addressed a significant need amongst patients. "*This kind of thing sells itself,*" commented a facility manager.

Patients therefore may not access existing services because health workers are unaware of local resources and are not community-orientated or because of delays in referral to more specialised psychological services.

Table 10 summarises the results of the intervention administered to 168 IPV survivors during the intervention. It reflects the interviewer's comprehensive range of mental issues, action taken by the interviewing health care provider on mental, medical, social and legal issues, information provided and requests made by the participants in each of these categories, and records planned actions. These results indicate the extent of the need for reliable referral resources. As we saw in Table 5 in the previous chapter, levels of psychopathology in women living with IPV are concerning, particularly since everything but depression seemed to remain undetected by health care providers. The AUDIT is a validated screening tool for alcohol abuse, and any score over 8 is cause for concern. In this sample, more than half of those who admitted to drinking alcohol appear to have a drinking problem.

The referral to a psychiatric nurse forms a subgroup of those referred to a mental health specialist, indicating that 10.7% of participants were referred to a psychologist or psychiatrist, while 46.4% were referred to a psychiatric nurse for care.

Table 10: Assessment of mental, medical, social and legal issues		
N=168	**n**	**%**
Mental issues		
Depression suspected	110	65.5
Anxiety disorder suspected	121	72.0
Alcohol use	48	28.6
Post traumatic stress disorder suspected	65	38.7
Referred to psychiatric nurse	78	46.4
AUDIT score > 8	26	15.5
Referred to mental health specialist	96	57.1
Medical issues		
HIV test done already	118	70.2
HIV positive (n=118)	14	11.9
HIV test requested	79	47.0
Referred for RPR (test for syphilis)	38	22.6
Referred for pregnancy test	8	4.8
Referred for x-ray	6	3.6
Treatment for injuries given	17	10.1
Emergency contraception given	4	2.4
Treatment for STI given	33	19.6
Post exposure prophylaxis given	2	1.2
Forensic documentation done	52	31.0
Pregnant when seen	9	5.4
Social issues		
Referred to NPO counselling	38	23
Referred to shelter	1	0.0
Referred to social worker	37	22.0
Safe to give leaflet	157	95.0
Legal issues		
Has laid a criminal charge	73	43.5
Intends to lay a criminal charge	18	10.7
Referred to police	30	17.9
Referred to legal NGO	23	13.7
Has a protection order	47	28.0
Intends to obtain a protection order	57	33.9

7.5.1 Psychiatric nurses

The Health Care Plan 2010 lifts out psychiatric nurses as specialised nurses. The clinical nurse practitioners are required to manage general mental health aspects whereas the psychiatric nurse will deal with more specialised diagnoses and unstable patients. Although

this may be heralded as a welcome recognition of mental health care as a priority, a number of concerns should be raised.

Firstly, the perception that psychiatry referrals are imbued with stigma surfaced repeatedly during the study. A follow-up researcher commented on her perceptions of participants' reactions:

> *"Referring to psychiatric nurses is problematic because it is very stigmatised and women don't want that [psychiatric] stigma on top of their problems because already abuse draws a lot of stigma and shame to them."*

A further problem is that psychiatric nurses tend to operate within the narrow confines of a biomedical model which reinforces psychiatric nurses' reliance on psychotropic medication. While in some cases such medication is clearly indicated, in many others it dampens down the patient's defences rather than empowering her to problem-solve in a constructive and supportive way. In section 4.5 we saw how the potential for comprehensive psychosocial care within mental health nursing has been reduced to a narrow biomedical range of care (Petersen, 1998). Even when nurses have been trained in a psychosocial approach, my observation as a lecturer in psychiatric nursing over the past decade is that the use of medication often precludes use of psychosocial skills. This should be a matter of concern, emphasising the need for advocacy around psychosocial services.

7.5.2 Psychologists

At Site C, health care providers described how patients seem to lose hope because on follow-up even two to three months later some still have not been contacted even to make an appointment. This phenomenon was also noted by our follow-up researcher in that district who commented that on interview a month later those referred had an appointment for months later. Rural health care providers emphasised that the urgent need for more psychologists justifies the opening of additional psychologist posts for the health service.

Regarding the services that psychologists provide, a key informant psychologist explained that standard IPV procedure is to do an evaluation and if necessary refer to a psychiatrist for medication; or to a social worker *"just to normalise things"* if they feel they want a divorce or are worried about the custody of the children. Any cases related to the Domestic Violence Act, she refers to a social worker *"just to look at the situation and make sure they are safe."*

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Yet she also admitted that she doesn't know where to find the social workers in the town of Sites D and E so she can only write a referral letter.

This key informant spoke of how she was receiving referrals desperate for her to see the children as well because they were so traumatised. She therefore has been doing play therapy with them *"to work on their feelings and to act it out in a safe environment."* She also calls in the parents and does parental guidance with them about how to handle children better in these circumstances. She emphasised the urgent need for more psychologists since her district is so understaffed producing long waiting lists which is far from satisfactory since, in her view, people need to be seen when they are in the crisis that prompted the appointment.

7.5.3 Social workers

In the former Boland-Overberg district, in addition to the ubiquitous strain of being completely over-stretched, a key informant identified another significant problem. Social workers are employed by different organisations and hence compete for their share of the limelight and recognition. Cohesiveness and mutual support in pursuit of common causes was notably absent. Other key informants reiterated her concern.

At sites D and E the clinical nurse practitioner commented that she doesn't refer to social workers for social problems any longer because she has not had a positive experience with their follow-up potential in terms of anything other than disability grants, pensions, and other paperwork. The programme manager for Women's Health in the district explained that the social workers in the surrounds of Sites D and E are inundated with social problems. The satellite clinic and day hospital (sites D and E) serving the coloured and black communities were without a social work post. There was only one social work post in the rural town itself.

A key informant reiterated this point from her experience of doing research as a medical anthropologist at a community health centre in the Cape Metropole. She found that neither the social worker nor the counsellor was available – so although in theory and on paper the services were there, in reality they were to all intents and purposes inaccessible.

7.5.4 Lay trauma and HIV counsellors

In our under-resourced setting, this valuable category of service providers potentially poses the same problem we have with nurses – most are South African women who have internalised the chauvinistic understandings that characterise our country and so respond to

patients from their own internalised oppression. The other issue that needs careful consideration is confidentiality since these counsellors are so much closer to the community. Health care providers related how patients complain that other people hear about their problems which had been discussed in privacy with these counsellors.

If one were to lay these significant considerations aside, what could the value be in involving IPV survivors who have transformed this issue in their own lives? A follow-up researcher noted that many were willing to give their time to help someone with difficulties they understand intimately.

Of all the sites, D and E (the most rural sites) were noteworthy for the particularly constructive involvement of their HIV counsellors. It transpired that they received supervision from the intern psychologist for the district who explained that about 60–70% of her caseload was rooted in domestic violence and / or alcohol abuse. She attended to the more complicated cases such as severe depression with suicidal ideation, while supervising the HIV counsellors to deal with the rest.

The HIV counsellor for these sites attended our focus group and expressed how helpful she had found the study since she was able to refer all her clients experiencing difficulties with abuse to our co-researcher. She had received positive feedback from patients thereafter. A clinical nurse practitioner argued that the DOT (TB prevention) worker and HIV counsellor were ideally positioned to screen since their interview was more private and they had more time to listen.

However, at a systemic level, a pervasive silo pattern is evident in the way health policies are currently rolled out. For example, HIV counsellors are trained with a very limited scope because they are not "mandated" to do other counselling. Disturbingly, a gender-based violence specialist at the Medical Research Council cautioned that during training many counsellors voiced "*absolutely astounding views ... around gender and control*" which reinforces the significance of the first concern I raised about lay counsellors. It appeared that the training of these staff at the STI clinic utilised a very narrow interpretation of pre- and post-HIV test counselling.

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7.5.5 Alcohol and substance abuse services

Key informants and participants in focus groups emphasised how extensive a problem alcohol and substance abuse currently is. Participants linked their own IPV to alcohol abuse by admitting that thinking about the seemingly insurmountable difficulties of their relationship leads them to binge drinking. Co-operative inquiry group discussion also interrogated the fact that although health care providers, and indeed society at large, lay blame for alcohol/substance abuse on the addict, it is often the subtext of another dominant problem – such as the nature of her intimate relationship. The co-researcher who did many of the follow-up interviews identified a triangle between husband, wife and alcohol. Concern was expressed about the need for co-dependent women, involved with alcoholics, to learn protective strategies. Co-dependency is a big problem:

> *"When ... they tell me about their husband ... and his behaviour, I just think that until this man has an intervention for his drinking problem nothing else is going to happen."*

There was a dearth of referral support for alcohol abuse in the rural areas surrounding Sites C, D and E. The only available resources are strongly Christocentric which can be off-putting for some. Significantly, the follow-up researcher at Site C noticed a pattern that participants who had been referred for alcohol abuse at first interview, did not return for follow-up.

7.5.6 Shelters in the NPO sector

The Sarah/Saartjie Baartman Women's Centre in the Cape Metropole, is the only one-stop centre for domestic violence in the Cape Province. On follow-up, most patients reported finding it an extremely helpful resource, having built sustainable, in-house partnerships with the trauma centre, Rape Crisis, SANCA (South African National Council for Alcohol and Drug Abuse), Muslim Aids Programme, job creation programmes, the Network on Violence Against Women, a shelter and a legal advice and training project. At date of interview, on 18 April 2007, Ekaia Letemba in Braamfontein, Gauteng, run by the department of Community Safety, was the only other similar centre in South Africa.

Disturbingly though, the staff at two community health centres in adjacent suburbs had no idea of its existence. This is an inherent difficulty with shelters, because of the need for secrecy, they can't be advertised too widely. The director of the Saartjie Baartman Women's Centre asserted that she would value establishing a partnership with state health care centres

to provide services for shelter residents. She spoke of how the shelter works in strong partnership with other organisations and that their approach to IPV is holistic, not viewing it simply as a medical condition. She explained her vision of how SBWC could be used as a training facility for nursing students who could thus be exposed at practical and in-depth levels to IPV work. She felt this would benefit nurses who could then graduate better informed and equipped to deal with IPV.

7.5.7 Forensic services and rape / IPV Fora

Forensic and social services are structured at district, provincial and national levels. Clinical forensic medicine has been identified by national government as a specialised health service. Here lies potential to establish counselling services and shelters as an alliance between our health and NPO systems around the one-stop rape / IPV centre concept, because it is a strong health initiative. A senior manager within the Metro District Health Service explained that this multi-sectoral forum needs to be created at sub-district level where all the role players from private sector, NPOs, health, education, social services and justice work together. Responsibility for ensuring that this happens needs to be given to a specific department. In this vision, each town in a rural district is responsible for its own rape forum, although the programme manager of Women's Health is there to support, discuss and find solutions if they struggle. The coordinator of police, justice, health and social services on the Rape Fora in former Boland-Overberg recommended including IPV since there are such close links between domestic violence, sexual abuse and child abuse. Further, the links between gender-based violence and HIV/AIDS has produced a crisis for women affected by both, and the Fora could provide constructive responses. The commitment of individual role players was lifted out as the key ingredient for making a difference:

> *"Fora are brilliant because all role players can communicate about nitty-gritty details and get things working at ground level and then feedback to regions and to province so that people in charge are happy and so supportive when budget allocation comes around."*

7.5.8 Police and Victim Empowerment Units

Police near Site C said they have more important things to deal with than domestic problems. This mirrored the attitude of the police station near Site B. Throughout data collection, we were confronted with police misinforming women and being otherwise obstructive. For

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example, police demanded evidence of a physical assault and / or a J88 (the document that goes into the police docket and becomes a public document once the case has been heard) in order to lay a charge whereas the Police National Instructions specify that one can lay a charge and/or get a protection order, and should not be prevented from doing either. Police also "kept" the original copy of protection orders, forcing participants to leave empty handed. Furthermore, every station commissioner should provide a list of local service providers, but didn't.

Police are supposed to refer domestic violence complainants to health services, and while in most cases they do not, one study in a local township found police helpful since they gave the IPV survivor a special interview. Thereafter they referred her on to their community health centre for injuries or other damage.

In South Africa there has been confusion around two separate victim empowerment initiatives. The trauma rooms at police stations, which we focus on, are partly community-based. They are staffed by volunteers, from the Victim Empowerment Programme, an initiative of the Department of Social Services to combine government and NPOs' attempts to address victim empowerment holistically. Problems were raised about a lack of clarity about the role of the VEP unit at police stations. Apparently damage has been done by VEP volunteers assuming the role of a social worker. A key informant clarified that the VEP role is essentially to contain and counsel women as they present, and to assist them with the completion of the application for a protection order. The VEP role does not include any court appearance. Nevertheless, she asserted that unpaid VEP supporters are doing an excellent job and are thus a very important resource.

7.5.9 The Legal Advice and Training Project

The Legal Advice and Training Project at the Saartjie Baartman Women's Centre assists women experiencing gender-based violence for a small fee. This project doesn't represent women in court, but gives advice and where necessary assists with protection orders and divorce, and prepares all documents for court. A para-legal can go to court with the woman if she doesn't want to face the perpetrator alone. The key informant who staffs this unit has had multiple similar experiences to those of us delineated under section 7.5.8 about the police above. She asserted the first principle that assault is a criminal offence for which any victim is entitled to lay a charge and get a protection order. However, in contemporary South Africa, it is clear that referral to police may or may not be helpful. Laying a charge is a fundamentally

punitive measure which may not be the optimal way to handle the relationship at this point. Unfortunately we found that health care providers tend to refer IPV survivors to the police, rather than to the Family Violence Unit at certain magistrates' courts. The researcher for (rural) sites C, D and E expressed the need for protection order application forms to be kept at the victim empowerment unit and police station as well as at family courts.

7.5.10 Protection orders – Domestic Violence Act of 1998

*"When husband's drinking is a big factor, and then the protection order is used as a first intervention and the husband spends a weekend in jail, this serves as effective behaviour modification ... these women are saying the marriage has gone back to what it used to be [before the drinking and abuse set in]" (*follow-up interviewer / co-researcher, 2007).

A gender-based violence specialist at the Medical Research Council explained that in their work evaluating the Domestic Violence Act, most women applied for the protection orders to end the abuse and to create change in his behaviour, not to leave him (Mathews & Abrahams, 2001). A legal key informant asserted that most women want the protection order, but not to lay a charge and furthermore have little intention of even using it. Also, many women have become discouraged about the value of protection orders because they knew someone who was not helped by it. People become despondent because they feel they don't get backing from our justice system.

It is a grave and unfortunate omission within the Domestic Violence Act that some form of duty is not actually imposed on health care providers to provide information to, and thus advocacy for, the patient regarding their legal rights. It is crucial that IPV patients are provided with information on how to access these protective mechanisms and contact with the health care provider is often the only point of entry into the formal system.

The legal key informant reported that once their perpetrator knows a woman has no intention of using the protection order or proceeding to lay a charge if he violates the order, he has even more control. The other problem is that perpetrators often convince the complainant to cancel her application for a protection order. Out of eight women applying for a protection order, the informant's experience was that only one will see the process through. She saw the problem being that they are still living with their perpetrator, have on average five children, and are

financially dependent on him. This legal gender-based violence specialist felt that a process should be initiated which prevents applicants from withdrawing their applications. If one considers this rather extreme suggestion in the light of the cycle of violence: honeymoon – tension-building – explosion – honeymoon (Walker, 1979), one may consider that it has validity, since a further problem is that when such clients return after another unbearable experience, the courts don't give them a second chance. This is all the more problematic in light of the informant's experience that men become more abusive than ever if the IPV survivor tries to leave him. The World Health Organisation's Report on Violence showed that on average an IPV survivor leaves the violent relationship four times before she successfully exits (Krug et al., 2002) which mirrors experience with other behaviour changes.

7.5.11 Ambivalence about the value of churches as a resource

The follow-up co-researcher noted that many participants talk about the potential helping role of faith communities, for example marriage counselling at the church – because it seems that is the only place you can really get it. She later also commented that every single interview had some sort of spiritual aspect to it, whether in the survivor's explanation or understanding of what's going on, or in terms of what she is planning on doing in the future or what she thinks the outcome will be.

However, it is problematic if the main place that offers 'marriage guidance' is a religious institution that forces couples to stay together because they see marriage as more important than abuse. A pervasive view seems to be that it is better to put up with abuse than to leave the marriage, which causes social stigmatisation.

A health care provider in a focus group claimed that the churches are not really involved with "the community":

> *"We don't really work together ... they have their way of doing things and we have our way of doing things and there is no real cooperation. We can't say to the patients when they come here, listen, we know of this church and you can go there for support if things go wrong over the weekend ... you see, then we would have to work together."*

Yet, on the other hand, the facility manager of the same site was very positive about the Tiktaakspan (Tic Task Team) where churches and many other local resources are linking up

as a team to address the scourge of methamphetamine abuse in their communities. In fact he suggested that since this is working so well in the town and surrounds of Site C, perhaps we could develop something similar around abuse where community voluntary workers committed to this issue provide the backbone of the service. It works by referring people back to the support groups in the community where churches are involved, but he cautioned:

> *"At the end of the day, we must be careful not to have too many groups ... there is already existing rape crisis groups, where woman and child abuse could be integrated."*

7.6 Evaluation of the safety assessment and plan encapsulated in the protocol

7.6.1 Critique of the safety assessment

Our experience as co-researchers was that the safety assessment in the original protocol had been formulated on the assumption that:

   a) The IPV survivor is badly injured.
   b) Her abuser is living with her.
   c) He will kill her if/when she gets home, or soon thereafter.

Our experience was at odds with these assumptions. Firstly, in our sample of 168 participants, only two survivors' wanted to be moved to safe housing. Also, contrary to the expectations of our reference group that controlling partners would accompany survivors, the participants almost always presented at the community health centre alone. During co-operative inquiry groups the validity of the assessment was interrogated. I was concerned about how accurately the tool represented women's risk since each factor above counts one point: "Has he threatened to kill you?" scores the same as "Is he presently at home?"

Also, what is the reason for doing it? Is one assessing whether the woman is at risk of being repeatedly assaulted? Or are you attempting to identify whether the woman could be killed? Certainly part of the thinking around danger assessments is to prevent intimate femicide from occurring.

One interview with gender-based violence specialists at the Medical Research Council, which focused on how to make the danger assessment more relevant to South Africa, informed that their national femicide study showed a 33% split between blunt objects, sharp objects and

guns as weapons of murder. However, the magistrate for Site C area explained that she viewed firearms as a far higher indication of lethality and consequently immediately grants a protection order if the perpetrator has access to a firearm. In fact, the Medical Research Council study also showed that ownership of a legal gun, combined with being a security worker, hugely increases a woman's risk. The all too often tragic paradox of course is that while a firearm suggests a higher indication of risk, no firearm does not necessarily present less risk. Nevertheless they recommended that one of the questions to ask would be "Does your partner own, or have access to, a gun?" In Chapter Three section 3.3.2 'Risk factors for IPV' we reported a USA study linking gun access by the abuser to higher levels of abuse (McFarlane et al., 1998).

Also, given how dangerous abusers are during and after their partner leaves them, the key informants recommended that it is crucial to take a proper history and to inform her that **if she is planning to leave him, she must not tell him or anyone else** that she is going to leave him.

And a further difficulty, what does it help a woman who has nowhere to go to be told she is at severe risk? It is different to do it in a first world context where safety net resources exist to provide back up. However our rural researcher still felt the assessment feedback was valuable because maybe some don't realise the grave danger they are in or the options available to them. She asserted that even if the patient knows she is at risk, it is good to have it validated authoritatively.

7.6.2 Critique of the safety plan

The first world orientation implicit in the safety plan (for example, that the IPV survivor would have a bank card and car keys, see Appendix A) was not well pitched at the socio-economic level of the participants we were serving since many of them could not drive, let alone owned a car. It was however helpful to teach about the importance of having one's key documents in order (and copies hidden safely elsewhere) as well as the other details mentioned above. Ideally, each subdistrict should make regularly updated written material on local resources and a template safety plan available to give out.

Our critique of this safety plan is that it makes too many assumptions about the woman's situation. For example, in our sample often the victims were not living with the perpetrator. They needed to stop him coming to their home. Certainly the safety plan had more relevance

when there is extreme physical violence. The significance of being able to go to someone who will concretely help them should not be underestimated. Millions of South African women could benefit from a service that addresses their issues, looks at options together and provides ongoing support.

7.7 Conclusion

In order to answer the second research question, this chapter first looked at whether IPV survivors found its implementation feasible, that is practical and helpful. While there were some difficulties in recruiting IPV survivors, participants expressed positive responses to the protocol intervention and its impact on their feelings and lives, if not situations. Overall 76% found the intervention beneficial. The impact of the interventions was also measured by the extent to which IPV survivors had implemented intended action plans by one month later. Having found the intervention largely feasible from the IPV survivors' perspectives, we then examined the feasibility and efficacy of three aspects of implementing the protocol: identification of IPV cases (section 7.4), making referrals (section 7.5), and the safety assessment and plan (section 7.6). But first – reflecting on the effectiveness of these components of the protocol in our study gave rise to considerations of organisational structural or systemic barriers to providing effective IPV care in the South African health care system (section 7.3).

This chapter has addressed health care providers' capacity to provide comprehensive care for IPV. A core question has been what potential is there for constructive, comprehensive IPV care within the PHC system? Our project looked at ways to change how organisations function in relation to IPV in order to understand some of the difficulties encountered. The way nurses have been moulded within sexist biomedical power structures to perform in particular ways, produces diminished creative potential; diminished capacity for insight; and diminished capacity for using initiative to be constructive. It takes courage to work with IPV. The theory chapter developed a compassionate approach to understanding the systemic limitations imposed on the individual potential and position of nursing. Clinical nurse practitioners still don't have an identity as a professional group of practitioners, instead caught in a no-man's land between being nurse and practitioner. The PHC sector is in flux and is also under-resourced and overburdened for attending to its current load. Given these issues, and the problem that nurses are completely inadequately supported by their work context, this thesis concludes that it is unrealistic to expect clinical nurse practitioners to fully provide

comprehensive primary health care, of the kind required by the Health Care Plan 2010 and by IPV interventions.

Quite apart from ethical arguments for intervention, our qualitative evidence indicates that the sequelae of IPV are vital areas of care for affected families. Therefore, a way must be found to reconcile to whatever extent is possible the clear evidence for the need and benefits to survivors of tackling IPV as a psychosocial health care issue, with the reluctance and incapacity of the primary health care system to do so. This challenge is taken up in Chapter Nine, which makes some recommendations for a way forward. For example, in theory, a key purpose of PHC should be to activate the capacity of the community to develop its own resources (Alma Ata conference, 1978). This thesis proposes a way of doing this for IPV that links with cutting edge chronic care policy that is to be rolled out in the Western Cape.

But first I complete the process of looking at findings that came out of the research project, by stepping back to look at the research process and team itself in Chapter Eight, which presents and discusses what was learnt about training and supporting researchers who were new to the action research paradigm.

CHAPTER EIGHT
WHAT DID WE LEARN FROM TRAINING AND SUPPORTING RESEARCHERS NEW TO ACTION RESEARCH?

8.1 Introduction

The purpose of this chapter is to explore what was learnt from training and supporting researchers who were new to the action research paradigm and methodology. With the exception of the facilitator, all of us were. The chapter is structured in accordance with our research journey. It starts by refreshing the reader about the action research paradigm – this was explored in detail in the meta-methodology chapter, Chapter Two. It then moves to what was learnt from designing and developing the study as well as selecting, training and preparing the research team. Finally a number of quality criteria that transcend the whole process, such as group power dynamics, researchers' grasp of action research, and my methodological journey provide a critique of the process.

The task of training and supporting researchers who are new to action research aims to maximise their ability to engage effectively with each stage of the action research cycle. Put simply, the four quadrants that an action research team moves through repeatedly while focusing on the research question(s) are planning, acting, observing and reflecting. Each member of the team should participate from start to finish, with a clear commitment to all four aspects of the process.

- Engaging in the planned actions and immersing oneself in the experience
- Capturing one's experience, for example in the form of writing, so that one can stand back and observe what has happened
- Reflecting on one's observations and experience in a way that extracts key lessons, new knowledge, abstract concepts and further questions
- Planning new actions and experiences on the basis of this new knowledge and ongoing questions

8.2 Action research in academia

8.2.1 Proposal writing and action research

The first logistical constraint we encountered was at the intersection of action research as it is meant to be practised, and university processes (Heron & Reason, 2008; Reason, 1988). A doctoral project can only begin once the clearly formulated research protocol has been registered with the relevant faculty. Thus from the outset, in terms of the ideals of professional action research, our project was methodologically flawed. The research team could only be recruited later, once the ethics committee had approved the project and funding had been received. Thus the other co-researchers were excluded from this fundamental planning stage.

My doctoral supervisor, Professor Mash (hereinafter BM), and I (KJ) designed the study since he is an experienced professional action researcher and professor of Family Medicine and Primary Care and I was his doctoral student. Contrary to the ethos of action research, this process required us to pre-determine the specific actions that would be taken by the members of the inquiry group, as well as the way in which data would be collected and analysed. The nature of action research is that it is a process of inquiry with a specific purpose that defines its boundaries, but should have the freedom to experiment and question as the participants see fit in each cycle of the inquiry. A variety of qualitative and quantitative data may be collected depending on the evolving needs of the inquiry process. The nature of institutional research and ethics committees, however, is to require accountability to specific and well-defined interventions, assessments and analyses that can be pre-approved. Action research is a relatively new paradigm and may require a different approach to its academic and ethical oversight. For example more attention could be paid to the rigour of the process to be followed than to the content of that process. If necessary, sequential reporting and approval of the specific research techniques, as they emerge in each cycle of the inquiry, could be recommended. The critical appraisal and quality criteria used in action research are often unknown to the members of oversight committees who may inappropriately apply criteria more relevant to research in other paradigms.

We thus required the co-researcher team to start with a predetermined action rather than with the "planning" phase where they could have participated in designing the action itself. In fact, one can start anywhere in the cycle, but "planning" is usually positioned first place in theoretical descriptions. Shortly, we will explore how this may have influenced co-researchers' ownership of the inquiry as well as their authentic engagement with the action

research process. It should however also be noted that the practical experience of using the published protocol for management of IPV in primary health care was the methodological starting point for the principal researcher and this was not wholly dictated by the need for ethical and doctoral approval.

8.2.2 Intellectual property of the learning

Methodologically speaking, ethical issues are raised by the fact that, in this professional action research project, KJ was involved in an inquiry in order to extract what was shared for the purpose of her own qualification. This was the premise on which all negotiations with team members were founded. It raises two issues. Firstly, to what extent did the rest of the group feel ownership of that intellectual property? Secondly, to what extent was consensus achieved in the last co-operative inquiry group meeting and to what extent was the learning from the group constructed thereafter by the principal researcher? These issues speak to key themes of action research, namely the practical construction of knowledge, who actually really feels ownership thereof, who is acknowledged, and who receives credit.

All co-researchers who had participated in the co-operative inquiry group were provided with pen-ultimate versions of Chapter Seven and Eight for feedback purposes. Their comments indicate that they concur with the details of findings presented, and that they valued participating in this methodologically innovative research project.

8.3 Recruitment of nurse researchers

The struggle to recruit nurse researchers taught us how scarce nurse researchers were in 2006/7 in the Western Cape. Also, to find the combination of a nurse doing a Masters degree and interested in researching IPV was extremely challenging. This could be seen to reflect a lack of interest in the subject, or perhaps a perceived lack of skills and capacity on the part of potential researchers. Significantly, the nurse researchers who stayed with the process were both dealing with IPV issues of their own.

Excluding KJ, of the ten potential researchers, seven were lost. Table 8.1 presents the reasons.

Table 11: Why did researchers stay or leave the project?

Potential researcher	Reasons for withdrawal	Co-researchers	Commitment to project
PC	Withdrew, due to demands of her schedule	NB	Took unpaid leave for five weeks from job in Eastern Cape to participate in one week training and four weeks of data collection. Attended 2/6 co-operative inquiry group meetings during that time.
LLR	Decided against doing a Master's degree so did not continue with project for second phase of data collection	LLR	Worked effectively as follow-up researcher for Site B in first phase of data collection, but due to work commitments, did not attend any co-operative inquiry group meetings.
LT	Intrauterine death	KT	Follow-up researcher and active participant in 3/6 co-operative inquiry group meetings
RX	Unsuitable: 1) participants expressed confidentiality concerns because RM was a lay priest in their community 2) ineffective	MA	Worked as our full-time rural researcher for three months of data collection and part-time for one month thereafter. Attended 5/6 co-operative inquiry group meetings.
JO	Withdrew immediately after training on grounds of incompatible work commitments		
CX	Needed to do rural follow-ups with JO as had no transport of own		
IS	Followed own therapeutic agenda. Forgot to attend co-operative inquiry group meeting. Participation in project discontinued.		

The reality of doing a research project funded by the National Research Foundation that required including capacity building of Masters' students, meant that it was difficult to find appropriately qualified and committed nurses to participate in the data collection as co-researchers in the action research process. Recruitment was the first challenge. Retaining a team in which the quality remained consistent was another.

The biggest challenge was to find a bilingual Xhosa- and English-speaking professional nurse who was doing or would do a Master's degree and was interested to participate in an IPV project. Eventually someone from the Eastern Cape was able to take leave for five weeks to

come and do the first interviews at Site B. Thus a compromise had to be made against the original intention of completing twelve weeks of urban data collection.

Last minute loss of co-researchers who had been recruited and trained beleaguered the process. The first loss was a Master's student scheduled to do first interviews at Site B in 2006. Another, who had agreed to do urban data collection at another site in the Cape Metropole in February 2007, withdrew in November 2006. Thus the focus was entirely on rural data collection in 2007 causing an imbalance in the urban / rural sample. There were 56 participants from the Cape Metropole and 112 participants from the Witzenberg and Breede Valley areas (former Boland-Overberg region).

With regard to the follow-up researchers, although Rev. M had seemed appropriate, participants made their discomfort clear to the co-researcher when informed that Rev. M was doing the follow-ups. They feared a breach of confidentiality, since she was an Anglican lay priest in that community. As it transpired, Rev. M did not follow the request that she be in a specific room where the participants had been advised to find her. Instead she asked a nurse to call out their names to which no one responded. Thus she saw no one. She was released from the project and I completed the follow-ups. Fortunately all but one of the participants were able to speak English adequately for the purposes of this interview. An advantage was that having done all first interviews at urban Site B, and follow-up interviews at urban Site A, I was acquainted with every aspect of the data collection and was therefore better able to supervise the rural data collection process.

For the rural arm, three potential follow-up researchers were trained. The first withdrew the day following the training on the pretext of other work commitments. The second had no access to transport. The third was intent on her own therapeutic agenda and the quality of her interview transcripts was inadequate. Since a nursing qualification was not a prerequisite for the follow-up interviews, an Honours student in Historical Studies was trained and became an asset to the research team.

8.4 Preparing the research team

8.4.1 Recruiting and training the co-operative inquiry group

In Chapter Five the programme for the original three day training, and follow-up day for phase two was outlined. It was quickly discovered that it had been far too condensed for such a complex and challenging research project. Consequently ongoing, and in some cases

intensive, supervision was necessary, which I provided. The research team met regularly, facilitated by BM, and these meetings constituted the co-operative inquiry groups of action research methodology, which also played a crucial role in enabling BM and KJ to detect and deal with difficulties experienced by the team.

Earlier in Chapter Four we examined how nurses' capacity for autonomy and initiative is systematically crushed during our professionalisation process to render us obedient, task-orientated cogs within the hierarchical medical machine (Menzies, 1960). It was argued that this systematic disempowerment of nurses provided evidence for Foucault's argument that power / knowledge can be used to sustain inequality (Gaventa & Cornwall, 2008). In terms of the action research cycle nurses in their professional lives are more accustomed to occupy the action and to some extent the planning phases of the cycle. One might predict therefore that nurses would more likely immerse themselves in managing and caring for these patients and planning how to do this, but struggle with observing and reflecting on their experience.

Based on our findings, our recommendation is that if one is doing an action research project with (in our experience South African) nurses, it is essential to do in-depth preparatory training, which immerses them in the action research paradigm. This training would aim to serve a dual purpose: to open the trainees' minds to inhabit the inquiry as autonomous equals and also to sift the potential candidates. The latter point speaks to whether they could manage the shift from research assistant to co-researcher, which could be determined by exploring their capacity for reflection. What can they learn from this? What do they think they can offer to it? How willing are they to go into the depths of their own lived experience? How willing are they to be initiated into this "new order" research paradigm where researchers are even required to become mindful of environmental issues (Reason, 1988), which symbolically can be seen to provide an intricate mirroring of micro and macro. How much understanding do they have of the balance between conscious and unconscious in all of us and how interested are they in becoming more sensitised to the symbolic world, which this awareness inhabits?

Also, every personality naturally gravitates, in their preferred learning style, towards one or two quadrants of the cycle, and is therefore less adept at the other two or three. During the training, it would be valuable to play games and do exercises which reveal where different team members are most comfortable within the research cycle since they can then use that awareness to support and develop their skills in the other areas during the research process. Also, this highlights a significant strength of good action research; namely that it can play to

the individual strengths of different role players within a group, while simultaneously offsetting each other's weaknesses.

These issues are crucial because in action research one is engaging in a transformative process. One engages so much as a whole person, with so much emphasis on self-awareness and being conscious and reflective that personal change and growth is inevitable. So alongside an assessment of whether potential candidates are open to their psyches, and what that could bring to the action research process, one also needs to look for individuals who have a capacity to think for themselves and be innovative. In other words, they need to be aware of and open to engagement, and the likely challenges to personal growth, with their whole selves. Moreover, Reason's (1988) advocacy for researchers who are embracing a new participatory paradigm takes it beyond simply being a research methodology and into the realm of someone who is willing to live the new paradigm in some way. This paradigm is about being collaborative and respectful towards each other and one's environment.

Methodologically this raises an important point. Expressed empirically, reliability and validity of research in analytical terms focuses on the measurement tool or intervention in use. Here we are suggesting that in action research the reliability and validity of the study may be definitively influenced by the co-researchers' ability/capacity to honestly engage with both the action and the reflection, and to account for each in a rigorous way.

In the interpretive hermeneutic paradigm, emphasis is laid on the person who is doing the interpretive or qualitative analysis, as an interpreter of others' experience. But in action research it seems to move to another level since in addition, one needs to be the interpreter and mediator of one's own experience. So making the effort to find researchers who are able to embrace and reflect on their own personal experience is arguably a vital aspect of quality control. Being able to create space in oneself such that there is a consciousness of "here am I having an experience" and "here am I observing myself having this experience".

This illustrates an interesting parallel between becoming involved in an action research project and going into psychotherapy. Much of contemporary spirituality also talks of this kind of awareness (Tolle, 1999). The process will take you places you didn't expect. It may uncover depths you did not anticipate. Personal awareness and growth is an inevitable "by-product". The emphasis on self-awareness also resonates with many contemporary spiritual practices such as meditation and mindfulness.

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8.4.2 The impact of IPV in the nurse researchers' lives

Training also included the introduction of the study to the health care providers at each research site. At Site B, the health care providers listened politely, but interacted minimally. The presentation for Sites D and E was very poorly attended. There were only three nurses, their supervisor, and a Victim Empowerment Police volunteer present. The session was harrowing as one nurse wept copiously until I took her outside and reassured her that she was not alone and that she had a valuable contribution to make. I also asked her permission to be included in the study in the hope that we could offer her something of value and she acceded. This seemed to calm her and the rest of the session went more smoothly. However, this pungent reminder of the ubiquity and destructive impact of IPV was bracing.

This reinforces the theme explored in the literature review, namely that co-researchers and health care providers share the same issues with their patients. Kim and Motsei (2002) found that nurses experience the same cultural values, and similar or higher levels of violence, as the patients they treat. Similarly, in their study of how the experience of IPV influences service provision by South African nurses, Christofides and Silo (2005) found that a total of 39% of nurses reported having experienced emotional and/or physical abuse themselves and 41% were aware of IPV amongst family and friends. This reflects a higher prevalence than the 25% reported in a national epidemiological study (Jewkes et al., 1999).

The evocative nature of working so closely with participants experiencing IPV was highlighted, when, during her first week of data collection, one co-researcher almost gave up. At the time, she was struggling with IPV issues herself. KJ provided constant support and encouragement during supervision and at the next co-operative inquiry group meeting the facilitator probed, with difficulty, encouraging the co-researcher to reflect more within herself, pointing out that her reflection might help others doing this work in the future. Ultimately, though, it was clear that this co-researcher was far more comfortable with action than with reflection. The incident is a reminder of how volatile a team working in an evocative area such as IPV can be, and how much effort is required in providing the researchers with ongoing, appropriate supervision.

More time could have been spent in the training and preparation, exploring how the researchers' own experience of IPV was likely to be activated and influenced by the inquiry process. Although throughout our training process the subject of violence was openly

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discussed, it was only on the final afternoon when practising interviews that personal experiences of abuse surfaced. It was salutary to realise that 75% of the co-researchers had personal experience of IPV.

8.5 The co-operative inquiry group process

The following discussions provide my critique of our action research process, which forms the foundation of our recommendations for other attempting such work.

8.5.1 Our group process and its potential for egalitarian, democratic dynamics

The implication of the fact that our professional action research project was university-based deserves mention here. Firstly, the funding we received was from the National Research Foundation, which has research capacity building as a key focus. In addition to the doctoral degree, around which the project centred, we were thus required to recruit researchers who would do Master's degrees. This led to the following rather complex dynamics:

1) Alongside being principal investigator, I was also an ex-lecturer of two of the co-researchers, as well as being the supervisor of both urban and rural co-researchers' Masters' degree.

2) I was also the project manager and therefore was required to check that co-researchers were doing interview procedures effectively and correctly, as well as to provide emotional support and understanding about co-researchers' own difficulties with this work.

3) I was also the doctoral student, so heavily invested in my initiative and passion.

4) I had freed myself of own IPV-related problems whereas two of the four co-researchers were enmeshed in their own IPV context. For the three of us, personal experience of IPV was the strongest motivation for immersion in the project.

5) The facilitator of the co-operative inquiry group was a professor and a doctor. Given nurses' professionalisation within an extremely hierarchical system (Marks, 1994; Rispel & Schneider, 1991), despite his significant skill at egalitarian facilitation, the power differential could have hampered the nurse co-researchers' ownership of the inquiry.

6) The co-operative inquiry group facilitator was my doctoral supervisor and therefore it was unlikely that I felt entirely safe to expose my own errors, many of which remained unconscious for quite some time, for this very reason.

Secondly, while on the one hand the links to our university enhanced our credibility with primary health care management at all levels, it seemed to cause a distance between us and

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the health care providers on the other. In retrospect it is clear that their hostility could be seen to reflect the mechanistic aspect of our approach to research in that we came in from the outside to do an intervention (which was imposed on them). Furthermore, we expected them to screen for us. This issue is explored shortly when my methodological journey is discussed.

8.5.2 Ownership of the inquiry purpose

The difficulties we encountered with recruiting and retaining our research team impacted on the co-operative inquiry group members' ownership of the inquiry purpose. Normally, the members of a co-operative inquiry group commit to dedicated participation in every co-operative inquiry group meeting in order to deepen the inquiry with each cycle and ultimately achieve a consensus on what has been learnt. Although the facilitator and I participated in all six co-operative inquiry group meetings, the involvement of other team members was incomplete (see Chapter Five, section 5.7.5). This directly affected, first how they engaged with the topic of the inquiry and second the extent to which they developed their own questions and inquiry process. Also the fact that three of us were nurses, and the other a junior researcher, seems to have influenced our sense of autonomy within this process. True to the submissiveness that hierarchical, mechanistic systems breed in underlings, we may unconsciously simply have been doing our best to please either the Professor/Doctor, principal investigator or both.

If ownership is perhaps too strong a term for what transpired in our particular study, the researchers nevertheless purposefully influenced the inquiry in various ways. The facilitator struggled to keep the discussion at a reflective level because my bias was to attend to project management issues, and also to ethical concerns related to participants' needs. Other co-researchers also provided narratives of their interviews without necessarily taking them to the reflective level. The facilitator played a crucial role in encouraging co-researchers to remain reflective in terms of our experience of trying to implement the protocol rather than simply recounting the individual experiences of participants and alluding to its impact on us as researchers.

The co-researchers' awareness of their feelings and reactions varied. One used her field notes to convey suppressed frustrations and/or distress to the project manager. These were usually confined to quite practical issues.

The fact that she and I were engaged in contractual / financial dealings typical of an employer / employee relationship is further evidence of how atypical our action research project was, contrary as it was to the egalitarian ethos of action research.

For the rest, participants displayed a combination of developing their own inquiry process in conjunction with engaging with the primary task, namely the team's research process (eg KJ's concerns about safety assessment and plan, MA's concerns about the viability of intervention at grass roots primary health care level, KT's desire to read up first interview material prior to follow-up interviews) and responding to the questions posed by the facilitator. The development of a particular personal line of inquiry that is aligned with the overall purpose is a sign of engagement and ownership of the inquiry process. The following quote provides a clear example of how a co-researcher felt ownership of the process since she had been directly involved in the planning of the change:

> *"What I found good was ... there were guidelines but it wasn't rigid ... we could make adaptations for the people in the study, for example, we adjusted the questionnaires as a team."*

Concerns about how effectively co-researchers grasped action research's emphasis on democratic and collaborative group dynamics are raised by the anxiety some felt about giving the "correct feedback". KT (Honours student, not a nurse) reported that this diminished as she spent more time at meetings whereas MA (nurse) remained plagued by performance anxiety related to the co-operative inquiry groups to the end. Fortunately this did not prevent her active participation in the co-operative inquiry group process. KJ, also a nurse, was prone to somatic symptoms such as neck spasms and headaches, which surfaced with virtually every co-operative inquiry group meeting, indicating her anxiety levels. However, this was more related to the strain of sustaining her multiple roles, and the ongoing and ultimate responsibility of the success of the project. In fact, the success of an action research project entails a particular twist. Unlike in the empirical-analytical paradigm, in the participatory-emancipatory paradigm one is forced to **trust the process** (including other people) to deliver. One cannot predetermine the outcomes. Therefore, as a researcher, during data collection, an undertow of uncertainty pulls at one's equilibrium.

NB, whose participation was comparatively brief, did not refer to having felt anxious about participating within co-operative inquiry group meetings. However, on interview

subsequently, she did not appear to have internalised a conceptual understanding of the action research process despite having actively participated in adapting the protocol to better suit her experience as a researcher in the second co-operative inquiry group meeting. She referred to these meetings "report back meetings" about, *"how we find the questionnaires, types of patients we met, stories that we heard and our feelings about stories from the patients."*

Clearly, the fact that her direct participation in the project was confined to five weeks, one in training and the other four collecting data, prevented her from internalising the full potential of the action research process. Ultimately, on interview, it was clear that she was actually unable to engage with a methodological discussion, as she did not seem to have a clear recall of the co-operative inquiry group principles. She was only able to say, *"I think things would have been more difficult if I were just alone there myself"*. NB described how, during a particularly disturbing interview, she developed an appalling headache. She linked this to her emotional distress. She expressed experiencing the co-operative inquiry group meetings as debriefing sessions, which she also found inspiring and motivating, enabling her to go back and do the fieldwork better. She expressed that in this way, the work had felt meaningful.

Yet even though she didn't reveal a theoretical display of methodological understanding, NB displayed a vibrant example of creative ownership of the inquiry in a brilliant initiative. Here she demonstrated her own natural ability to go around the cycle in a balanced and integrated way. When introducing IPV she noticed that women found it a stigmatised subject. On reflection she then planned to introduce the topic to her participants by referring to the Xhosa custom of the bride being given a blanket to hide all her problems thereafter. NB then challenged this patriarchal discourse in terms of the contemporary scourge of IPV and its inherent dangers. She found this relaxed the participants rendering them more open to discussing their difficulties.

Overall, reflecting on our co-operative inquiry group process, and how effectively we inhabited each phase of the action research cycle, a key critique could be around how willing we were, ultimately, to change the original IPV management protocol itself. As discussed in Chapter Five section 5.7.7, we had, as a team, modified the protocol between phases one and two (i.e. between the urban data collection phase and the rural data collection phase) and two and three (between the end of data collection, through six months of reflection and assimilation, to the final group meeting). We also refined the follow-up tool together at the original training (prior to phase one) and subsequently too in a co-operative inquiry group

meeting. However, at the fourth co-operative inquiry group meeting, with one week in hand, BM was keen for KJ to take the reflection to a deeper level by reformulating the intervention for Sites D and E according to the ideas we had been formulating in the co-operative inquiry group process hitherto. But there was no time to fit in another co-operative inquiry group to do so , and KJ felt intimidated by the enormity of the task, with such a short turn-around time, so did not seize the opportunity to make maximum use of this modelling stage. In retrospect we have wondered how possible we made it for our learning to be fed back into changing the action, which is essentially the domain of unique possibilities within the action research paradigm. KJ's resistance spoke to her residual empirical-analytical mindset, which was more comfortable with the safety of continuing the action that we had been practicing in Site A,B and C, at Sites D and E, and learning from it.

8.5.3 The relationship of nurse co-researchers to nurse health care providers at the sites

Our research team design accentuated the outsider status of four of the five researchers. One co-researcher was from another province although she spoke the same language as most of the staff at Site A. However, essentially her experience within the community health centre was one of alienation and isolation. Not only did she struggle to get referrals from health care providers, but also they never showed her where their tearoom was. This I only discovered on interview some months after she had finished her data collection. It speaks powerfully to her status as an outsider.

By contrast the rural co-researcher had grown up in the town of Sites D and E which are close to the town of Site C and so she knew many of the health care providers at all three sites. They certainly welcomed her presence and cooperated well with her. She referred to feeling as if her professional status had been elevated by her role in the research team, since she felt valued by the staff as a resource. This produced a dialectical tension within her since on the one hand she felt encouraged and uplifted to be part of such a team whereas on the other she felt piercing self-doubt and couldn't believe that she really was part of such a team., "*It meant a lot to me as a human being*".

The two other follow-up researchers simply did their follow-up interviews once a week for a month or two without engaging with members of the community health centre in any significant way. Thus such boundary issues did not surface.

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8.5.4 The reflexive task: my own methodological journey

'Reflectivity' and 'reflexivity' are terms that tend to be conflated. In essence, 'reflexivity' refers to the awareness of one's own theories and emotional responses. Action researchers prioritise this as a crucial skill since it relates to cleaning oneself as a research instrument (Mash, 2002). Psychoanalysts' preoccupation with counter transference mirrors this work. 'Reflectivity' refers to the ability to reflect on and learn from one's experience by observing and reflecting on it in order to generate new knowledge.

One of the biggest challenges of this thesis has been writing it up as principal investigator and doctoral student, while simultaneously being a novice action researcher. Partly because I cherish the quality and standards of this project, it has been so hard to recognise and acknowledge my own mistakes. I now see how easily I dissected and analysed the rest of the team's shortcomings, but was far more reticent about admitting to my own, even into my consciousness.

It is also difficult to discern for myself what negative aspects of my own professionalisation and on-going experience within nursing, albeit academic over the past decade, I have internalised. For example, BM's questioning my use of the term "supervision" alerted me to a possible blind spot within myself. I felt he was projecting a somewhat militaristic and superficial approach to management onto me. Under the circumstances of this project and my multi-faceted role, I saw "supervision" as project management combined with emotional support ("holding") of the team. The latter component fits with the psychological sense of supervision. Yet the conflicting tasks (8.5.1) prevented me from truely providing same. On investigation, it transpires that BM's concerns were founded since both English and Afrikaans definitions of the word make no reference to the psychological understanding of the term: "supervision, inspection, control" (Chambers English Dictionary, 1988) and "toesighouer" (MA's references to my role in her fieldnotes) – "overseer, minder, floor walker" (Reader's Digest, 1987). If one accepts that the term "supervision" is contaminated by the above associations, then perhaps the role could be better framed as "support" which is clearly defined as engaging people in a process of reflection, which allows space for self-regulation.

These issues provide the backdrop to my methodological journey, which started with envisioning this project as a randomised controlled trial. As a thoroughly inexperienced researcher located within a medical school, I had allowed myself to believe that this was the "gold standard" of research methodology. Fortunately, my supervisor encouraged me to think

in terms of action research and the protocol moved in that direction instead. I had brushed against action research once before, but this was my opportunity for really working with the paradigm, and my choice thereof was instinctive. I recognised a resonance with my own deeply spiritual value system. I trusted the egalitarian ethos, as so much of my nursing career has felt marred by oppressive patriarchal aspects of the bio-medical hierarchy. Also, this opportunity to create and model a complex health intervention appealed, but my understandings were very limited as evidenced by the following scant paragraph which was the sum total of attention to action research methodology in the original doctoral protocol:

> "A co-operative inquiry group (Mash & Meulenberg-Buskens, 2001) will be created with the principal researcher, research assistants and promoter to plan, observe, document and reflect on the implementation of the protocol."

At this stage, my understanding of the project was that it was to yield findings, which would centre on the bio-psychosocial needs of women experiencing IPV. By the beginning of the second phase of data collection, I had realised that if health care providers were so resistant to asking one screening question, then how relevant was the perfection of an intervention for them to use? Surely the priority was in fact to explore their resistance and understand that better? This produced a major shift in my orientation to the project, and significantly influenced the theory explored and foci from there on.

A final and rather salutary shift came with the realisation that our study design was mechanistic. We had identified community health centres that were willing to have the project come in from outside and provide a specialist service, and we had identified co-researchers who could go as outsiders into the health centre and do first and second interviews. What if instead we had identified community health centres who were interested to engage with the topic and then we had worked with the health care providers who chose to participate from the start? Surely the issues around resistance would have been far less pronounced? The whole project could have had very different outcomes.

I became aware that my research activities and particularly my role as outsider-researcher and insider-'ex'-nurse distanced me from the personnel. On the whole I found health centre management more welcoming and willing to participate than were the health care providers, which I think was linked to my status as a university lecturer. Management was comfortable with forming an alliance with our Stellenbosch University project, and they understood the

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significance of the need for services for IPV. The health care providers however were comparatively hostile – at least to start with and by the time their attitudes had eased up, I was moving on.

8.6 Conclusion

Professional action research is a valuable methodology for use in the health sector, not least because it is ideally used in real life working environments. However, within the health sector, and particularly with nurse researchers, in-depth training in the use of this methodological paradigm is of paramount importance because it requires an innovative and reflective mindset.

We saw that the institutional processes required to register an academic research project prevent purist action research, specifically in the initial planning phase – and not all academics tasked with overseeing research proposals are steeped in the action research framework. Some suggestions for how institutional processes could open up to action research approaches were made. The impact of conducting research while accountable to institutions (Stellenbosch University and the National Research Foundation) with their own trajectories did not entirely end with the research planning phase, and we further touched on these issues in the course of the chapter.

Many questions arise when research is conducted through a collective process as envisaged by action research, in a context where intellectual property is privatised. We looked at the implications for who benefits from the intellectual property created, and for co-researchers being empowered to take full ownership of research goals, process and quality of findings.

The principal investigator and co-researchers constituted the co-operative inquiry group which was facilitated by the doctoral supervisor . Finding the combination of skills (nurse, doing a Masters degree, language skills) and commitment (willing to do IPV research, performing consistently and adequately) ideally needed in co-researchers locally was a tall order, and the chapter described how we accommodated reality in identifying, recruiting and retaining co-researchers. The challenging processes of training and retaining the co-researchers were explored, and recommendations made as to how to improve the selection and training. One finding is that within the health sector, and particularly with nurse researchers, training in the use of action research methodology itself would be important. We examined the inherent contradiction between the role nurses are taught to play in the health

system, and action research's concept of engaged, autonomous, innovative and reflective co-researchers collaborating in transforming themselves, each other and the context.

A key insight of this chapter is that, in contrast to empirical-analytic enquiries where reliability and validity of research findings rests on the measurement tool or intervention in use, and interpretive-hermeneutic enquiries where research integrity rests on the principal researcher doing the analysis of others' experience, with action research what is central is the co-researchers' capacity to honestly engage with the research cycle of act-capture-reflect-plan which includes mediating one's *own* experience and impact. This requires a different stance from that of the stereotypical independent observer of classic science, and an openness to personal transformation which may be experienced as akin to psychotherapy or spiritual journeys. When the research topic is a traumatic experience, in this case IPV, undergone by many of the researchers themselves – it ultimately emerged that 75% of the nurse research team had personal experience of IPV – the research journey will be correspondingly that much more demanding on researchers.

Of course, since praxis seldom reflects principle perfectly, the journey was not a smooth one. The chapter reflected on how complex power and interpersonal dynamics that were embedded in the relationships between the principal investigator, co-researchers severally and individually, and the thesis supervisor who was also the facilitator of group meetings, may have impacted upon the research, in particular by hampering emotional transparency, greater adventurousness and egalitarian approaches. Hallmarks of the group process were the majority of the team's struggle to occupy the reflective mode, resorting rather to reporting, and discussion of patient care and logistical or management issues, and levels of performance anxiety experienced by group members. Action research uniquely offers the potential of our learning being fed back into changing the action, and perhaps this potential was not fully realised in our process. Nevertheless, despite patchy participation by co-researchers in the co-operative inquiry group, which both reflected and furthered the relative dislocation of co-researchers from ownership of the research topic, process and methods, the research group did purposefully influence the inquiry (modifying the protocol and follow-up tool), and some co-researchers did develop a personal line of inquiry and approach. Examples were given of a spectrum of co-researcher responses to and use of the research team meetings, which functioned as a report back, debriefing and support meeting for some while also enabling reflection. The chapter closes with my own reflection on the research journey from a randomised controlled trial to modelling a complex health intervention to trusting the process.

Internal shifts in myself opened the inquiry up, from a focus on investigating the best PHC intervention for IPV survivors, to wanting to understand health care providers' resistance to take even the first step of that intervention – including owning features of the research design which may have contributed to the resistance.

With these perspectives in mind, we turn to giving the learnings from the research expression in the conclusions and recommendations of Chapter Nine, regarding policies for IPV care at three levels within the PHC sector of South Africa, and regarding the training and support of action researchers.

CHAPTER NINE
WAYS FORWARD TO BETTER IPV CARE:
CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

This study has provided a snapshot of the rewards and challenges of activating awareness around IPV as a significant bio-psycho-social issue within a primary health care system in transition. It has also explored an atypical, but unusually fertile research methodology in an effort to search deeper and differently. This chapter has been written in two parts. The first attends to IPV-related issues and recommends a comprehensive model for future IPV care. The second concludes our methodological findings and imagines the methodological possibilities forward.

The first research goal identified the standard of care for IPV in the PHC sector of the Western Cape as being inexcusably inadequate. It also revealed a significant mental health risk in IPV patients. The second research goal tested a protocol for screening and management of IPV for feasibility and modification. This intervention was found to be too long, and clinical nurse practitioners too poorly resourced and supported to provide comprehensive IPV care. Our model is outlined in sections 9.2 and 9.3. The third research goal learnt from the process of training and supporting researchers new to the action research paradigm, and is concluded in section 9.4.2.

We have seen that contemporary South African primary health care practice neglects a key component of the original vision as expressed in 1978 at the International Conference on Primary Health Care at Alma Ata. Comprehensive primary health care was defined as:

> *"Care based on the needs of the populations ... requires the active participation of the community and family, and is undertaken by non-specialized general health workers collaborating with personnel in other government and non-governmental sectors. These general health workers should be trained in the use of simple but effective techniques that are widely applicable, such as mobilizing community action, stimulating self-help groups, and providing health education, with particular emphasis on health promotion and disease prevention"* (World Health Organization, 1997, p.7).

A key solution that this thesis proposes for our crisis of IPV care is the activation, engagement and elevation of a network of committed individuals who can start healing their communities by creating and sustaining a genuinely supportive safety net for IPV survivors and children. Hoff (1995, p. 160-1) argued that despite the dominance of individualistic philosophies in helping professions, a social network approach was gaining ground because self-help groups develop the strengths of the group members and can play a vital part in all phases of crisis management. Hoff notes that the success of such groups resides in the creation of a climate of empowerment and the characteristic bonding among members (Hoff, 1995, p. 160).

9.2 Tools for IPV assessment and management

The protocol we implemented was a bio-psycho-social model that took between 60 and 90 minutes for each participant. Clearly this is far too long for a PHC system that allows seven minutes per consultation (PGWC, 2006). This thesis concludes that care for IPV survivors does not fit the 'quick fix' paradigm, so prevalent within the biomedical approach. Instead, viable IPV care is far more compatible with the contemporary model of chronic care. Understanding IPV as a chronic condition indicates that sometimes there is no 'cure', but as with HIV/AIDS, the quality of life and overall mental and physical health for affected individuals, family systems and communities can be significantly enhanced. Continuity of care is another aspect of the chronic care model that is relevant here.

As Chapter Four examined, Taylorist organisational dynamics in nursing produce a task-oriented approach to work which fits neatly within the biomedical model. So a distressed patient presents and is referred to a psychiatric nurse for medication. We found this orientation extended to other team members, most obviously that of social workers where the focus was on completing forms rather than seeing the patient as a whole (see 7.5.3). By contrast, good IPV care demands a high standard of emotional labour which along with feminist awareness, empathy, time and listening is relatively inaccessible in the local (biomedical) health systems.

In this chapter, recommendations are made for IPV health policy in the PHC sector. Firstly, structural changes to documentation that make recording of IPV mandatory, have a far higher success rate with changing health care provider behaviour than training and education on their own do (Harwell et al., 1988; McLeer & Anwar, 1989; Olson et al., 1996). Since all parties consulted requested a one page IPV screening and referral flow chart, we offer a

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flowchart (Figure 3) to serve as the first tier of our model for IPV care in health systems. This should be recorded in clinic statistics for the annual report to be fed through to a national IPV data base.

The flow chart includes cues to alert health care providers to the possibility that this woman is having difficulties in her relationship, and so to ask, *"Are you unhappy in your relationship?"* or *"How are things going in your relationship?"* The term 'screening' can be misleading. Strictly-speaking, screening refers to an activity that is applied systematically to an entire population, involving a meticulous register and rigorous recall procedure. In South African health care systems, evidence of an established culture of such screening is scant. We recommend case-finding, where the problem is looked for opportunistically when certain patients / presentations appear. In addition this study suggests that it is worth asking about IPV routinely as part of the assessment performed with certain clinics such as HIV/AIDS, family planning and chronic diseases of lifestyle.

To continue with the workings of the flowchart, if IPV is identified, the health care provider gives relevant clinical care before referring the patient to the IPV specialist (champion) for that facility (see section 9.3). The latter interviews the patient using our modified assessment tool (see section 9.2.2) and then refers, as relevant, for psychological, legal and social support. S/he also introduces the client to the ongoing IPV therapeutic group process. When the client has completed the *Lifestyle Intervention for Empowerment Programme (see Appendix N)*, she moves into a support group. The IPV specialist remains available to IPV clients should they request support or other expertise post intervention.

Figure 3: **FLOWCHART FOR IPV IDENTIFICATION AND MANAGEMENT**

Attending Chronic

Care Service   **Cues**

| Parts of routine assessment/annual review

 • Chronic Diseases
 • HIV
 • Family Planning | • Vague non-specific symptoms
 • History of mental illness, medication, psychological symptoms
 • Fatigue, sleep problems, unexplained somatic complaints
 • Symptoms of depression
 • Feeling anxious / dizzy / thinking too much
 • Chronic pain syndromes
 • Repeated sexually transmitted infections, HIV & ARV preparation
 • Assault or trauma
 • Suspected alcohol or substance abuse |

Hypothesis

Asks, "Are you unhappy in your relationship?"

Yes

CLINICAL (see overleaf)

1. Check sexually transmitted infections / HIV
2. Document & care for injuries (use J88)
3. Check pregnancy, offer contra-ception, termination, sterilisation

Refer to IPV Champion

| **LEGAL**

 1. Refer to any or all of the following:
 a. Family court for Protection Order
 b. Victim Empowerment Unit at Police Station for support
 c. NPO sector for legal aid | **PSYCHOLOGICAL**

 1. Listen to patient's story
 2. Do mental problems checklist and consider anxiety disorder, depression, substance abuse, post-traumatic stress disorder
 3. Follow-up counselling, support | **SOCIAL**

 1. Assess social support and explore possibilities
 2. Assess safety: risk, feedback, safety plans
 3. Help with maintenance for children
 4. Refer to relevant organisations |

The Therapeutic Group Process with 'Lifestyle Intervention Empowerment Programme', chronic care model

Support Group

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Clinical care (on back of flow chart)

Pregnant?   Yes ……   No …….

Normal menses in last month: Yes ……   No …….

Contraception given? _____

SEXUALLY TRANSMITTED SYNDROMES:

Vaginal Discharge Syndrome   ☐   Genital Ulcer Syndrome   ☐
Lower Abdominal Pain   ☐   Moluscum Contagiosum   ☐
Genital Warts   ☐   Pubic Lice   ☐
Herpes Simplex Virus   ☐

Other medical condition(s)

_____

SPECIAL INVESTIGATIONS NEEDED:

                                                                Year/Date

    1.   **Prior Voluntary Counselling & Testing**   _____

       Positive   Negative   Not done
       ☐   ☐   ☐

    How did your partner react when you disclosed your status?

_____
_____
_____

2.   Do you want HIV testing now?   Yes ……   No ……

Rapid plasma reagin: Yes ……   No ……

Pregnancy test: Yes ……   No ……

X-rays: Yes ……   No ……

TREATMENT PLAN/GIVEN:

Injuries   Yes ……   No ……

Emergency contraception   Yes ……   No ……

Sexually transmitted infections   Yes ……   No ……

Post-exposure prophylaxis HIV   Yes ……   No ……

Other medical conditions:

Since only approximately 30% of the study sample was injured, we split off the forensic documentation for use only when applicable. Mental health assessment tools for primary care, developed for the South African context by Professor Mash were included (Mash 2002). However, questions 9 and 10 on the mental problems checklist below, are the product of our action research process.

9.2.2 Tool for comprehensive initial assessment of IPV client

Folder No: _____   *Date:* _____

CONFIDENTIAL REPORT ON IPV EXAMINATION

PATIENT INFORMATION:

Name: _____   Age: _____

Current Residential Address: _____

Tel No: (h): _____   (w): _____   (cell): _____

Safe to phone?   _____   _____   _____

Partnership Status: Married how? _____

Same-sex partner ☐ Single ☐   Co-habiting ☐ Divorced ☐

Genogram:

ADDITIONAL INFORMATION

Has a criminal charge been laid? ☐ Yes   ☐ No

If yes, what charge was laid?
Assault ☐   Grievous bodily harm ☐   Rape ☐   Indecent assault ☐
Contravention of protection order ☐

Name of police station:_____ CAS No: _____

If no, does the patient intend laying a charge?

☐   ☐   ☐

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Yes   No   Unsure

Does patient have a Protection Order?   Yes ☐ / No ☐

Name of magistrate court:

_____

If no, intends to apply for protection order; Yes ☐ / No ☐ / Unsure ☐

HISTORY OF MOST RECENT ABUSE

Location, date and time of incident:

_____

Identity of abuser: _____

Nature of the abuse

PHYSICAL   **EMOTIONAL**   **SEXUAL**   **FINANCIAL**

Hitting ☐   Being insulted ☐   Unwanted Touching ☐   Withholding Money ☐

Kicking ☐   Shouting ☐   Infidelity ☐   Taking Money ☐

Use of a   Restricting contact   Sexually transmitted   Controlling All
Weapon ☐   with Family/Friends ☐   infections ☐   Financial Decisions ☐

Pushing ☐   Threats ☐   Forced Intercourse ☐   Other _____

Choking ☐   Controlling her   Other _____
                      Activities ☐

Burns ☐   Other   _____

Other_____

Patient's description of most recent abuse (Use exact words as far as possible. Describe severity of abuse.)

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Other episodes of abuse:

Describe frequency & severity of past abuse, using direct quotes from the patient. Describe mechanism, location and extent of injury and/ or symptoms/conditions.

Frequency over last 2 years: 0-10 ☐‎ / 11-20 ☐‎ / >20 ☐‎

Patient's description:

_____

_____

_____

_____

ASSESSMENT OF EMOTIONAL STATUS:

Mental Problems Checklist

1. Are you thinking too much? ……………………………………….................... ☐
2. How are you sleeping at the moment? ………………………………................... ☐
3. Do you feel exhausted or tired even when you are not working hard? ……......... ☐
4. Do you feel sad or like crying for no reason?…………………………................ ☐
5. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? i.e. listening to music or going out with friends…..…........... ☐
6. Do you sometimes have the feeling as though you are going to hear bad news?… ☐
7. a) Have you ever felt you should cut down on your drinking? ..………………… ☐
    b) Have people annoyed you by criticising your drinking? ………………….. ☐
    c) Have you ever felt bad or guilty about your drinking?……………………… ☐
    d)   Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover?………………………………………… ☐
8. Have you experienced traumatic events that made you feel extremely threatened or endangered? Or witnessed someone else in this situation?…………………….. ☐

9. Do you or your partner ever use any of the following substances: Dagga, mandrax, tic, cocaine/crack, heroine, benzene or solvents, glue, ecstasy? In the last month? ....   In the last year? ....
10.   How many days last month did you take painkillers?......................................

If positive to any one further assessment may be required.
        If positive to **1, 2, 6** consider **anxiety disorders.**
        If positive to **7** consider **alcohol use disorders.**
        If positive to **8** consider **post traumatic stress disorder.**
        If positive to **9 or 10** consider **substance abuse disorder.**

REFERRAL FOR MENTAL HEALTH

Depression requiring further assessment?   Yes ☐   No ☐

Post traumatic stress disorder requiring further assessment?   Yes ☐   No ☐

Anxiety disorder requiring further assessment?   Yes ☐   No ☐

Alcohol/substance use disorder requiring further assessment? Yes ☐   No ☐

DANGER ASSESSMENT:

A danger assessment must be done for all patients who disclose domestic violence. Record answers to the following questions. The answers to the questions can be assigned a value for risk assessment. Assign a value for the answers as follows: No = 0   Yes = 1

Add up the total to provide a risk rating: **1 – 2 ➔   Caution**

3 - 5 ➔   High Risk

6 -11 ➔   Severe Risk

Has he threatened you with physical violence?   Yes ☐   No ☐

Has he threatened the children with physical violence?   Yes ☐   No ☐

Is there a firearm in the house?   Yes ☐   No ☐

Has he threatened to kill you?   Yes ☐   No ☐

Has he threatened to kill the children?   Yes ☐   No ☐

Does the patient think he is capable of killing her?   Yes ☐   No ☐

Were alcohol and / or drugs consumed prior to the last incident of abuse? Yes ☐   No ☐

Has the abuse escalated in either frequency or severity?   Yes ☐   No ☐

Have you ever received medical treatment for injuries sustained

as a result of abuse?   Yes ☐   No ☐

Have you ever thought of killing yourself?   Yes ☐   No ☐

Have you ever thought of killing the children?   Yes ☐   No ☐

Score: 1-2 ☐   3-5 ☐   6-11 ☐   **TOTAL RATING** ☐

SAFETY PLAN:

Help the client think and plan the following:

?	Where can you go if you need to leave home?
?	Who can you trust to tell about the domestic violence?
?	Where can you leave money, clothing, copies of documents and valuables if necessary?
?	How will you ensure your children's safety?

Advise patient to hide a readily available packed bag with essential items such as:

- Her ID book, birth certificates, hospital cards, and other important documents.
- Keys, money and bank card.
- Clothes for her and her children.
- Important telephone numbers.
- Copy of the protection order and suspended warrant of arrest if she already same.

Make a list together of other things to take with her, for example:

- Children's favourite toys, books.
- Children's school books and uniforms.
- Toiletries (toothbrush, deodorant, etc).
- Other valuable personal items, for example, photos and jewellery.

REFERRAL LEGAL AND PSYCHO-SOCIAL ISSUES

Referral letters supplied?	Yes	☐	No	☐
Magistrate court for protection order	Yes	☐	No	☐
Police station for criminal charge	Yes	☐	No	☐
Counselling	Yes	☐	No	☐
Legal support	Yes	☐	No	☐
Social worker	Yes	☐	No	☐
Shelter	Yes	☐	No	☐

Other:_____
_____
_____
_____
_____
_____

FOLLOW UP:

Date and time of appointment if made for follow-up?_____

Signature: _____
Health Facility: _____
Date: _____

9.2.3 Output: PALSA Plus

In 2007, Professor Mash invited me into the mental health working group for PALSA Plus (Practical approach to lung health and HIV/AIDS in South Africa) to contribute to the 2008 edition. PALSA Plus has been contracted by the Western Cape Department of Health to provide clinical nurse practitioners with a clinical manual consisting of diagnosis- and management-related algorithms for common presentations in primary care. I participated in the compilation of the traumatised/abused clients' chart, and focused on care for IPV (see Figure 4 below).

PALSA Plus has been contracted by the Department of Health to provide these tools for use by clinical nurse practitioners throughout the primary health care system. Clearly, if this chart could be updated to include our findings for the next edition, the potential improvement of national health care for IPV is extremely promising. The clear, informative boxes in our flowchart could be incorporated into a new PALSA Plus chart specifically for case finding and managing IPV. There is also scope for linking IPV patients in with the chronic care system of support groups for IPV discussed below.

In retrospect, the CAGE questionnaire may have been a preferable screening tool to use, since the only drinking problems I detected were when using the following questions, rather than those specified in Figure 3:

1. Have you ever wanted to cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover?

Figure 4: The PALSA PLUS algorithm for the traumatized/abused client (2008 edition)

Traumatized/abused client

• A traumatic experience may be accidental, criminal or abusive. Domestic abuse can be physical, emotional, sexual or financial.
• In South Africa, rape occurs 30 times more often than elsewhere in the world, and a woman is murdered by her male partner every 6 hours.
• The elderly and people with mental and physical disabilities are particularly at risk.
• A traumatic event can have physical effects but also a deep effect on a person's mental health.

Recognize the severely ill client: OR refer same day:
• If injuries need further attention
• In need of shelter – in immediate risk of being harmed
• Recent rape/sexual violence (if the client wishes to lay a charge, see below)
• At risk of harm to self or others (see page X-MHA/suicide)

Lead-in questions:
'Are you unhappy in your relationship?'
'Has something happened to you that's changed your life?'

Approach to the abused/traumatized client
The primary care practitioner's role is to be supportive, identify underlying mental problems and those at risk and refer the client to appropriate resources.
Listen and support
• Just listening to the client's story in a supportive and non-judgmental way can help. (See page 43 for tips on communicating and counseling).
• Do not reject or give up on the client who fails to follow your advice. Respect her choices and remain supportive.
• Focus on coping mechanisms to help the client to identify their strengths, support structures and resources to cope.
Screen for mental problems
• Anxiety and depression are common. 1 or more might indicate that the client has a mental problem (see page X anxiety/depression):
   • Low mood or sadness   • Sleep problems   • Feeling tense or anxious
   • Loss of interest or pleasure • Decreased energy or increased tiredness • Worrying a lot about things
Screen for substance abuse
Ask your client: 'Do you take > 21standard drinks /week (men) or > 14/week (women)?' 'Are you misusing prescription or illicit drugs?' 'Has your drinking or drug use ever caused harm to yourself or to others?' If yes to 1 or more, consider substance abuse. See page X.
Review
• Offer to see the client again. A supportive relationship with the same health practitioner helps to contain frequent visits for multiple problems. (See page X)
Refer to available supportive resource
• Psycho-social: consider social worker, psychologist, occupational therapist, trauma counselor, or psychiatric nurse.
• Legal: refer to the police and their Victim Empowerment office, legal advice office, shelter, NGO support and advice offices.

Approach to the sexually abused/raped client
If recently raped, legal, medical, and emotional issues should be addressed at a designated health facility for management of survivors of rape and sexual assault.

Prevent HIV and syphilis
Give first dose of post exposure prophylaxis within 72 hours of rape
Offer …..

The content for sexual abuse/rape to be completed

Prevent chlamydia and gonorrhoea
If asymptomatic:
• Ceftriaxone 250mg IMI stat
• Doxycycline 100mg twice a day for 7 days
If symptomatic, treat syndromically (seepages X)
Use condoms for 3 months with regular partner

Prevent pregnancy
If not using a contraceptive and of child-bearing age

[1] A drink first thing in the morning to steady the nerves or get rid of a hangover.

9.3 Seeing IPV care as chronic care

Chronic disease management is currently one of the Western Cape's eight priorities in health. A chronic disease management model contravenes the traditional bio-medical model where patients come in, are diagnosed, receive medication and leave. The Head of Chronic Care for the Western Cape, Unita Van Vuuren, reported that in 2006 - 2007, a team of specialists conducted a rapid appraisal of health care provider practice, patient support, health promotion and organisational structure. These four elements informed their appraisal, which resulted in a conceptual framework for the management of chronic diseases. At the time Unita Van Vuuren was head of chronic diseases for the Cape Metropole, and working on both the task and reference teams for the province. Her mental health background equipped her with an appreciation of how well multi-disciplinary team approaches can work in conjunction with a champion for the facilitation of chronic care per facility. In over 20 years of experience working in this health system, she identified that a major drawback for getting new health initiatives going was that staff constantly come and go: to night duty, on leave, to new positions elsewhere, and there was no dedicated person to continue what had been started (Mash, Levitt, Van Vuuren & Martell, 2008).

Current chronic care policy, therefore, initiates the concept of 'champions' who provide continuity of leadership for chronic care and practice. The champion humanises the organisational structure by providing the right environment for that client to get the correct diagnoses and treatments. In chronic care the champion coordinates the team and maintains organisational integrity of vision. In urban areas, the teams can comprise the following: family physician, clinical nurse practitioner, health promoter, psychiatric nurse, social worker, pharmacist, dietician, dedicated clerk, orthopedic nurse, occupational therapist. However, in rural areas there are scarcely enough nurses to staff the clinics, and other members of the team are often absent. There are also minimal posts available for much-needed social workers and psychologists. By September 2007, over 50% of Metro community health centres had a champion to coordinate chronic diseases for that facility.

This model could work for IPV care. The IPV champion's fulfilment of their role would be part of their job description, recognised within their performance agreement by their facility manager. Our point is that it is crucial that the champions are selected not according to their profession or roles, but rather in terms of specific characteristics and qualities which they possess. Thus the champion could be any member of staff at the community health centre

who is interested in working with IPV. Policy must specify particular qualities that this person should exhibit:

- interest / desire to work with IPV;
- empathy and good listening skills;
- respect for client confidentiality and autonomy;
- collaborative approach to problem-solving;
- effective multi-disciplinary team player; and
- good networker for intersectoral collaboration to promote support group project.

Here we see how this profile requires an IPV champion who is capable of handling the demands of emotional labour. As explored in 4.2.2, emotional labour is hard work because it is often painful and draining. Also, one gives of oneself, and the giving of personal attention is not formulaic (James, 1989). Chapter Seven showed how participants appreciated the supportive, genuinely concerned style of the co-researcher. Many health care providers tend to be directive in their style of communication with patients and this implies an unbalanced relationship regarding power, expertise and authority. The IPV champion needs to work with a guiding style as this is ideal for helping people solve behaviour change problems and the counsellor focuses on how to help the patients make their own decisions about behaviour change (Rollnick et al., 2008, p. 18). The following synonyms for guiding are offered, and provide clues as to the skills of the task, *"enlighten, encourage, motivate, support, lay before, look after, take along, accompany, awaken, elicit"* (Rollnick et al., 2008, p.15). The egalitarian ethos stands in stark contrast to the synonyms offered by the experts for directing, *"manage, lead, take charge, preside, rule, reign, conduct, determine, steer, prescribe, tell, show the way, govern, authorise, take the reigns, take command, point toward, administer"* (Rollnick et al., 2008, p. 14).

Facility managers are thus required to select an appropriate staff member to perform the role of IPV specialist for review after one year. The facility would then release this staff member and if necessary plan to cover her/his previous duties with other or additional staff for a number of hours per week (for example, 12 hours = 1.5 days). The IPV champion uses this time to fulfill her / his role of champion, facilitating the IPV needs of identified patients within the community health centre on an ongoing basis. However, this IPV specialist cannot do all the counselling as s/he is also responsible for coordinating her IPV team and maintaining organisational integrity of vision and practice.

The chronic care model adopted recently by the Western Cape province, if applied to IPV, would work in the following way:

1) Once identified as an IPV survivor, the patient is referred to the designated IPV champion who will assess the patient according to our modified protocol as outlined in 9.2.2 above.

2) The patient joins the weekly therapeutic group process facilitated by the IPV specialist who will be guided by the Lifestyle Intervention for Empowerment Programme flipchart (see *Appendix N*). As facilitator, s/he uses this tool in conjunction with the group process to attend to stabilising the IPV survivor's health, modifying her behaviour and consciousness-raising with regard to rights and resources. It was developed by a team facilitated by Unita Van Vuuren and entails a combination of sessions all of which patients need to attend before being referred to a support group.

3) The champion ensures that their community health centre has an ongoing support group for participants affected by IPV. Given the stigma surrounding IPV, it may need to be framed as a 'Women's Health' group, closed to specific referrals. The development of a system of support groups could be financed by the budget allocated for "social capital" (see 9.3.1), and coordinated by NPOs.

The chronic care model also emphasises issues such as continuity of care and a team approach.

9.3.1 Community-based support groups for IPV

Social capital is a contested contemporary social scientific term used for the existence or building of trust and relationships within and across different organisations and communities. It is also a term for a provincial strategy that has been adopted by all departments within the Western Cape health system. The Department of Social Services is using a developmental approach, backed by a budget, to drive this effort aimed at activating each community's capacity to develop and sustain its own resources.

Therefore, the development of a system of IPV-related support groups as a referral network for women of all ages, fits directly within social capital's orbit. Participants at every research site expressed the desire to participate in an IPV support group. At two sites, participants

volunteered to facilitate it, indicating their desire to be of assistance to women in similar circumstances. The following objectives speak to my vision of how this could work:

1. Set up and sustain a system of support groups for women who are in relationships characterised by physical / sexual / emotional / verbal / spiritual / financial abuse. This includes separate groups for teenagers.

2. Champion to develop and maintain a reliable referral resource network for the support group from local health and social services, police and Family Violence Courts, non-profit organisations, schools and religious organisations to which women affected by IPV can be referred.

3. Develop the capacity and self-esteem of facilitators (IPV survivors) in training to run the support group programme.

4. Build communication, job and problem-solving skills within support groups.

5. Grow a network of community members connected by their concern about IPV and who are committed to working together on this issue.

In 3.3.6, literature demonstrating the increased susceptibility of IPV survivors to HIV infection exposed the significant overlap between the two health risks. Historically, the silo approach to HIV care has resulted in a lack of careful attention to IPV in the lives of HIV+ patients. Yet the psychosocial work-up for anti-retroviral roll-out provides ideal scope for sensitive examination of IPV issues. This thesis has argued that it is essential for contemporary South African health systems to prioritise the effective co-ordination of IPV treatment. The extension into every aspect of HIV care, not least the training of the counsellors, is strongly recommended.

In the mid-eighties, Campbell (1986, p. 16) reported that the effects of consciousness-raising groups have been measured in at least two reported studies. Both found participants to have a significant positive change from pre-test to post-test self-esteem scores following attendance at a series of weekly discussion groups. Campbell (1986, p.18) also reports that group interventions for abusers, combined with a policy of mandatory arrest of batterers by police officers, is a most effective means of diminishing violence in intimate relationships (Gondolf, 1985). Support groups could potentially offer that supportive social environment where people feel listened to and empathised with. Specific tasks would be referred to relevant resources.

9.3.2 Role of psychiatric nurses

> *"Part of my job as a psychiatric nurse is to ask what is happening, what is stressful?"*

Current policy dictates that all referrals to psychologists or psychiatrists have to be made via psychiatric nurses. One can understand this as a gatekeeper mechanism because there are so few mental health specialists, particularly in rural areas. But it also indicates the recognition of the crucial role mental health nurses are to play in primary health care. Given the high incidence of mental health problems in our sample, the obvious choice of IPV champion at any facility may have been the psychiatric nurse. But:

> *"Psychiatric nurses are going to have a huge load if everyone is referring abuse to them. You think that's going to be manageable? ... They are going to need a lot of skills and training but they would be the best of the lot because of their soft skills."*

In making the comment above, a facility manager stressed that extra psychiatric staff must be appointed to prevent rapid burn-out. He was developing an appointment system at Site C to aid in the prevention of burn-out amongst his staff. For the task of IPV, the capacity, motivation and interest of the care provider is essential since what these women need is someone who actually cares about their issues. A follow-up researcher reported noticing how in many cases the psychiatric nurse seemed to prioritise other psychiatric conditions over IPV.

Also, as we explored in Chapter Seven, referrals to psychiatric services are highly stigmatised and women don't want that stigma on top of their other problems because abuse already draws a lot of stigma and shame to them. Also most psychiatric nurses tend to medicate as a rule of thumb. While there is a role for psychotropic medication in certain cases after a thorough assessment has been done, it does dampen down the defences of the affected woman rather than empowering her in a constructive, problem-solving kind of way. Good psychiatric nurses still utilise a range of psychosocial rehabilitation skills to encourage their clients forward. Another key informant recommended appointing an extra psychiatric nurse, but specifically one who has feeling for this kind of thing:

> *"It takes a special kind of person in my opinion to be either a psychiatric nurse or that (IPV) specialised person – when you have to deal with the emotional side and really giving of yourSelf."*

9.3.3 Role of clinical nurse practitioner or doctor

These clinicians need to be informed about the dynamics and dangers of IPV in patients. Further, they need to be aware of the cues that may indicate IPV problems so that relevant clients can be identified and referred. Necessary clinical tasks must be attended to before moving client on to the IPV champion. Some clinical nurse practitioners and doctors will fit the profile and therefore may be selected as the IPV champion for their facility.

9.3.4 Role of social worker

Social workers can be effective at placing desperate clients in community shelters. In rural areas, social workers obtain food parcels for poverty-stricken clients. Social workers are ideally placed to deal more effectively with IPV, therefore if social workers fit the profile outlined in 9.3, then they could also function as IPV champions, but they would need appropriate emotional and practical support.

9.4 Methodological conclusions

9.4.1 Professional action research: promising possibilities for transformation

The empirical-analytic paradigm has dominated the production of knowledge since the Enlightenment era, by positioning itself as the gold standard of scientific work, enshrined within university settings. This thesis has argued that the tenacious hold the empirical-analytical mindset has had on the definition of science is problematic since its self-satisfaction blinds it to its own deficiencies. Such exponents tend to be so immersed in their own perspective that they fail to comprehend the value of triangulating their analyses with techniques from other paradigms to bring different dimensions to light for the gathering of crucial insights.

For example, the empirical-analytical approach suggests that a randomised controlled trial would be the way forward for evaluating the model emerging from this study. However, the design of randomised controlled trials tends to prevent an understanding of exactly what components or aspects were beneficial. This thesis has demonstrated how experiential learning, provided by a professional action research process that centers around a co-operative inquiry group process, can enable researchers to make more sense of what really is helpful or unhelpful.

Secondly, the empirical-analytical approach assumes that a randomised controlled trial that provides evidence for an effective intervention in the USA can be generalised to complex social situations in other parts of the world, permeated by very different norms and cultural matrices.

Thirdly, qualitative work enables one to determine what outcomes are meaningful and beneficial from the participants' perspectives. When working quantitatively one is forced to choose the primary and secondary outcomes for a trial that in itself embeds certain assumptions about what a good outcome is. For example, in this thesis it is argued that leaving the perpetrator may not be perceived as the best outcome by abused women, but a quantitative study might measure the number of women who left their partners as the primary outcome.

The advantage of an action research project, by contrast, is that it facilitates research that is deeply embedded in its context, providing effective means to construct interventions that respond to local needs rather than testing interventions on the assumption that they are generalisable. This links to my view that IPV research needs to be responsible research. By this I refer to an interpretation of ethics at its most profound, in terms of respecting the essential humanity of all concerned.

Barrett's model (see Table 12) of seven levels of consciousness operant among people in organisations can equally be applied to research. It is my contention that the process of professional action research can potentially elevate researchers' awareness to successively higher levels of consciousness since the paradigm comfortably inhabits all levels. The key factor determining a successful action research project is that the facilitator inhabits the level of consciousness demonstrated by Freire in his work with South American peasants, namely the seventh level of service. If the facilitator can hold all seven levels of consciousness in awareness, then s/he can potentially train anyone to perform action research while simultaneously providing researchers with an excellent role-model.

Table 12: The Seven Stages / Levels of Group Consciousness (Barrett, 2006, p.16)

Level	Motivation	Focus
7	Service	Caring for humanity, future generations, and the planet
6	Making a difference	Cooperating with and forming alliances with other groups
5	Internal cohesion	Aligning group members around a shared vision, mission and values
4	Transformation	Involving group members and giving them a voice in decision making
3	Self-esteem	Creating order, performance, and effectiveness that engenders respect and group pride
2	relationship	Building harmonious internal relationships that create a sense of belonging
1	survival	Establishing conditions of financial stability and safety for group members

Part of the aim of this doctoral study was to innovate professional action research and show its applicability in a particular context. We explored the potential of action research to apply a range of qualitative and quantitative techniques and found that this approach provides data that captures the complexity of the particularities.

Nurses within the PHC context formed a specific focus in this thesis. Action research as a methodology offers potential solutions for addressing much more than just the provision of care for IPV. In and of itself, action research provides potential solutions to loss of purpose and a sense of powerlessness which can be attributed to the need for a deeper meaning and connection with our work (Wright, 1998). As we saw in Chapter Seven, this demoralisation is a significant human resource issue in the contemporary PHC system:

> *"If Snow and Willard (1989) and others are correct in their assertion that there is a great longing in nursing for nurses to connect more deeply with themselves and their patients, then there is a need to examine what contexts can be created for this to be done safely and lovingly. Spirituality seems to be little more than a footnote in modern nursing education, and many nurses ... find it difficult in the everyday workworld to find the space to explore what has heart and meaning for them"* (Wright, 1998, p.191).

As we saw, action research requires engagement with ongoing cycles of planning, implementing, collecting and analysing data on outcomes, discussing outcomes with research team and stakeholders, reaching conclusions and producing new, fine-tuned sets of action research steps. As Chisholm identifies (2001, p.324), this highly cyclical nature is cardinal to action research. Secondly, an action research approach offers a constructive orientation to system improvement or development. Chisholm points out that action research tries to generate knowledge of a system while simultaneously attempting to alter or develop it (Lewin, 1946, in Chisholm, 2001, p.324). Ideally this creates a system that continuously learns from experiences and constructively implements findings by creating conditions that foster and support learning. Along with Chisholm, I argue that the development of such a learning system increases its capacity to deal with greater complexity and a changing environment (Huber, 1991 in Chisholm, 2001, p.324).

9.4.2 Training of future nurse action researchers

Hills (2001, p.340) discusses how, historically, nursing education has relied on a behavioural educational model which utilises behavioural objectives as the sole criteria to evaluate students' clinical performance. Since nursing is a practice-based profession, clinical competency for safe practice remains a key priority. Hills thus contends that behaviourism and concern for safety have focused evaluation on nursing skills and tasks to the exclusion of other

important aspects of nursing. She refers to the Collaborative Nursing Program of British Columbia which has developed a programme that focuses nursing practice on people, their health and healing experiences. Also, it moves the emphasis of nursing education from a behavioural to a caring, emancipatory paradigm (Bevis & Watson, 1989, in Hills, 2001, p.340).

Hills describes her study which worked with nurse educators in an inquiry process that engaged in three empowering processes that encouraged transformative change: creating collaborative relationships, engaging in critical dialogue, and reflection-in-action (2001, p.341). Based on its findings (see sections 8.4 and 8.5), this thesis recommends that to optimise chances of success when doing an action research project with nurses, it is essential to do in-depth preparatory training which immerses participants in the action research paradigm. This training should serve a dual purpose: to open trainees' minds to inhabit the inquiry as autonomous equals and also to sift potential candidates. The latter is crucial because in current working environments not everyone may be able to shift from research assistant to co-researcher. This could be evaluated by exploring their capacity for reflection and their ability to relate in a non-hierarchical manner. Egalitarian dynamics among the team, optimise the chances of co-researchers taking ownership of the inquiry and thus contributing freely to the shared learning process.

9.4.3 Future action research possibilities in universities

"Universities have become self-guiding and self-serving organizational systems, despite their evident reliance on a vast array of social resources and subsidies for their very existence ... (they) exhibit few of the characteristics of learning organizations ... (thus) the institutions that claim the position of the premier and most advanced knowledge producers in society frustrate learning and social change in most of their internal processes and in their articulation with the surrounding society" (Levin & Greenwood, 2001. p.103).

As discussed in section 8.2.1, within the Health Sciences Faculty, portals to innovative research designs are somewhat blocked by the dominance of an empirical-analytical approach to research. *Appendix O* provides the general application checklist required by the Health Research Ethics Committee of Stellenbosch University. Perusal of same reveals the detailed extent to which the study design and application needs to be cast in stone prior to starting the study, with the underlying design assumption being that of a clinical trial. By contrast, this thesis has elaborated on the value of an ethical approach which is willing to think out of the box so that professional action research techniques can be utilised to innovate changed practice through engagement in a series of action research (learning) cycles.

Appendix P provides the Ethics Committee Application Form for the Faculty of Arts and Social Sciences. Clearly here the approach is more flexible in terms of the range of research possibilities beyond statistical approaches. The form could be enhanced by adding 'co-operative inquiry group process' to the list of options offered in 7.1. Also 9.3 encapsulates the ethical imperative to link research with action in health research, making findings available to advocacy activists, policy-makers, NPOs and the public as well as the academic research community (Jewkes, Watts, Abrahams, Penn-Kekana & Garcia-Moreno, 2000, p.102):

> *"Researchers need to consider sophisticated dissemination strategies for their findings which, in addition to academic, peer-reviewed journals, include newsletters, web-based publications, technical reports, press releases of key findings and verbal feedback to community meetings and professional conferences, and to parliamentarians and government officials."*

This thesis concludes that in an effort to promote interdisciplinary degrees, an interdisciplinary ethics application procedure should be developed to provide an intelligent compromise between the divergent guidelines alluded to above. Furthermore, the Health Sciences Research Ethics Committee should develop an action research application procedure that accommodates its unconventional research process by focusing on the research principles to be followed while allowing flexibility for the evolution of project details in accordance with this research process.

9.4.4 Feminism, Action Research and Complexity Theory

A refreshing discovery has been the synergy between complexity theory, feminism and action research as explored in Chapter Two. These approaches all respect the possibilities of living systems amongst people, and can be used to enliven principles that facilitate the development of such functional environments within an organisational context. Our focus here was on the primary health care system in the Western Cape which was discovered to be largely mechanistic in its orientation. To its credit though, all levels of management we had contact with throughout the study, were supportive of our IPV study. Furthermore, management appears open to developing appropriate responses to evidence-based findings, and have enthusiastically implemented a cutting-edge policy on Rape and Sexual Assault over the past decade.

Commitment to a 'new order paradigm' which synthesises theory with action to effect healthy change, is a key ingredient which action research, feminism and complexity theory share. Such a fusion can be fruitfully engaged with, sweeping out cobwebs, letting in light and re-orienting formerly dysfunctional aspects of our health system. The fact that District Health Services are currently transforming is ideal timing for the successful introduction of this alternative ethos.

9.5 Conclusion

This study holds a mirror up to the sickness of South African society. While the focus has been on the victims, and by implication perpetrators, it also illuminates potential roles for bystanders to move beyond passivity to constructive action. This applies as much to health care providers, as it does to society at large. These issues are too important and their impact too severe for anyone to be complacent. Throughout this work, I have been vividly aware that while my sample confined me to female IPV survivors, the impact of their experience and suffering on the family system they are part of, can only be profoundly destructive for children and adolescents affected by IPV. And of course, the men need care and rehabilitation too.

Ultimately, the scourge of IPV points to extremely high levels of dysfunctional family relationships in South Africa. This study has been able to investigate and come up with recommendations for providing care for IPV in the South African PHC sector, which sees the ugly face of IPV and its impact most immediately. However, many other strategies need to be investigated and ways of addressing IPV formalised. It is only in the combination of preventative and care-based approaches that this social illness can be addressed at all levels. Clearly the high level of Gini inequality in South Africa contributes strongly to the persistence of patriarchal gender relations, also strengthened by unemployment, lack of relevant education and masculinities that have extremely limited positive expressive space. While social and economic policies driven by the state need to turn the impact of poverty and inequality around, much can be done on the level of community organisations and interface between the public sector and civil society to curb IPV. Voluntary work within community policing systems, for example, offers avenues for developing a community message of 'zero tolerance' for violent behaviour. Churches and other community-based organisations have the responsibility to foster relationships that are in line with the Human Rights section of the Constitution. Activism against sexism and patriarchy is surely needed to raise awareness and to inform all social players about the need to address IPV as an urgent priority. The work and effect of the Treatment Action Campaign is an example of what can be done to turn perceptions and practices around.

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Abbreviations

IPV   intimate partner violence

NPO   non-profit organisation

PHC   primary health care

USA   United States of America

Appendix A: Original Protocol

Researcher: **_____** *Patient Name:* **_____** *Folder No.* **_____**

REPORT ON DOMESTIC VIOLENCE EXAMINATION

PATIENT INFORMATION:

Name: **_____**   Age: **_____**

Current Residential Address: _____

_____

Tel No: (h): _____ (w): _____ (cell): _____

Safe to phone? _____ _____ _____

Date of Examination: / / Time of Examination: h

_____ _____

Marital Status: Married in COP ☐ / Married with ANC ☐ / Traditional ☐ Divorced ☐ /
Same-sex partner ☐ / Single ☐ / Co-habiting ☐

Children number total: _____ Own: ☐ Step: ☐

Ages and gender of children: Girls: 0-5yrs ☐ / 6-10yrs ☐ / 11-15yrs ☐ / 16-20yrs ☐ / 20yrs ☐
Boys: 0-5yrs ☐ / 6-10yrs ☐ / 11-15yrs ☐ / 16-20yrs ☐ / 20yrs ☐

Whereabouts: House ☐ / Sub-district ☐ / W.Cape ☐ / Out of W.Cape ☐

Patient Accompanied by: relative ☐ / friend ☐ / other _____ / Did perpetrator accompany? _____

ADDITIONAL INFORMATION

Has a criminal charge been laid? [   ] Yes [   ] No

If yes, what charge was laid? Assault ☐ / grievous bodily harm ☐ / rape ☐ / indecent assault ☐ /
Contravention of protection order ☐

Name of SAPS station: _____ CAS No: _____

If no, does the patient intend laying a charge?

[   ] Yes

[   ] No

[   ] Unsure

Does patient have a Protection Order? Yes ☐ / No ☐

Name of magistrate court: _____

If no, intends to apply for protection order; Yes ☐ / No ☐ / Unsure

1.   HISTORY OF MOST RECENT ASSAULT

Location of incident: _____

Date of incident: _____

Time of incident: _____

Relationship of assailant: partner ☐ / ex- partner ☐ _____

Nature of the abuse

PHYSICAL		**EMOTIONAL**	**SEXUAL**	**FINANCIAL**	
Hitting	☐	Name Calling	☐ Unwanted Touching	☐ Withholding Money	☐
Kicking	☐	Yelling/Shouting	☐ Infidelity	☐ Taking Money	☐
Use of a weapon	☐	Restricting contact with Family / Friends	☐ STI's	☐ Controlling All Financial Decisions	☐
Pushing	☐	Threats	☐ Forced Intercourse	☐ Other _____	
Choking	☐	Controlling her activities	☐ Other _____	_____	
Burns	☐	Other _____	_____	_____	
Other		_____			

Patient's description of most recent assault (Use exact words as far as possible. Describe severity of assault.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2. Other episodes of assault:

Describe frequency & severity of past abuse, using direct quotes from the patient. Describe mechanism, location and extent of injury and/ or symptoms/conditions.

Frequency over last 2 years: 0-10 [   ] / 11-20 [   ] / >20 [   ]

Patient's description - qualitative

_____

_____

_____

—

How has your previous experience of care been at this health centre?

_____

—

_____
_____
_____
_____
_____

3. **Emotional Status:**

Mental Problems Checklist

The questions can be used to test the hypothesis of "mental problems?" The questions were developed in the context of Khayelitsha a Xhosa speaking township.

9. Are you thinking too much ?…………………………………………………………. ☐
10. How are you sleeping at the moment?……………………………………………… ☐
11. Do you feel exhausted or tired even when you are not working hard? ……………. ☐
12. Do you feel sad or like crying for no reason ?…………………………………… ☐
13. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? I.e. listening to music or going out with friends………………….. ☐
14. Do you sometimes have the feeling as though you are going to hear bad news?…. ☐
15. a) Have you ever felt you should cut down on your drinking?………………………. ☐
   b) Have people annoyed you by criticizing your drinking? …………………………. ☐
   c) Have you ever felt bad or guilty about your drinking?………………………………. ☐
   e) Have you ever had an eye-opener first thing in the morning to steady your Nerves or to get rid of a hangover?……………………………………………… ☐

16. Have you experienced traumatic events that made you feel extremely threatened or Endangered? Or witnessed someone else in this situation?………………………….. ☐

Researcher: _____   Patient Name: _____   Folder No. _____

If positive to **any one** further assessment may be required – see Mental Problems Flowchart.

If positive to **2, 3, 4, 5** then consider **depression.**
If positive to **1, 2, 6** consider **anxiety disorders.**
If positive to **7** consider **alcohol use disorders.**
If positive to **8** consider **post traumatic stress disorder.**

Mental Problems Checklist

These questions can be used to test the hypothesis of "mental problems?" The questions are taken directly from the ICD-10 Classification.

1. Low mood or sadness?………………………………………………….. ☐
2. Loss of interest or pleasure?……………………………………………… ☐

3.	Decreased enery and / or increased fatigue?………………………	☐
4.	Have you had any problems with sleep?……………………………	☐
5.	Feeling tense or anxious?………………………………………..	☐
6.	Worrying a lot about things?………………………………………..	☐
7.	a) No. of standard drinks in a typical day when drinking?…………	☐
	b) No. of days / wk having alcoholic drinks?………………………..	☐
8.	Have you experienced traumatic events that made you feel extremely threatened or Endangered? Or witnessed someone else in this situation?……………… ☐	

If positive to **any one** of these questions further assessment may be required – see Mental Problems Flowchart

Positive to **1, 2, 3** or **4** consider **depression**
Positive to **5** or **6** consider **anxiety depression**
If **7** is 21/wk or more for men or 14/wk or more for women consider **alcohol use disorders**

In the last year have you used any of the following substances?
1. Dagga

2. Mandrax

3. Tic

4. Tobacco / cigarettes / pipe

5. Cocaine / crack

6. Heroine

7. Benzene or solvents

8. Sniffed Glue

9. Ecstasy

Depression requiring further assessment?   Yes   ☐   No   ☐

PTSD requiring further assessment?   Yes   ☐   No   ☐

Anxiety disorder requiring further assessment?   Yes   ☐   No   ☐

Alcohol/subs use disorder requiring further assessment? Yes ☐   No   ☐

4.   Medical Information:

Pregnant?   ☐ Yes   ☐ No

Normal menses in last month: ☐ Yes   ☐ No

_____

Other medical symptoms coded as per ICPC: _____
Researcher: _____   Patient Name: _____   Folder No. _____

STI SYNDROMES:

Vaginal Discharge Syndrome ☐

Genital Ulcer Syndrome ☐

Lower Abdominal Pain ☐

Moluscum Contagiosum ☐

Genital Warts ☐

Pubic Lice ☐

Herpes Simplex Virus ☐

5. Examination:

General Appearance: _____

Height: _____ Weight: _____ Body Build: _____

Description of Injuries: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ Folder No. _____

6. Body Charts:

Right   Left

Patient Name: _____ Folder No. _____

Right

Left

Patient Name: _____ Folder No. _____

Left   Right

Right

Left

Inner

Outer

Outer

Inner
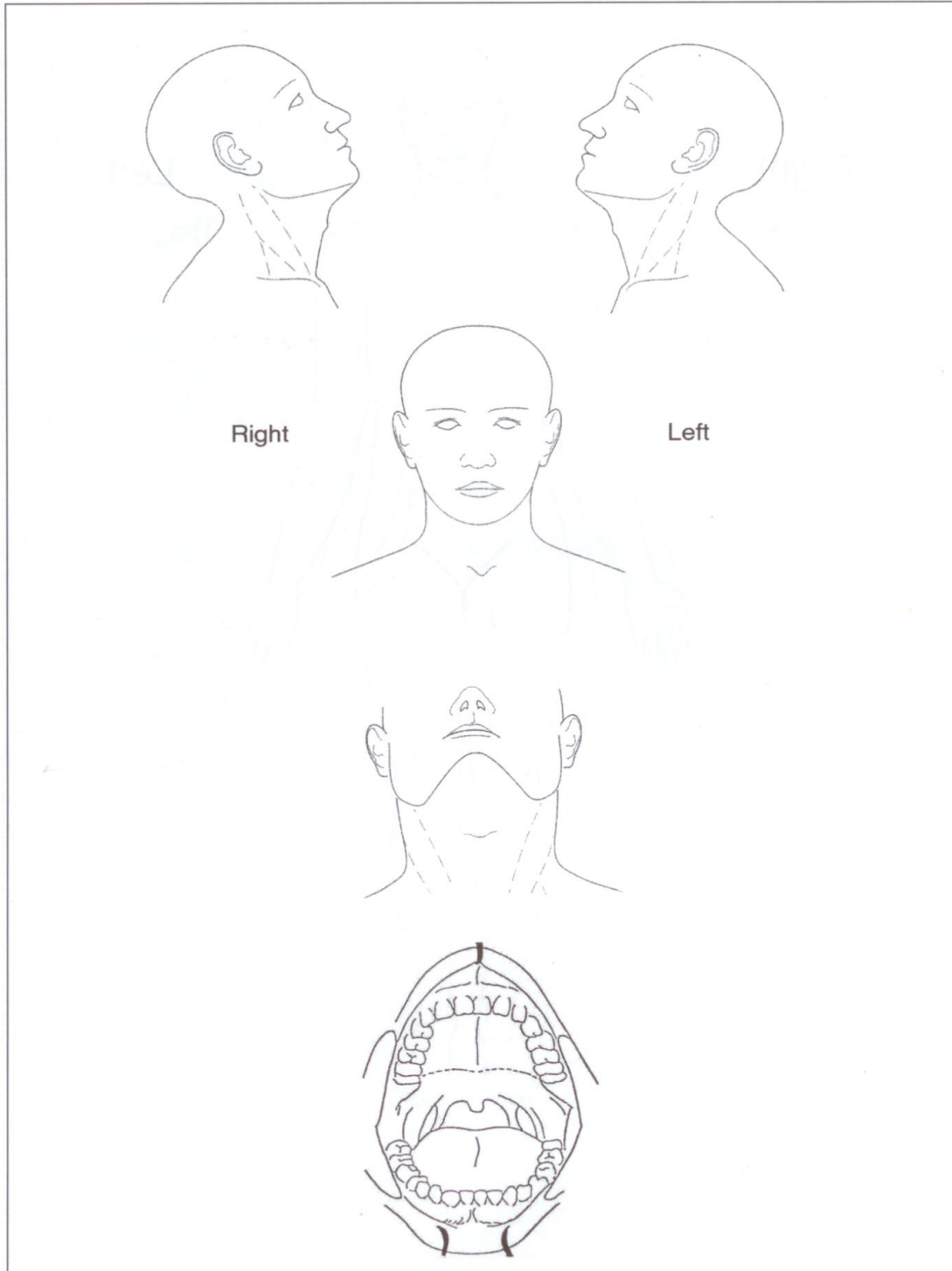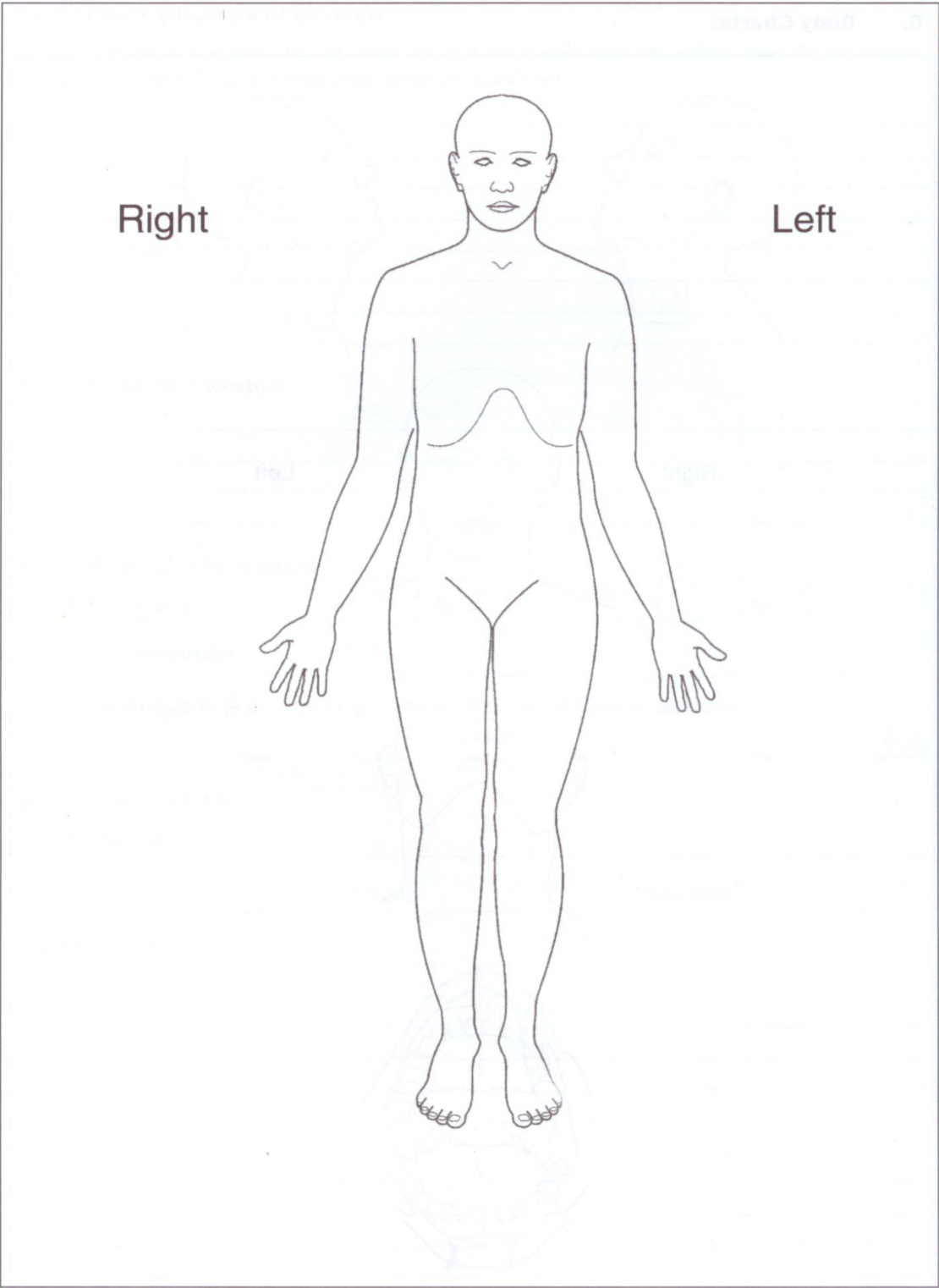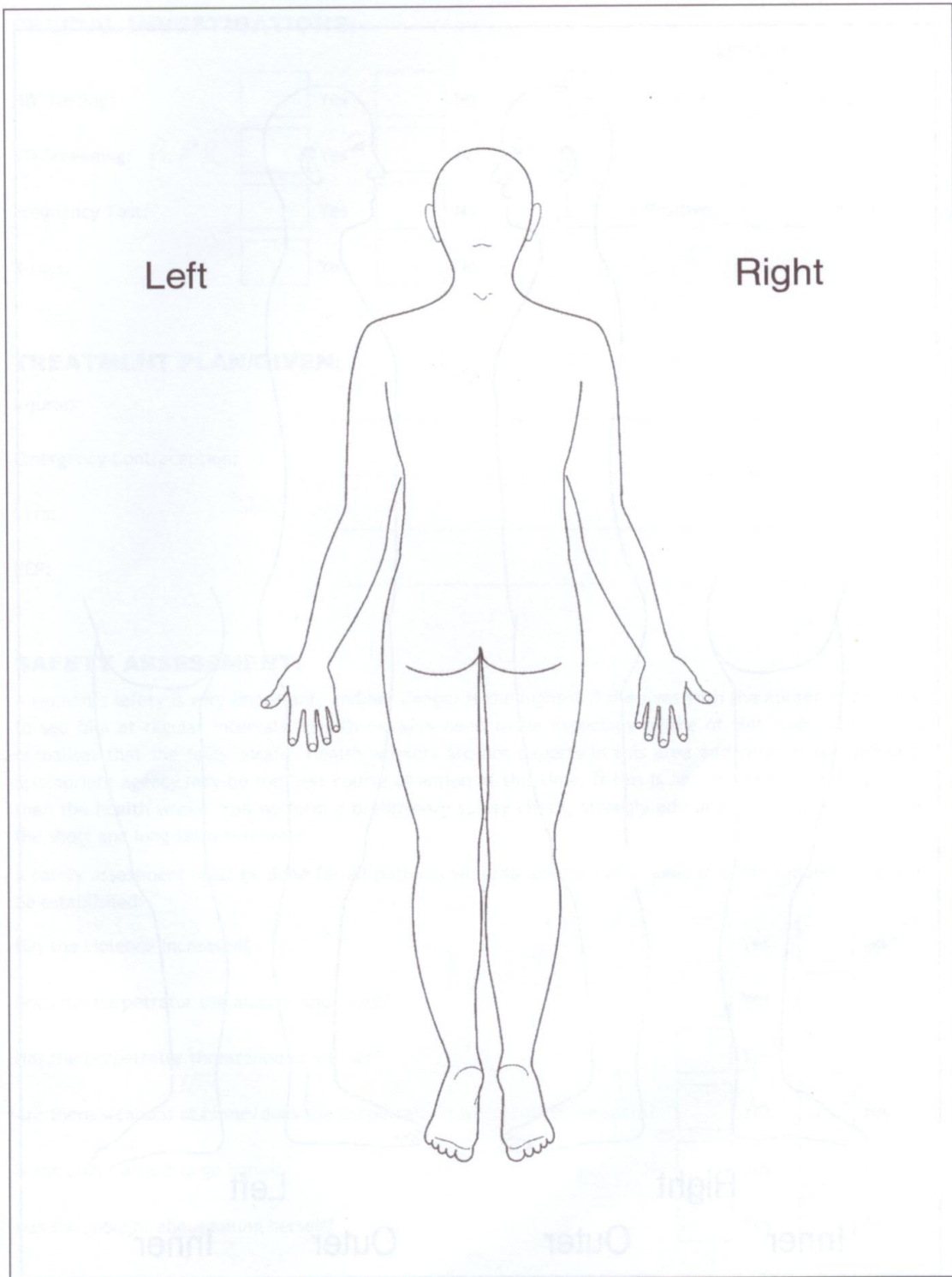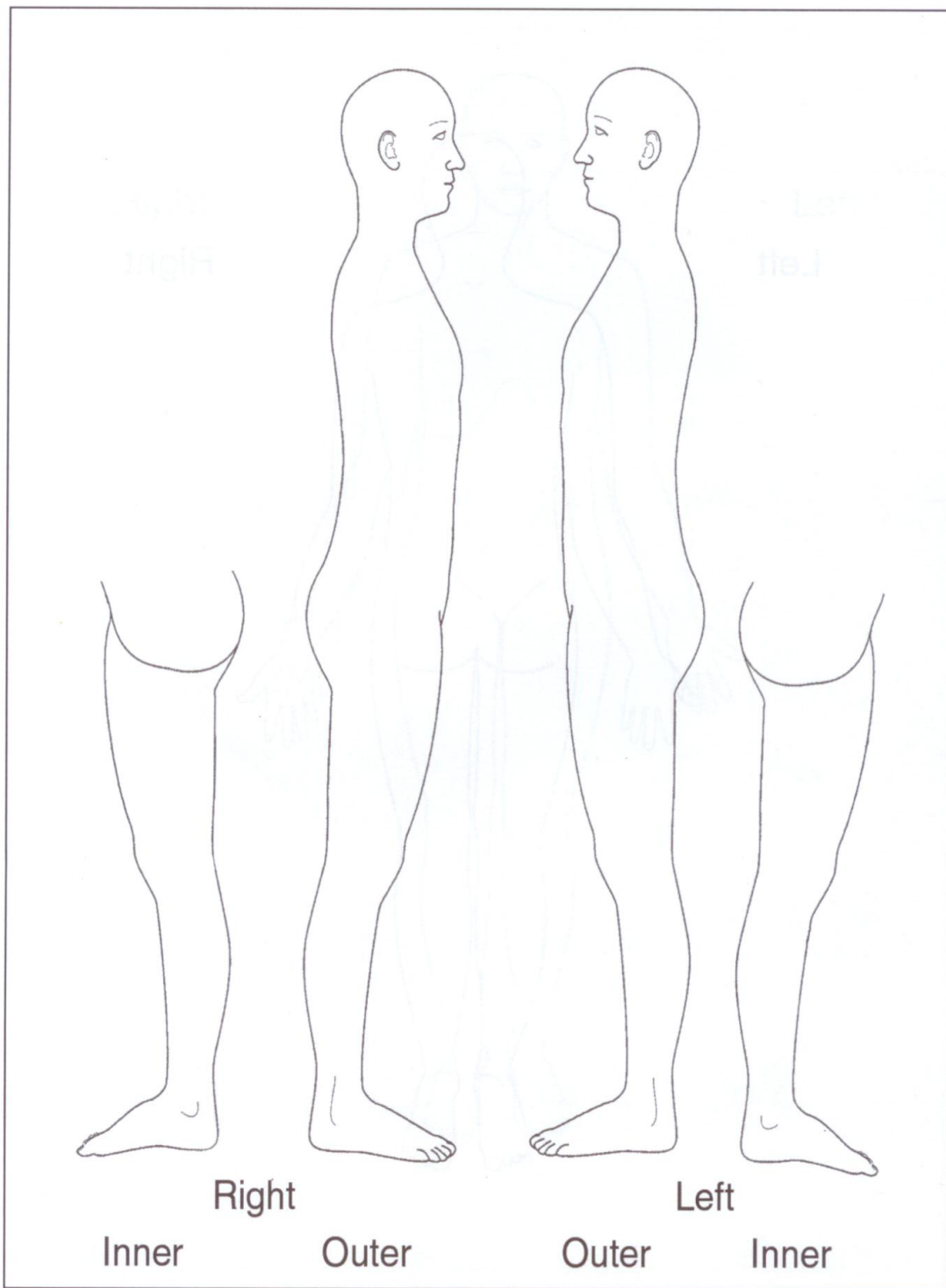
SPECIAL INVESTIGATIONS NEEDED:
                                Year/Date

1.   **Prior VCT**   _____   [ ] Positive [ ] Negative [ ] Not done

        How did your partner react when you disclosed your status?
        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

        _____

3.   **Do you want testing now?**   Yes [ ]   No [ ]

RPR: [ ] Yes   [ ] No

Pregnancy test: [ ] Yes   [ ] No

X-rays: [ ] Yes   [ ] No

TREATMENT PLAN/GIVEN:

Injuries: [ ] Yes   [ ] No

Emergency contraception [ ] Yes   [ ] No

STI's: [ ] Yes   [ ] No

PEP: [ ] Yes   [ ] No

Other medical conditions: _____

SAFETY ASSESSMENT:

A safety assessment must be done for all patients who disclose domestic violence. Record answers to the following questions. The answers to the questions can be assigned a value for risk assessment. Assign a value for the answers as follows: No = 0   Yes = 1

Add up the total to provide a risk rating: *0 – 3*   ➔   *Caution*

                                                      4 - 7   ➔   *High Risk*
                                                      8 – 11 ➔   Severe Risk

Has he threatened you with physical violence?	☐ Yes	☐ No	
Has he threatened the children with physical violence?	☐ Yes	☐ No	
Is there a firearm in the house?	☐ Yes	☐ No	
Has he threatened to kill you?	☐ Yes	☐ No	
Has he threatened to kill the children?	☐ Yes	☐ No	
Does the patient think he is capable of killing her?	☐ Yes	☐ No	
Were alcohol and / or drugs consumed prior to the last incident of abuse?	☐ Yes	☐ No	
Was SAPS intervention necessary?	☐ Yes	☐ No	
Is he presently in the home?	☐ Yes	☐ No	
Has the abuse escalated in either frequency or severity?	☐ Yes	☐ No	
Have you ever received medical treatment for injuries sustained as a result of abuse?	☐ Yes	☐ No	

Score: 0-3 ☐ / 4-7 ☐ / 8-11 ☐   **TOTAL RATING**   ☐

SAFETY PLAN:

Help the client think and plan the following:

> **?**   What will you do when you leave the health facility?
>
> **?**   Will you seek help from SAPS and/ or courts?
>
> **?**   How will you ensure your children's safety?
>
> **?**   Where can you go if you need to leave home?
>
> **?**   Who can you trust to tell about the domestic violence?
>
> **?**   Where can you leave money, clothing, copies of documents and valuables if necessary?
>
> **?**   Will you accept a list of important telephone numbers referrals to help with longer-term safety   planning?

Advise patient to hide a readily packed bag with essential items such as:

- Your ID book.
- Children's birth certificates, hospital cards and other important documents.
- House and car keys, money and bank card.
- Clothes for you and your children.
- Important telephone numbers.
- Copy of the protection order and suspended warrant of arrest if you already have one.

She may also make a list of other things to take with her, for example:

- Children's favourite toys.
- Children's school books and uniforms.
- Toiletries (toothbrush, deodorant, etc).
- Other valuable personal items, for example, photos and jewelry.

REFERRAL LEGAL AND SOCIAL ISSUES

Referrals made? ☐ Yes ☐ No

OPTION 1: _____

OPTION 2:_____

OPTION 3:_____

OPTION 4:_____

OPTION 5:_____

Magistrate court for protection order ☐ Yes ☐ No

Police station for criminal charge ☐ Yes ☐ No

NGO for counseling ☐ Yes ☐ No

NGO for legal support ☐ Yes ☐ No

PGWC social worker ☐ Yes ☐ No

Shelter ☐ Yes ☐ No

Other: _____

INFORMATION LEAFLET:

Safe to give a leaflet ☐ Yes ☐ No

FOLLOW UP:

Appointment made for follow-up?

Date & Time: _____

Signature: _____

Health Facility: _____

Date: _____

Appendix B: Participation Leaflet and Consent Form

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

PRIMARY HEALTH CARE FOR INTIMATE PARTNER VIOLENCE IN THE WESTERN CAPE: NATURE OF CARE AND IMPLEMENTATION OF PROTOCOL FOR HOLISTIC MANAGEMENT

REFERENCE NUMBER:

PRINCIPAL INVESTIGATOR: KATE JOYNER

ADDRESS: NURSING DEPARTMENT, FACULTY OF HEALTH SCIENCES, STELLENBOSCH UNIVERSITY

CONTACT NUMBER: 021 938 9293

You are invited to take part in a research project. Please listen carefully to this explanation of the project and ask questions about anything that you do not fully understand. It is very important that you understand what this research is about and how you could be involved. Also, your participation is **entirely voluntary** and you are free not to participate. If you say no, this will not affect you negatively in any way. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University **and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.**

What is this research study all about?

This study is being conducted at 4 community health centres: Guguletu, Ceres, Worcester and Bishop Lavis. 75 participants are to be recruited at each site making 300 in total.

This project provides assessment and treatment for women who are in abusive relationships. We are doing it because this is lacking in our health service and we want to evaluate how helpful it is for women like you. We will take a detailed history of your experiences of abuse, document any visible injuries, refer you for any necessary tests, help you assess your safety and develop a safety plan and refer you to relevant resources.

Why have you been invited to participate?

You are an adult woman who has experienced abuse from your partner during the last 2 years.

What will your responsibilities be?

It is your responsibility to come to the follow-up appointment.
It is also your responsibility to give authorisation for the collection of evidence and release of Information:
I hereby authorise   _____   CHC / Hospital
                            (name of clinic or hospital)
And   _____
                            (name of health worker)

Please tick:

☐ To document all injuries and collect any blood, urine, tissue or any other specimen needed.

☐ To take photographs of my injuries.

☐ To supply copies of relevant medical records including laboratory reports to the South African Police if requested.

I recognise that the Domestic Violence Examination Form is solely to direct the appropriate clinical and forensic management of me and to record any injuries I may have evidence of. This information is confidential and will remain with my confidential medical records.

I understand that the medical and forensic information handed over to the South African Police Service will be contained in the J88 form.

Person examined: _____   _____
                              (Print name)   (Signature)

Witness: _____   _____
                              (Print name)   (Signature)

Date: _____

Will you benefit from taking part in this research?

We expect that you will benefit in the following ways: you will receive a safety assessment and the researcher will work out a safety plan with you. Your mental health will be assessed and you will be referred for support as well as for any relevant medical tests. If you are injured, a detailed record will be made of the evidence of assault which you can use should you need to prove the abuse in the future. You will also be advised about what legal options are available to you and will be referred accordingly.

Are there in risks involved in your taking part in this research?

This study deals with a sensitive area. It is possible that if your partner finds out that you are taking part in this project, he may feel threatened and react badly

Who will have access to your medical records?

We will pay special attention and care to protecting the confidentiality of all participants. Therefore all information you share will not be made available to anyone outside of the research team. In any written material that results, your identity will remain anonymous.

What will happen in the unlikely event of some form of injury occurring as a direct result of your taking part in this research study?

This study does not have any insurance. The health service will provide necessary care.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but R50.00 will be provided for your transport and meal costs when you attend the follow-up appointment. There will be no costs involved for you, if you do take part.

➢ Is there any thing else that you should know or do?

➢ **You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your researcher.**

➢ **You may receive a copy of this information and consent form for your own records.**

Declaration by participant

By signing below, I …………………………………..…………. agree to take part in a research study entitled PRIMARY HEALTH CARE FOR INTIMATE PARTNER VIOLENCE IN THE WESTERN CAPE: NATURE OF CARE AND IMPLEMENTATION OF PROTOCOL FOR HOLISTIC MANAGEMENT

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.

- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.

- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

- I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....……......……………. on (*date*) …………...………. 2006.

....
Signature of participant   Signature of witness

Declaration by investigator

I (*name*) ……………………………………………..……… declare that:

- I explained the information in this document to …………………………………..

- I encouraged her to ask questions and took adequate time to answer them.

- I am satisfied that she adequately understands all aspects of the research, as discussed above

- I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....……......……………. on (*date*) …………...………. 2006.

....
Signature of investigator   Signature of witness

Declaration by interpreter

I (*name*) …………………………………………..……… declare that:

- I assisted the investigator (*name*) ……………………………………………. to explain the information in

  this document to (*name of participant*) …………….…………………………….. using the language

  medium of Afrikaans/Xhosa.

- We encouraged her to ask questions and took adequate time to answer them.

- I conveyed a factually correct version of what was related to me.

- I am satisfied that the participant fully understands the content of this informed consent document and has had all her questions satisfactorily answered.

Signed at (*place*) ....…......……………. on (*date*) …………...……….. 2006.

....
Signature of interpreter   Signature of witness

Appendix C: DEELNEMERINLIGTINGSBLAD EN -TOESTEMMINGSVORM

TITEL VAN DIE NAVORSINGSPROJEK: Primêre Gesondheidsorg vir Intieme Verhouding Geweld in die Wes-Kaap: Mate van Sorg en Implimentering van Protokol vir Holistiese Hantering.
VERWYSINGSNOMMER:
HOOFNAVORSER: Kate Joyner
ADRES: Departement Verpleegkunde, Fakulteit van Gesondheidswetenskappe, Stellenbosch Universiteit.
KONTAKNOMMER: 021 938 9293

U word genooi om deel te neem aan 'n navorsingsprojek. Luister asb. sorgvuldig na die verduideliking van die projek en vra vrae oor enige iets wat u nie ten volle verstaan nie. Dit is baie belangrik dat u verstaan waaroor die navorsing gaan en hoe u kan betrokke wees. U deelname is heeltemal vrywillig, so u is vry om nie deel te neem nie. Indien u nee sê, sal dit u nie negatief affekteer op enige manier nie. U is ook vry om van die studie te onttrek op enige tydstip, al stem u in om deel te neem.

Hierdie navorsingsprojek is deur die Komitee vir Mensnavorsing van die Universiteit Stellenbosch goedgekeur en sal uitgevoer word volgens die etiese riglyne en beginsels van die Internasionale Verklaring van Helsinki en die Etiese Riglyne vir Navorsing van die Mediese Navorsingsraad (MNR).

Wat behels hierdie navorsingsprojek?

Die studie word uitgevoer by vyf gemeenskap gesondheid sentrums: Guguletu, Ceres, Worcester, Elsies Rivier en Bishop Lavis.

Hierdie projek voorsien beraming en behandeling vir vroue wat in 'n mishandelende verhouding is. Daar is 'n tekort in ons gesondheidsdiens, en ons wil evalueer hoe dit vir vroue affekteer. Ons sal 'n gedetailleerde geskiedenis neem van u ervaring van mishandeling, alle sigbare beserings dokumenteer, u verwys vir die nodige toetse, u veiligheid beraam, 'n veiligheidsplan ontwikkel en u verwys na relevante hulpbronne.

Waarom is u genooi om deel te neem?

U is 'n volwasse vrou wat mishandeling ervaar het van u maat, gedurende die laaste twee jare.

Wat sal u verantwoordelikhede wees?

Dit is u verantwoordelikheid om te kom vir 'n opvolg besoek. Dit is ook u verantwoordelikheid om magtiging te gee vir die versameling van bewyse en om inligting te verskaf:

Hiermee gee ek magtiging vir _____ CHC/ Hospitaal
<div align="center">(Naam van kliniek of hospitaal)</div>

en   _____
<div align="center">(Naam van gesondheidswerker)</div>

Maak asb. 'n regmerkie:

   ☐ Om alle beserings te dokumenteer en om enige bloed, urine, weefsel, of
      enige ander monster te neem indien nodig.

   ☐ Om fotos te neem van my beserings.

   ☐ Om kopiëe van relevante mediese rekords, insluitende laboratorium verslae,

vir Suid-Afrikaanse polisie te verskaf, indien versoek.

Ek herken dat die Huishoudelike Geweld Ondersoek Vorm alleenlik is om die gepaste kliniese en forensiese hantering te begelei en om enige beserings waarvan ek 'n bewys het, te rekordeer. Hierdie inligting is vertroulik en sal binne my konfidensiele mediese rekords bly.

Ek verstaan dat die mediese en forensiese inligting wat aan die Suid-Afrikaanse Polisie Diens oorhandig word in die J88 vorm gehou sal word.

Persoon ondersoek: _____   _____
                                             (Naam in druk)   (Handtekening)

Getuie: _____   _____
                                             (Naam in druk)   (Handtekening)

Datum: _____

Sal u voordeel trek deur deel te neem aan hierdie navorsingsprojek?

Ons verwag dat u sal voordeel trek op die volgende maniere: u sal 'n veiligheidberaming ontvang en die navorser sal 'n veiligheidsplan vir u uitwerk. U geestesgesondheid sal evalueer word en u sal verwys word vir bystand, sowel as vir die nodige mediese toetse. Indien u beseer is, sal 'n gedetailleerde rekord gemaak word vir bewys van aanranding wat u kan gebruik indien u dit nodig het in die toekoms. U sal ook geadviseer word oor wetlike opsies wat beskikbaar is vir u en u sal ooreenstemmend verwys word.

Is daar enige risiko's verbonde aan u deelname aan hierdie navorsingsprojek?

Die studie handel met 'n sensitiewe area. Dit is moontlik dat u maat bedreig mag voel en sleg mag reageer indien hy uitvind dat u deelneem aan die projek.

Wie sal toegang hê tot u mediese rekords?

Ons sal spesiale aandag en sorg gee om die vertroulikheid van alle deelnemers te beskerm. Dus sal alle inligting wat u met ons deel nie beskikbaar gemaak word vir persone buite die navorsingspan nie. In enige geskrewe materiaal wat hieruit voortspruit, sal identiteit anoniem bly.

Wat sal gebeur in die onwaarskynlike geval van 'n besering wat mag voorkom as gevolg van u deelname aan hierdie navorsingsprojek?

Die studie het nie enige versekering nie. Die gesondheidsdiens sal die nodige sorg voorsien.

Sal u betaal word vir deelname aan die navorsingsprojek en is daar enige koste verbonde aan deelname?

Nee, u sal nie betaal word vir deelname aan die navorsingsprojek nie, maar R50 sal voorsien word vir u vervoer en voedsel indien u die opvolg besoek bywoon. Deelname aan die navorsingsprojek sal u niks kos nie.

Is daar enigiets anders wat u moet weet of doen?

> ➢ **U kan die Komitee vir Mensnavorsing kontak by 021-938 9207 indien u enige bekommernis of klagte het wat nie bevredigend deur die navorser hanteer is nie.**

> ➢ **U sal 'n afskrif van hierdie inligtings- en toestemmingsvorm ontvang vir u eie rekords.**

Verklaring deur deelnemer

Met die ondertekening van hierdie dokument onderneem ek, …………………………....…....…..…..…….,

om deel te neem aan 'n navorsingsprojek getiteld Primêre Gesondheidsorg vir Intieme

Verhouding Geweld in die Wes Kaap: Mate van Sorg en Implimentering van Protokol vir

Holistiese Hantering.

Ek verklaar dat:

- Ek hierdie inligtings- en toestemmingsvorm gelees het of aan my laat voorlees het en dat dit in 'n taal geskryf is waarin ek vaardig en gemaklik mee is.
- Ek geleentheid gehad het om vrae te stel en dat al my vrae bevredigend beantwoord is.
- Ek verstaan dat deelname aan hierdie navorsingsprojek **vrywillig** is en dat daar geen druk op my geplaas is om deel te neem nie.
- Ek te eniger tyd aan die navorsingsprojek mag onttrek en dat ek nie op enige wyse daardeur benadeel sal word nie.
- Ek gevra mag word om van die navorsingsprojek te onttrek voordat dit afgehandel is indien die studiedokter of navorser van oordeel is dat dit in my beste belang is, of indien ek nie die ooreengekome navorsingsplan volg nie.

Geteken te *(plek)* ....……………….. op *(datum)* …………....……….. 2007.

....
Handtekening van deelnemer   Handtekening van getuie

Verklaring deur navorser

Ek *(naam)* …………………………………....……………… verklaar dat:

- Ek   die   inligting   in   hierdie   dokument   verduidelik   het   aan

  …………………....…..................................…………..

- Ek haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.
- Ek tevrede is dat sy al die aspekte van die navorsingsprojek soos hierbo bespreek, voldoende verstaan.
- Ek 'n tolk gebruik het/nie 'n tolk gebruik het nie. (*Indien 'n tolk gebruik is, moet die tolk die onderstaande verklaring teken.)*

Geteken te *(plek)* ....……………….. op *(datum)* …………....……….. 2007.

....

Handtekening van navorser   Handtekening van getuie

Verklaring deur tolk

Ek *(naam)* …………………………………...……………… verklaar dat:

- Ek die navorser *(naam)* …………................................………………… bygestaan het om die inligting in

  hierdie   dokument   in   Afrikaans/Xhosa   aan   *(naam   van   deelnemer)*

  …………………………….......................... te verduidelik.

- Ons haar aangemoedig het om vrae te vra en voldoende tyd gebruik het om dit te beantwoord.

- Ek 'n feitelik korrekte weergawe oorgedra het van wat aan my vertel is.

- Ek tevrede is dat die deelnemer die inhoud van hierdie dokument ten volle verstaan en dat al haar vrae bevredigend beantwoord is.

Geteken te *(plek)* ....…………….. op *(datum)* …………...……….. 2007.

....
Handtekening van tolk   Handtekening van getuie

Appendix D
   INCWADANA ENGOLWAZI NGOMTHATHI-NXAXEBA KUNYE NEFOMU YEMVUMELWANO

ISIHLOKO SEPROJEKTHI YOPHANDO: UNCEDO LOKUXHATSHAZWA KWABABHINQILEYO ZIZINQANDAMATHE ZAZO KWIPHONDO LWENTSHONA KOLONI NENQUBO EZAKULANDELWA KWINKATHALO SELE IYONKE EZAKUTHI ITHATHWE.

INIMBOLO YONXULUMANO:

UMPHANDI OYINTLOKO: KATE JOYNER

IDILESI: NURSING DEPARTMENT, FACULTY OF HEALTH SCIENCES, STELLENBOSCH UNIVERSITY

INOMBOLO YOQHAGAMSHELWANO: 021 938 9293

Uyacelwa ukuba uthathe inxaxheba kuphando olunzulu. Ndicela umamelisise kule nkcazelo yolu phando uze ubuze imibuzo xa ungaqondi. Kubalulekile kakhulu ukuba uluqonde olu phando okokuba lungantoni na yaye ungabandanyeka njani na kulo. Awunyanzelekanga ukuba uthathe inxaxheba kolu phando. Kwaye uvumelekile ukurhoxa xa ungafuni. Awusayi kuchaphazeleka nganto xa ungavumi. Uvumelekile nangaliphi na ithuba ukuba orhoxe nangona uvuma ukuthatha inxaxheba.

Olu phando luvunywe yikomiti yophando loluntu kwi dyunivesithi yase Stellenbosch kwaye luya kuqhutywa ngokwemiqathango yasemthethweni kunye nemigaqo yesivumelwano sika zwelonke uHelsinki woMzantsi Afrika yemigaqo *for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.*

Luma lunga nantoni oluphando?
  ➢ *Oluphando lumalunga nokuphatheka kwabantu ababhinqileyo gadalala kuba siyabona ukuba ayiselwe so into yokuhlukunyezwa kwabantu ababhinqileyo ngamaqabane abo.*
  ➢ *Oluphando luzakuqutyelwa kumaziko empilo amane la alandelayo: Gugulethu, Ceres, Worcester, Bishop Lavis. Kufuneka abantu abayi 75 kwiziko ngalinye batsho ke bebonke babe yi 300.*
  ➢ *Ngoluphando sifuna ukubona ukuba alingebi luncedo na kumakhosikazi ahlukunyeziwe yaye asahleli kwimeko ezinjalo. Sizakuthatha inkcukacha zonke zokuxhatshazwa kwakho namava othe wadibana nawo nomonzakalo othe wawufumana ze sikuthumele nakolunye uvavanyo olufunekayo sizokwazi ukujonga ukuba ukhuseleke kangakanani na ze sikuthumele kwindawo ezonokunika uncedo.*

Kucelwa abantu abatheni ukuba bathathe inxaxheba?
Ucelwa kuba ungumnu obhinqileyo omdala onamava ngokuhlukunyezwa liqabane lakhe kwiminyaka emibini edlulileyo.

Yintoni elindelekiyo kuwe?
Kufuneka ubuye emva kwenyanga.

Ingaba ikhona into ozakuyifamana ngokuthatha inxaxheba koluphando?
Silindele ukuba ufumana uvavanyo necebiso elikhuselekileyo. Uyakuvavanywa ngokwasengqondweni ze ufumane inkxaso enokunceda nasempilweni uyakuvavanywa. Ukuba kukho umonzakalo uyakubhalwa

phantsi njengobungqina obuyakusetyenziswa xa kuthe kwayimfuneko ukuba kubonakaliswe ikuba iqabane lakho belikuhlukumeza. Uyakucetyiswa ukuba xa ufuna abasemthethweni uye phi na.

Ingaba kukho ubungozi ongathi ubufumane ngokuthatha inxaxheba koluphando?
Oluphando libuthathaka kwabathandanayo ngoba ukuba iqabane lakho lingafunabisa ukuba uthatha inxaxheba koluphando lingoyika liqonde uba lingabanjwa litsho licinga amacebo okoyikisa kakubi.

Ngubani ozakubona inkcukacha zakho?
Igana lakho alizukwaziswa. Zonke inkcukacha zakubayimfihlelo yakho nomphandi akukho mntu ungomnye oyakufikelela kuyo.

Kwakenzeka ntoni ukuba unokwenzakala koluphando?
Oluphando alunayo i-insurance. Iziko lempilo lakwenza oko kusemandleni alo.

Ingaba uzakubhataleka ngokuthatha inxaxheba koluphando yaye ingaba alunazindleko kuwe?
Akukho ntlawulo uzakuyifumana ngokuthatha inxaxheba kodwa xa uthe wabuya emva kwenyanga ngokomyalelo uyakufumana i R50 yokukhwela. Akukho zindleko uzakukuzifumana ngokuthatha inxaxheba.

Ikhona enye into onqwenela ukuyazi?
Ungatsalela umnxeba kwisigqeba soluphando lunzulu kule nombolo:
(021) 938 9207 ubuze ngento ongayiqondiyo nezikhalazo zakho ezithe azaphenduleka ncam kumphandi. Uzakuyifumana ikopi yalenkcazelo nesivumelwano uzigcinele.

Isifungo somthathi nxaxheba:
Kutyikitywe ngezantsi: Mna _____ Ndiyavuma ukuthattha inxaxheba
Kwisifundo sophando esibizwa ngokuba yinkathalo yempathombi kwamaqabane athandanayo entshona koloni:

Umphandi_____   Umthathi-nxaxheba _____   Folder no._____

ISIVUMELWANO:
Ukunika imvume yokuqokelelwa kobungqina nokunikezelwa kwenkcukacha:

Mna ndinika imvume_____CHC/Hospital
<div align="center">(Igama le kliniki okanye isibedlele)</div>

Kunye_____
<div align="center">(Igama lika nompilo)</div>

Nceda korekisha:

☐ Yokubhala umonzakalo, uthatha igazi, uxilongwa komntsontso nezihlunu nezinye ke izinto ezifunekayo.

☐ Ukuthatha imifanekiso

☐ Ukunikezela ikopi zoxilongo, nezase laboratory emapoliseni xa ethe azicela.

Ndiyayiqonda ukuba ifomu yoxilongo lokuhlukunyezwa iya kwindawo ezifuna ubungqina ngomonzakalo wam. Yaye ndiyayazi ukuba yonke le nkcukacha ilihlebo.

Ndiyayiqonda ukuba le nkcukacha izakuthunyelwa emapoliseni kwifomu eyi J88.

Isigulana: _____   _____
                    (bhala igama)   (isityikityo)

Ingqina: _____   _____
                    (bhala igama)   (isityikityo)

Umzali/Umntu okugcinayo: _____   _____
                                              (bhala igama)   (isityikityo)

Date: _____ / _____ / _____

Igama leziko: _____

Isitampu saseburulumenteni:

Uhlobo lwenkathalo nemigaqo-siseko eyakuthi ithathwe kuyo yonke lenkqubo.
Ndiyafunga ukuba: Ndiyifundile ndayiva le nkcazelo nesivumelwano ngoba sibhalwe ngolwimi lam lenkobe. Ndiyibuzile imibuzo ndaphenduleka. Ndiyayiqonda ukuba andinyanzelekanga yaye andiqweqwediswanga ukuba ndithathe inxaxheba koluphando ndizithandele. Ndingarhoxa ukuba ndiyafuna nanini na andizubekwa tyala. Ndingayekiswa ukuqhubekekha no phando ngumphandi xa ngaba ubona kuyimfuneko okanyo andihambi ngokusemgaqweni.

Kutyikitywe *(indawo)* _____   *(umhla)* _____

Utyikityo lo mthathi-nxaxheba _____ Utyikityo lwengqina: _____

Ufungo ngumphandi _____

Mna *(igama)* _____ ndiyafunga ukuba:
- Ndicacisile inkcukacha ezikweli phepha ku _____
- Ndamkhuthaza ukuba abuze imibuzo yaye ndathatha ixesha elaneleyo ukuphendula yona.
- Ndanelisekile kukuba uyayiqonda yonke into equlethwe loluphando selucacisiwe apha ngasentla.
- Okanye ndisebenzise toliki *(Ukuba itoliki ibekhona kufuneka ityikitye ngezantsi)*

Utyikitywe *(indawo)* _____   *(umhla)* _____

Utyikityo lomphandi: _____ Utyikityo lwengqina: _____

Isifungo yi toliki

Mna _____ ndiyafunga ukuba:

- Ndimncedisile umphandi *(igama)* _____ ukucacisa le nkcazelo ekweliphepha

   (igama lomthathi-nxaxheba) _____ ndisebenzisa ulwimi lakhe lenkobe, isiXhosa.

- Simkhuthazile ukuba abuze imibuzo yaye sathatha ixesha elaneleyo ukuyiphendula.

- Ndigqithise inkcazelo njengoko bekulindelekile kum.

- Ndanelesekile ukuba umthathi-nxaxheba kolu phando uyayiqonda into equlethwe sesi sivumelwano yaye nemibuzo yakhe iphendulekile.

Ityikitywe *(indawo)* _____   *(umhla)*_____

Isityikityo se toliki: _____Isityikityo sengqina: _____

Appendix E

Depression Assessment Guide

Checklist

I. Low mood / sadness: "Do you feel sad or like crying for no reason? ...." ☐

II. Loss of interest or pleasure: "As a person there are things that you enjoy doing, such as listening to music or going out with friends, do you find that you no longer enjoy these things?"... .... ☐

III. Decreased energy and/or increased fatigue: "Do you feel exhausted or tired even when you are not working hard?"... ☐

If YES to any of the above, continue below

1. Sleep disturbance: "How are you sleeping at the moment?"................................. ☐

2. Appetite loss / increase: "How are you eating at the moment? Have you lost interest in food?... ☐

3. Concentration difficulty: "Does your mind have difficulty working? Do you find that recently you forget things easily?"... ☐

4. Psychomotor retardation or agitation: "Do you feel that you are slowed down and take longer to do things?"... ☐

5. Decreased libido: "Have you lost interest in sex?"... ☐

6. Loss of self-confidence or self-esteem: "Do you feel less worthy than or beneath other people?".. ☐

7. Thoughts of death or suicide: "Have you had thoughts about ending your life?".. ☐

8. Feelings of guilt: "How are other people feeling about you? Responding to you? What do you feel about this? Is it your fault?"... ☐

Summing up

*Positive to I, II or III and at least 5 positive from 1 to 8. All occurring most of the time for 2 weeks or more is an indication of **depression**.*

Flowchart

If the patient fulfills the diagnostic criteria for depression:

↓

Consider whether other medical conditions could be causing the symptoms

- Neoplasms, arthritis, thyroid disorders, chronic infectious diseases, chronic medical conditions e.g. heart problem, diabetes

↓

Consider whether the symptoms could be related to medications

- Beta blockers, antihypertensives (e.g. reserpine, methyldopa), contraceptives, corticosteroids

↓

Consider whether the person has an anxiety disorder or post traumatic stress disorder

↓

Consider whether the person has an alcohol use disorder

↓

Treat for depression

Appendix F

Anxiety Assessment Guide

Checklist

I   Feeling tense or anxious: "Do you sometimes have the feeling as though you are going
to hear bad news?"... ☐

II   Worrying a lot about things: "Are you thinking too much?".. ☐

If YES to any of the above, continue below

1. General symptoms of worry and anxiety? i.e. restlessness, difficulty concentrating,
irritability, easily fatigued.. ☐

2. Experienced attacks of intense, sudden fear, or anxiety?... ☐

Nausea..Dizzy, light headed or faint...................... ☐
Pounding heart.............................   Numbness or tingling sensations.............. ☐
Sweating..................................... Feelings of unreality.............................. ☐
Trembling or shaking...................... Fear of dying....................................... ☐
Chest pains................................. Fear of losing control............................. ☐
Difficulty breathing.........................

3. Experience fear or anxiety in and / or avoid specific situations such as:

Leaving familiar places... ☐
Travelling alone, e.g. taxi, car, train... ☐
Being in crowds, confined places or public places... ☐

4. Experience fear or anxiety in and / or avoid social situations where you are the focus of
attention, such as:

Speaking in front of others.. ☐
Social events such as parties.. ☐
Eating in front of others.. ☐
Worrying a lot about what others will think... ☐

Summing up

*Positive to I and II and 1, but negative to 2, 3, and 4 consider **Generalised Anxiety Disorder***
*Positive to I and multiple recurrent symptoms from 2 consider **Panic Disorder***
*Positive to I and 2, 3 consider **Agoraphobia***
*Positive to I and 2, 4 consider **Social Phobia***
*Anxiety disorders are associated with significant functional impairment at work or at home and distress
to the patient*

Flowchart

If the patient has symptoms of anxiety:

↓

Consider whether other medical conditions could be causing the symptoms
- E.g. Thyrotoxicosis

↓

Consider whether the symptoms could be related to medications
- E.g. Theophylline, beta agonists

↓

Consider whether the person has depression

↓

Consider whether the person has an alcohol use disorder

↓

Consider whether the person has a specific anxiety disorder
- Generalised anxiety disorder
- Panic disorder
- Agoraphobia
- Social Phobia
- Post traumatic stress disorder

Appendix G

Post Traumatic Stress Disorder Assessment Guide

Checklist

I. Have you seen or experienced a traumatic event that made you feel very afraid, helpless or shocked? i.e. rape, domestic violence, or any event that was experienced as a trauma for the individual person... ☐

If YES to the above, continue below

1. Do you re-experience the event in any of the following ways:

Recurring memories of the event in thoughts or pictures.................... ☐	Acting or feeling as if you are back in the event... ☐
Recurring and distressing dreams of the event............................... ☐	Becoming distressed when something reminds you of the event..................... ☐

2. Do you avoid certain things that remind you of the event such as:

People, places or activities associated with the event............. ☐	Thoughts associated with the event....... ☐
Feelings associated with the event....................................... ☐	Unable to remember important parts of the event...................................... ☐

3. Is your mood affected in any of the following ways:

As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? I.e. listening to music or going out with friends............................... ☐	Having a reduced or restricted range of emotions and feelings, e.g. unable to have loving feelings......................... ☐
Feeling detached or separate from other people............................ ☐	Difficulty thinking about or planning your future e.g. does not expect career, marriage, children, normal life span.. ☐

4. Do you:

Have sleep problems?.................... ☐	Often have the feeling as though you are going to hear bad news?.................. ☐
Feel more angry or irritable than usual?... ☐	Startle or "get a fright" very easily?......... ☐
Find that recently you forget things easily or have difficulty getting your mind to work?............................... ☐	Feel more anxious or worried than usual?.. ☐

Summing up:

Consider PTSD if 1 or more symptoms in all 4 categories and symptoms have been present for more than 1 month.
PTSD is often accompanied by significant distress in relationships, work or family functioning.

Flowchart

If the patient has symptoms of PTSD:

↓

Consider whether other medical conditions could be causing the symptoms

- E.g. Thyrotoxicosis

↓

Consider whether the symptoms could be related to medications

- E.g. Theophylline, beta agonists

↓

Consider whether the person has depression

↓

Consider whether the person has an alcohol use disorder

↓

Consider whether the person has another specific anxiety disorder

- Panic disorder
- Agoraphobia
- Social Phobia

↓

Post Traumatic Stress Disorder

- In PTSD co-morbidity of panic attacks, phobic avoidance and depression is common

Appendix H

The 10-item AUDIT questionnaire has 92% sensitivity and 94% sensitivity and 94% specificity for harmful alcohol use or problem drinking (1996).

	Score				
Question	0	1	2	3	4
How often do you have a drink containing alcohol	Never	Monthly or less	2-4 times / month	2-3 times / week	4 or more times / week
How many drinks do you have on a typical day when you are drinking?	None	1 or 2	3 or 4	5 or 6	7 – 9*
How often do you have 6 or more drinks on one occasion	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you were unable to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Have you or someone else been injured as a result of your drinking?	Never	Yes, but not in last year (2 points)		Yes, during the last year (4 points)	

Has a relative, doctor or other health worker been concerned about your drinking or suggested you cut down?	Never	Yes, not in last year (2 points)		Yes, during the last year (4 points)	

Score or greater than 8 (out of 41) are suggestive of problem drinking and indicates a need for more in depth assessment. Cut off of 10 points recommended by some to provide greater specificity.
*5 points if response is 10 or more drinks on a typical day

Appendix I

SEMI-STRUCTURED QUESTIONNAIRE FOR FOCUS GROUPS

1) What do you see as the major barriers to screening, treating and referring survivors of IPV?

2) What could be some reasons that patients do not disclose? How could we help to overcome disclosure barriers?

3) What could we do to help, so that providers do not feel too overwhelmed by screening?

4) Is there a concern that a batterer would retaliate against the woman and/or the provider if he found out the woman had talked about his violence?

5) Is there a concern about being asked to testify in a court case?

6) Do you think that if the health care provider was a victim or perpetrator of violence it might be harder to ask patients about violence?

7) Do you think there are other barriers that get in providers' way that make them hesitant to screen patients?

8) What are other organizational difficulties that we have not yet talked about that you believe might get in the way of implementing and sustaining this project?

9) Should there be an emphasis on what staff can do to help other staff who are victims of violence?

10) If there were some ambivalence, what would help the staff to feel more positive about this project?

Probes: Three most important items to make this project a success?
         Anything additional that hasn't been touched on?

Appendix J : J88

REPORT BY AUTHORISED HEALTH CARE PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION
To be completed electronically or in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police station	2. CAS No/OB No:	3. Investigating Officer Name: Landline No: Cell No: Email:

5. Date of medical examination Day　　Month　　Year	4. Time of medical examination (24 hour clock)

6. Name of health facility	7. Physical address of facility/practice

8. Name of examining health care practitioner	9. Qualifications of examining practitioner

10. Registration no. of practitioner	11. Telephone number: Landline: Cell phone:	12. Email address of practitioner

13. Full names of person examined	14. Date of birth

15. Sex:　M □　F □	16. Health care facility record number:

17. Patient accompanied by:	18. People present during examination

B. MEDICAL HISTORY

1. Intellectual/learning disability None　　　　　　　Yes ____　No _____ Possible impairment　Yes ____　No _____ Definite impairment　Yes ____　No _____ Learning disability　Yes ____　No _____ Specify:	2. Other disabilities and or impairments: a. Hearing impairment:　Yes ___　No ___ b. Visual impairment:　Yes ___　No ___ c. Other physical disability: Yes ___　No ___ d. Mental illness:　Yes ____　No ____ Specify:
3. Risk factors (State source & method of obtaining information e.g. caregiver, interpreter used)	4. Relevant medical history that can assist with differential diagnosis (State source & method of obtaining information e.g. caregiver, interpreter used and language)
5. Relevant medication taken	6. History of the alleged assault Start date/time of incident _____ End date/time of incident _____ Physical assault :　　Yes ____ No _____ Sexual assault :　　　Yes ____ No _____

C. GENERAL EXAMINATION

1. Condition of clothing
a. Changed clothes Yes ___　No ___
b. Torn/ripped　　Yes ___　No ___　Specify item of clothing: _____
　 Describe
c. Stained
　 Possibly blood　Yes __　No __　Specify item of clothing: _____　Swabbed Yes ___No __

Describe where on clothing _____
d. Possibly semen Yes __ No __ Specify item of clothing: _____ Swabbed Yes ___ No ___
Describe where on clothing _____
Other:
e. Left at the scene Yes ___ No ___ Specify item of clothing:
f. Clothing sent to Forensic Science Laboratory Yes ___ No ___

Signature of health care practitioner:
Date (dd/mm/yyyy):

2. Height (cm)	3. Weight (kg)	4. General body build:
Measured: ☐☐☐	Measured: ☐☐☐	Muscular Yes ___ No ___ Frail Yes ___ No ___
Estimated: ☐☐☐	Estimated: ☐☐☐	Percentiles (children only):

6. Clinical evidence of drugs or alcohol at time of the examination (e.g. Nystagmus, ataxia, slurred speech, dilated pupils, etc):

History of intoxication/drugged at the time of the assault Yes ___ No ___
Blood samples taken Yes ___ No ___   Alcohol evidence collection kit completed Yes ___ No ___
Urine samples taken   Yes ___ No ___

7. Clinical findings: Describe the nature, position, and extent of the abrasion, bruise, laceration, scars or other injury together with its date & possible causation. The position of all injuries must be noted on sketches. (Add pages if required)

D. ORAL EXAMINATION

1. Gums	2. Frenulum of tongue
3. Frenulum of upper lip	4. Tongue
5. Palate	6. Teeth
7. Inside of cheeks	

Signature of health care practitioner:
Date (dd/mm/yyyy):

R   L
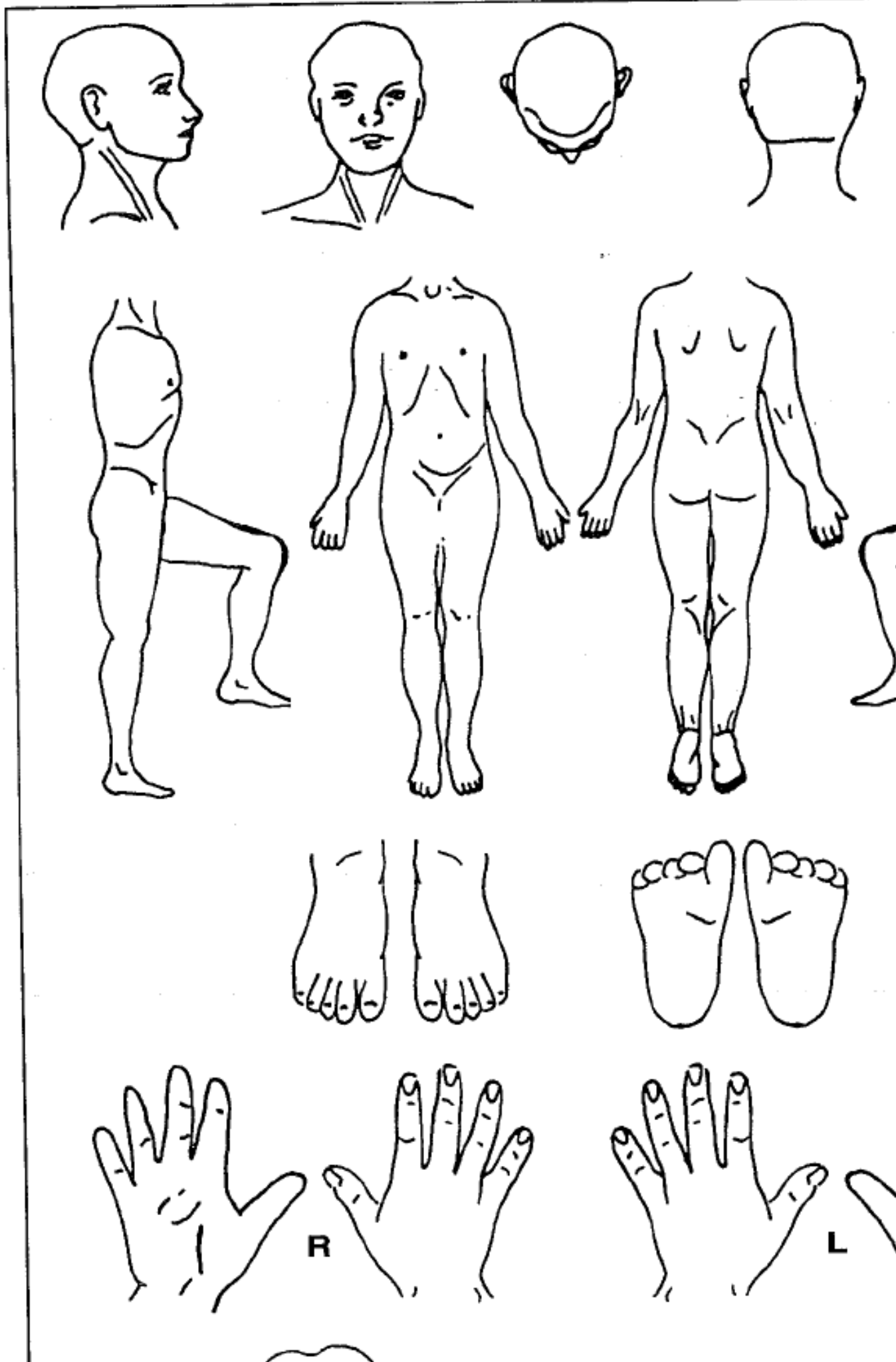
Signature of health care practitioner:
Date (dd/mm/yyyy):

E. HISTORY OF RELEVANCE TO A SEXUAL OFFENCE

1. Since the alleged offence took place has the person: Wiped Yes ___ No __ Bathed/washed Yes ____ No __ Urinated Yes ___ No __ Defecated Yes ____ No ____ Showered Yes ___ No ___	2. Condom used during alleged sexual offence: Yes ____ No ____
3. Currently pregnant: Yes ___ No ___ If yes: duration: _ _ weeks	4. Menstruating at time of alleged sexual offence: Yes ____ No ____
5. Ever had vaginal delivery Yes ___ No ___ If yes: Number	Menstruated since the alleged sexual offence: Yes ____ No ____

F. ANAL EXAMINATION

1. Perineum

2. Mucocutaneous appearance
   Skin surrounding orifice:
   Orifice:

3. Venous engorgement

4. Dilatation

G. GYNAECOLOGICAL EXAMINATION

1. Breast development: Tanner stage 1-5	2. Pubic hair: Tanner Stage 1-5
3. Mons Pubis	4. Clitoris
5. Frenulum of clitoris	6. Urethral orifice
7. Labia Majora	8. Labia Minora

9. Posterior Fourchette/Commissure	10. Vestibule
	   Fossa navicularis
	   Paraurethral folds

Configuration: 11. Hymen Posterior rim: Edge of hymen:	
12. Vagina	13. Discharge (describe)
14. Cervix	

H. MALE GENITALIA

1. Genital development: Tanner stage 1-5	2. Pubic hair: Tanner Stage 1-5
3. Prepuce & frenulum	4. Glans

5. Shaft	6. Scrotum

Signature of health care practitioner:
Date (dd/mm/yyyy):

SCHEMATIC DRAWING OF FINDINGS
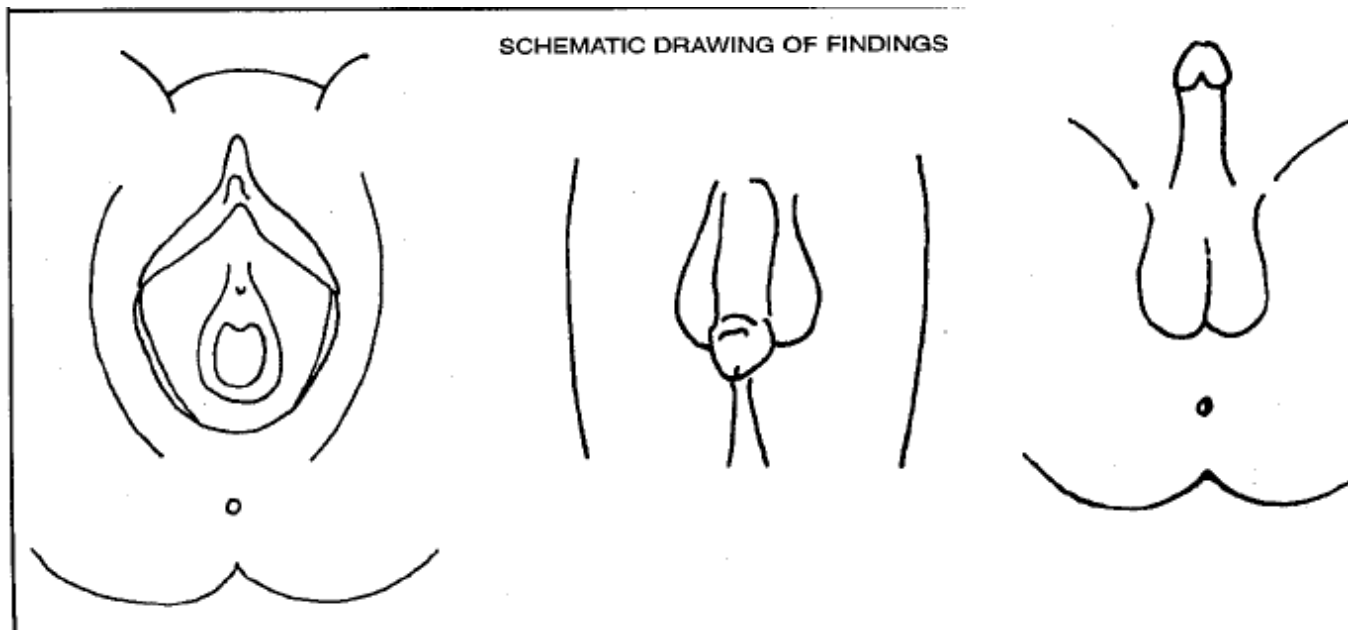
J. SAMPLES TAKEN FOR INVESTIGATION

1. Sexual assault evidence collection kit seal no.:	2. Alcohol collection kit seal no.:
3. Clothing kit seal no.:	4. J88 form handed to: Name: Rank: Signature:

K. TECHNOLOGY USED

Photographs taken: Yes ___ No ___ Name of photographer:	Colposcope used Yes _____ No _____ Toluidine Blue used Yes _____ No _____

L. CONCLUSIONS (TAKE ACCOUNT OF ALL FINDINGS)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature of health care practitioner:
Date (dd/mm/yyyy):

Appendix K: Adapted Protocol

Folder No: _____   *Date:* _____

CONFIDENTIAL REPORT ON IPV EXAMINATION

PATIENT INFORMATION:

Name: _____   Age: _____

Current Residential Address: _____

Tel No: (h): _____   (w): _____   (cell): _____

Safe to phone?   _____   _____   _____

Partnership Status: Married how? _____

Same-sex partner ☐ Single ☐ Co-habiting ☐ Divorced ☐

Genogram:

HISTORY OF MOST RECENT ABUSE

Location, date and time of incident:

_____

Identity of abuser: _____

NATURE OF ABUSE

PHYSICAL

Hitting

Kicking

Use of a weapon

Pushing

Choking

Burns

Other

EMOTIONAL

Being insulted

Shouting

Restricting contact with family/friends

Threats

Controlling her activities

Other

SEXUAL

Unwanted touching

Infidelity

Sexually transmitted infections

Forced intercourse

Other

FINANCIAL

Witholding money

Taking money

Controlling all financial decisions

Other

Patient's description of most recent abuse (Use her exact words as far as possible. Describe severity of abuse.)

Other episodes of abuse:

Describe frequency & severity of past abuse, using direct quotes from the patient. Describe mechanism, location and extent of injury and/ or symptoms/conditions.

Frequency over last 2 years: 0-10 [   ] / 11-20 [   ] / >20 [   ]

Patient's description:

_____

_____

_____

_____

_____

_____

IF RELEVANT:

Has a criminal charge been laid? [   ] Yes   [   ] No

If yes, what charge was laid?

Assault ☐   Grievous bodily harm ☐   Rape ☐   Indecent assault ☐

Contravention of protection order ☐

Name of police station:_____ CAS No:

_____

If no, does the patient intend laying a charge?

Yes   ☐   No ☐   Unsure ☐

Does patient have a Protection Order?   Yes ☐ / No ☐

Name of magistrate court:

If no, intends to apply for protection order; Yes ☐ / No ☐ / Unsure ☐

ASSESSMENT OF EMOTIONAL STATUS:

Mental Problems Checklist

1. Are you thinking too much?
   …………………………………….................... ☐
2. How are you sleeping at the moment?
   ………………………………….................. ☐
3. Do you feel exhausted or tired even when you are not working hard?
   …………………………………………....... ☐
4. Do you feel sad or like crying for no reason?
   ………………………………….............. ☐
5. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? i.e. listening to music or going out with friends…………………………….......... ☐
6. Do you sometimes have the feeling as though you are going to hear bad news?………………………………….. ☐
7. a) Have you ever felt you should cut down on your drinking?
   ..………………………………………… ☐

   b) Have people annoyed you by criticising your drinking?
   ……………………..……………….. ☐

   c)   Have you ever felt bad or guilty about your drinking?
   ………………………………………… ☐

   d) Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover?
   ………………………………………… ☐
8. Have you experienced traumatic events that made you feel extremely threatened or endangered? Or witnessed someone else in this situation?………………………………….. ☐

9. Have you used substances such as dagga or tic? Any others? (e.g. mandrax, glue, benzene or solvents, ecstasy, cocaine/crack)
   In the last month? ………………………………...........
   In the last year? ....

10. How many days last month did you take painkillers?.............................

If positive to any one further assessment may be required.

If positive to **2,3,4,5** consider **depressive disorders.**
If positive to **1, 2, 6** consider **anxiety disorders.**
If positive to **7** consider **alcohol use disorders.**
If positive to **8** consider **post traumatic stress disorder.**
If positive to **9 or 10** consider **substance abuse disorder.**

REFERRAL FOR MENTAL HEALTH

Depression requiring further assessment?   Yes [ ]   No [ ]

Post traumatic stress disorder requiring further assessment?   Yes [ ]   No [ ]

Anxiety disorder requiring further assessment?   Yes [ ]   No [ ]

Alcohol/substance use disorder requiring further assessment? Yes [ ]   No [ ]

DANGER ASSESSMENT:

A danger assessment must be done for all patients who disclose domestic violence. Record answers to the following questions. The answers to the questions can be assigned a value for risk assessment. Assign a value for the answers as follows:

No = 0   Yes = 1

Add up the total to provide a risk rating: **1 – 2** ➜   ***Caution***

3 - 5 ➜   ***High Risk***

6 -11 ➜   **Severe Risk**

1) Has he threatened you with physical violence?

2) Has he threatened the children with physical violence?

3) Is there a firearm in the house?

4) Has he threatened to kill you?

5) Has he threatened to kill the children?

6) Does the patient think he is capable of killing her?

7) Were alcohol and / or drugs consumed prior to the last incident of abuse?

8) Has the abuse escalated in either frequency or severity?

9) Have you ever received medical treatment for injuries sustained

as a result of abuse?

10) Have you ever thought of killing yourself?

11) Have you ever thought of killing the children?

Score: 1-2 ☐   3-5 ☐   6-11 ☐   **TOTAL RATING**

SAFETY PLAN:
Help the client think and plan the following:

?   Where can you go if you need to leave home?
?   Who can you trust to tell about the domestic violence?
?   Where can you leave money, clothing, copies of documents and valuables if necessary?
?   How will you ensure your children's safety?

Advise patient to hide a readily available packed bag with essential items such as:
- Her ID book, birth certificates, hospital cards, and other important documents.
- Keys, money and bank card.
- Clothes for her and her children.
- Important telephone numbers.
- Copy of the protection order and suspended warrant of arrest if she already same.

Make a list together of other things to take with her, for example:
- Children's favourite toys, books.
- Children's school books and uniforms.
- Toiletries (toothbrush, deodorant, etc).
- Other valuable personal items, for example, photos and jewellery.

REFERRAL LEGAL AND PSYCHO-SOCIAL ISSUES

Referral letters supplied?	Yes ☐	No ☐
Magistrate court for protection order	Yes ☐	No ☐
Police station for criminal charge	Yes ☐	No ☐
Counselling	Yes ☐	No ☐
Legal support	Yes ☐	No ☐
Social worker	Yes ☐	No ☐
Shelter	Yes ☐	No ☐

Other:
_____

FOLLOW UP:

Date and time of appointment, if made, for follow- up?

_____

Signature: _____

Health Facility: _____

Date: _____

Appendix L: First Follow-Up Tool

IPV FOLLOW-UP INTERVIEW

PATIENT INFORMATION:

Name:	_____

Folder No:_____

Date of interview:	_____

In-depth Interview Candidate: YES	NO

Thank you making the effort to be here. We appreciate you being part of this project. The last interview was intended to help you with the abuse.

1)	How useful did you find it? (protocol itself)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

2)	We value your opinion and would like to know what should be done	differently?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

3)   Has anything changed as a result of your initial meeting with the researcher? If so,   please explain:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4)   How are things going for you in the relationship at the moment?

_____

_____

_____

_____

_____

_____

_____

_____

_____

5)	Do you have any comments about the healthcare provider who saw you at the last	meeting?

_____

_____

_____

_____

_____

_____

_____

_____

SPECIAL INVESTIGATIONS

6)	HIV Testing done?	Yes	No	Pos	Neg

7)	STI detected?	Yes	No	Pos	Neg

8)	treatment received?	Yes	No

9)	RPR done?	Yes	No	Pos	Neg

10)	Treatment received?	Yes	No

11)	Pregnancy Test:	Yes	No	Pos	Neg

12)   X-rays: Yes   No

13)   How did you find the safety assessment?

_____

_____

_____

_____

_____

14) A safety plan was discussed with you. How was it useful or not useful?

_____

_____

_____

_____

_____

_____

_____

_____

very useful   useful   not useful   harmful

15)   Went to magistrate court for protection order? Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

very helpful   helpful   unhelpful   harmful

16) Went to police station for criminal charge? Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

_____

_____

_____

_____

very helpful   helpful   unhelpful   harmful

16) Went to NGO for counseling?   Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

_____

_____

_____

_____

very helpful   helpful   unhelpful   harmful

17) Went to NGO for legal support?   Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

very helpful   helpful   unhelpful   harmful

18) Went to PGWC social worker   Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

_____

_____

_____

_____

very helpful   helpful   unhelpful   harmful

19) Went to shelter screening appointment?   Yes

      No

How was it helpful or unhelpful for you?

_____

_____

_____

_____

_____

_____

_____

very helpful   helpful   unhelpful   harmful

20) Other: _____   Yes   No

How was it helpful or unhelpful for you?

_____

_____

_____

very helpful   helpful   unhelpful   harmful

Appendix M: Adapted Follow-up Tool

IPV FOLLOW-UP INTERVIEW

PATIENT INFORMATION:

Name: _____

Folder No:_____

Date of interview: _____

In-depth Interview Candidate: YES   NO

Thank you making the effort to be here. We appreciate you being part of this project. The last interview was a service intervention and we want to know how you experienced it.

1) How was it necessary for you?:

_____

_____

_____

_____

_____

2)   How useful did you find the first interview?

_____

_____

_____

_____

_____

_____

_____

_____

_____

3)   What made a difference / did not make a difference and how?

_____

_____

_____

_____

_____

_____

_____

_____

4)   Has anything changed as a result? If so, please explain:

_____

_____

_____

_____

_____

_____

_____

5) We value your opinion and would like to know what should be done differently?

_____

_____

_____

_____

_____

_____

Emotional status:

6) **Adherence to referral appointment?**   Yes

   No

6) **Was it helpful?**   Yes

   No

7) **How was it helpful?**

_____

_____

_____

_____

_____

_____

_____

_____

_____

8) **How are things going for you in your relationship at the moment?**

_____

_____

_____

_____

_____

_____

_____

_____

_____

9)   Do you have intentions of leaving this relationship?

Yes   No

10)   If yes, how do you plan to do it?

_____

_____

_____

_____

SPECIAL INVESTIGATIONS FROM GUGLETU COMMUNITY HEALTH CENTRE (CHC)

Researcher to obtain results for:

11)   HIV Testing   Yes   No

Pos   Neg

12)   STI Screening:

Type _____   Yes

No   Pos   Neg

Type _____   Yes

No   Pos   Neg

Type _____   Yes

No   Pos   Neg

13)   Pregnancy Test: Yes

No   Pos   Neg

14)   X-rays: Yes

No

TREATMENT RECEIVED

SAFETY PLAN

Was the safety plan discussion helpful?

Yes   No

How was it useful / not useful?

_____

_____

_____

LEGAL AND SOCIAL REFERRAL

Were the following referrals made?:

Adherence?

Magistrate court for protection order   Yes   No   Partial

Yes   No

What it helpful for you?

_____

_____

_____

Police station for criminal charge: Yes   No   Partial

Yes   No

What has your experience of this been?

_____

_____

_____

_____

NGO for counseling   Yes   No   Partial

Yes   No

_____

_____

_____

NGO for legal support

Yes   No   Partial   Yes   No

_____

PGWC social worker

           Yes   No   Partial   Yes   No

_____

_____

_____

_____

Shelter   Yes   No   Partial   Yes   No

_____

_____

_____

Social welfare (grants)   Yes   No   Partial

       Yes   No

_____

_____

_____

_____

_____

Other: _____   Yes   No   Partial

      Yes   No

_____

_____

_____

_____

Was patient satisfied with the referrals you made for her?

INFORMATION

Is it safe to give patient written literature regarding
referral agencies, safety plans, and shelters?

Yes   No

_____

_____

_____

If not, how have you conveyed the information?
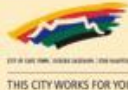
_____

_____

Appendix N: Life empowerment training programme
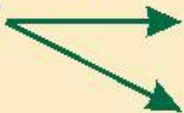
SETTING GOALS

*   **What do you expect to achieve for** ⟶ **yourself**
                                          ↘ **others**

*   **See yourself as having achieved it**

*   **Work hard - it is then impossible to fail**

*   **Let your God be your partner**

WRITE DOWN YOUR GOALS 1b

LEARN TO LIVE
IN THE MOMENT

WHAT HELPS YOU TO
RELAX YOUR BODY?

WHAT HELPS YOU TO
RELAX YOUR MIND?

HOW DO YOU CALM
YOUR
SPIRIT?

PRESCRIPTION:
Do the exercises
10 minutes twice a day

2

WE ARE ALL THE SAME INSIDE

We all want to be liked and accepted by others

We all want to feel that we are of significance, that there is meaning to our lives

IF THESE NEEDS ARE NOT MET, PROBLEMS WITH HEALTH WILL ARISE

3b

SEE LIFE'S PROBLEMS AS LEARNING OPPORTUNITIES

4a

UNDERSTANDING YOUR CIRCLE OF INFLUENCE

CIRCLE OF WORRY

CIRCLE OF INFLUENCE
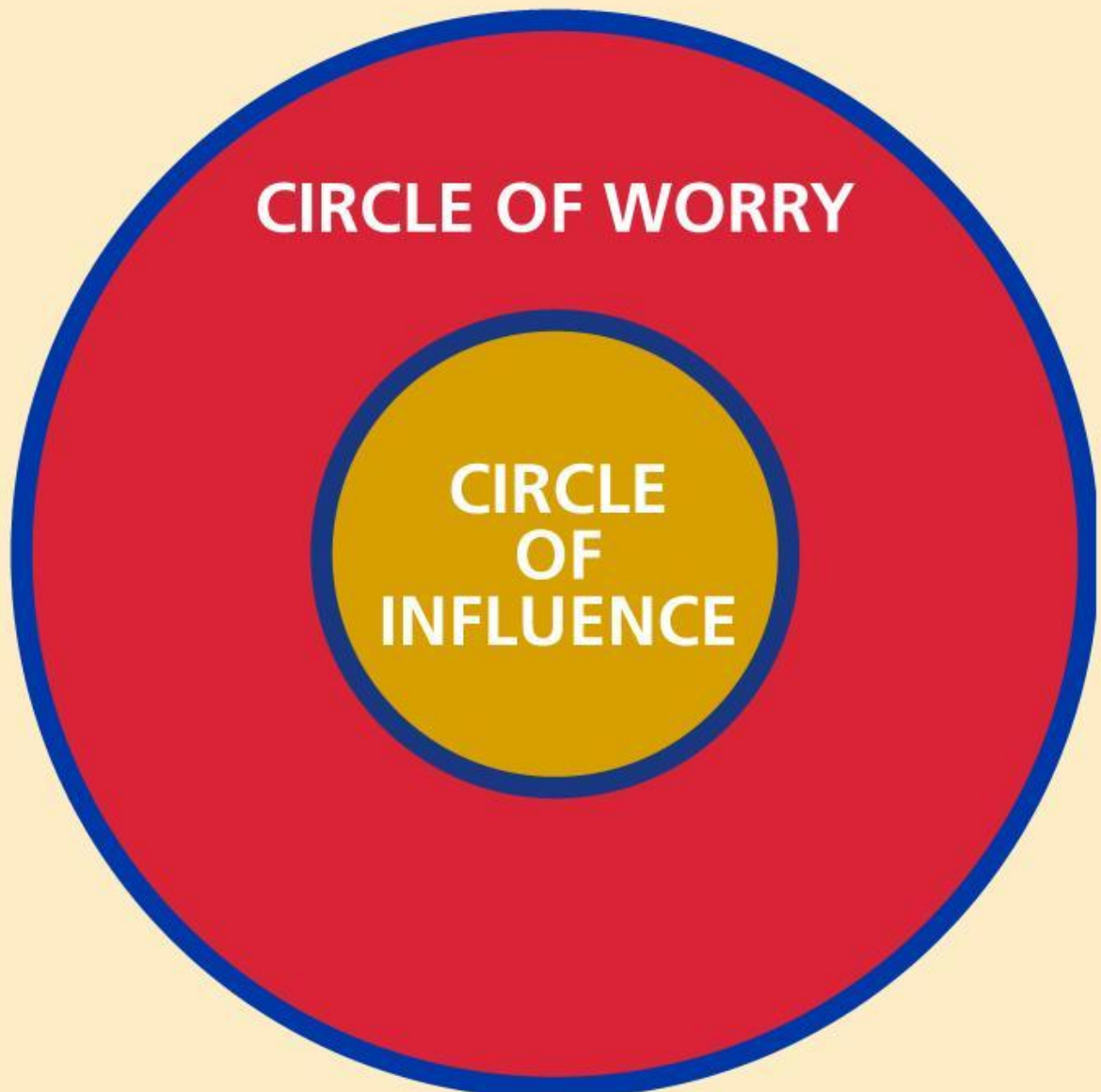
LET GO WHAT YOU CAN'T CONTROL

4b

YOU MAY HAVE TO RESOLVE ISSUES IN YOUR LIFE BEFORE YOU CAN MOVE ON

Separate yourself from feelings
Try to forgive and understand:
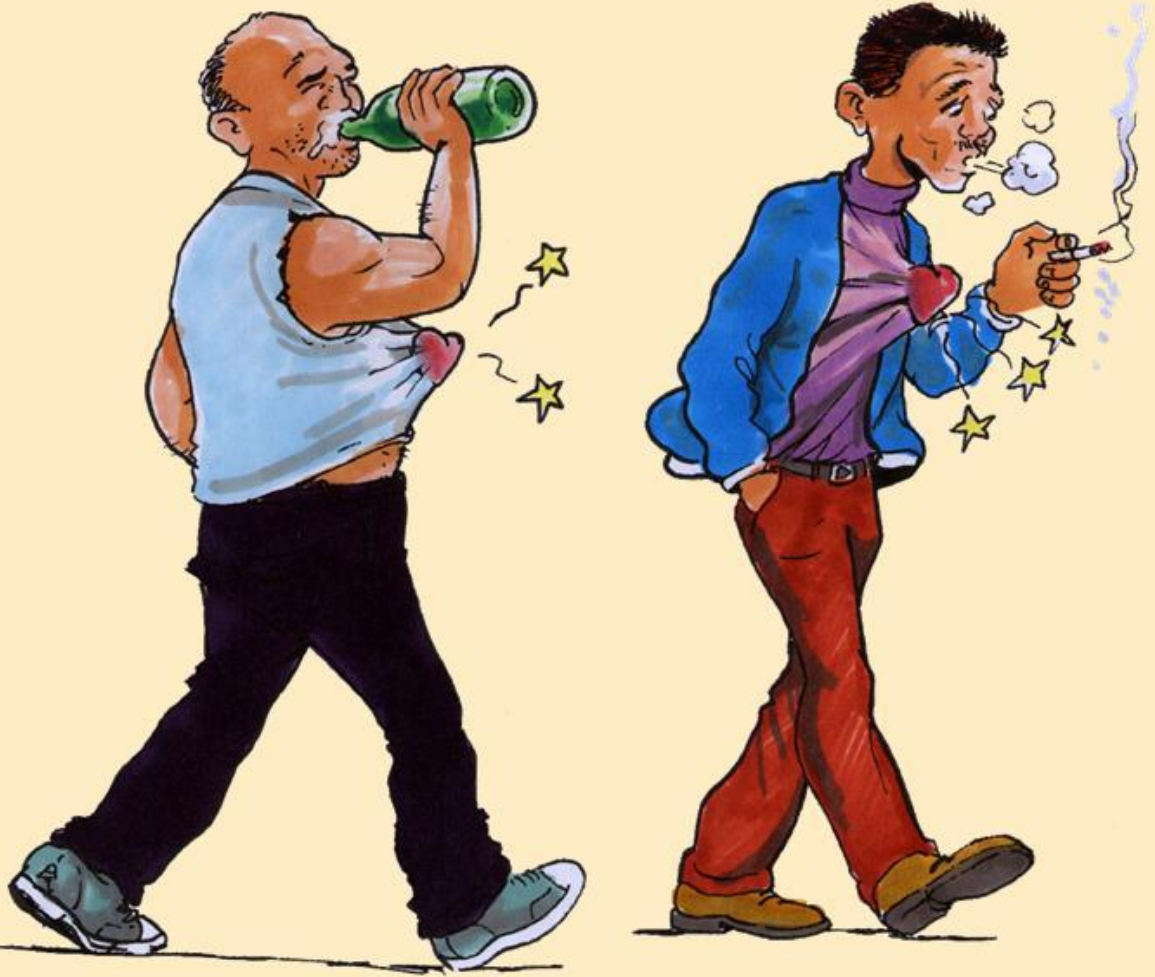- The situation
- Yourself
- The other person(s)

4d

ARE YOUR NEGATIVE EMOTIONS MAKING YOU ILL?

5a

THE PATH TO HEALING IS A PROCESS

Understand your real situation

Take responsibility

Confront the situation with your God's help or with someone you can trust

Accept and deal with your emotions

Develop new habits – resist the old

Adopt a thankful attitude

Help others

5d

Appendix O: Health research ethics general checklist

HEALTH RESEARCH ETHICS COMMITTEES
Faculty of Health Sciences, Stellenbosch University
CHECKLIST-GENERAL
To be completed by Applicant and checked by Ethics Admin Office

PROTOCOL TITLE:

PROTOCOL NUMBER		PROTOCOL VERSION		PROTOCOL DATE	

	CV (max 2 pages)	Investigator Declaration	Conflict of Interest statement signed.	Admin Office Comments
PRINCIPAL INVESTIGATOR:				
SUB-INVESTIGATORS				
1.				
2.				
3.				
4.				
5.				
6.				
OTHER STAFF				

	Applicant Y /N / NA	Comments	Admin Office
Applicant Signature			
Supervisor Signature			
HODiv Signature			
Protocol synopsis			
Full protocol			
Page numbers on protocol?			
Budget			
Informed Consent Form			
Questionnaires			
Other measuring tools/instruments.			

Recruitment material/ Advertisement(s)			
DoH or other letters of approval to conduct research			
Material Transfer Agreement			

A. Section B: *To Be completed by Applicant*

INFORMED CONSENT FOR RESEARCH CHECKLIST.

Element	Yes (PI)	Yes/No (Reviewer)
1. That consent is being sought from the participant to participate in research.		
2. The purpose of the research and where it will be conducted.		
3. The expected duration of the participant's involvement in the research.		
4. The total number of participants that will be involved at this site and/or South Africa and worldwide.		
5. A description of **all** the processes and procedures to which the participant will be subjected, emphasising any experimental procedures that are innovative and have not been used in medical practice.		
6. The principal investigator's name and contact details.		
7. Explanation of participants responsibilities.		
8. Explanation of any randomization process if applicable).		
9. Circumstances that may result in the project being terminated or the participant being withdrawn.		
10. A description of foreseeable risks and discomforts.		
11. A description of benefits to the participant or others both during and after the research. If there are no expected benefits, the participant must specifically be made aware of this.		
12. Disclosure of alternative procedures and course of treatments available if applicable		
13. Description of extent to which confidentiality will be maintained and protected.		
14. Statement that sponsors of the study, study monitors or auditors or REC members may need to inspect research records.		
15. Statement that the Health Research Ethics Committee has approved the research.		

16. Contact details of the committee.		
17. Explanation of how research related injury will be managed and details of insurance if applicable.		
18. Explanation as to whom to contact in the event of research related injury.		
19. Participation in the study is entirely voluntary		
20. Participants are free to withdraw at any point without explanation or any negative consequences. Their routine health care will not be adversely affected.		
21. Participants must be informed of their rights to be told any new relevant information that arises during the course of the trial and the ICF should be revised, where appropriate to incorporate this information.		
22. That the study will be conducted according to the International Declaration of Helsinki and other applicable international ethical codes for research on human subject.		
23. Any expense to which the participant may be liable.		
24. Explanation regarding payment for participation or out of pocket expenses		
25. Identity of the funder , where applicable and any potential conflict of interests.		
26. Where appropriate, the participant should also be requested/advised to inform his general practitioner and life insurance company or medical aid of his/her participation. ☐ Not considered appropriate/necessary		
27. Simple, clear language has been used (Maximum Grade 8 reading level) and all medical and technical terms have been explained.		

Section C. To be completed by Applicant

	Yes(PI)	Yes/No (Reviewer)
1. Does the study have relevance and scientific or clinical value and applicability to the proposed research population?		
2. Does the protocol include an adequate literature review?		
3. Is the selection of subjects equitable and appropriate; adequate consideration and protection of vulnerable research populations.		
4. Is the design and methodology appropriate to answer the research question?		
5. Is the methodology clearly described, in		

sufficient detail?		
6. Is the statistical analysis plan, including sample size calculations, clearly outlined and justified?		
7. Are the inclusion and exclusion criteria clearly defined and appropriate?		
8. Have risks been minimized and is there an acceptable balance between potential risks and benefits?		
9. Does the PI have the necessary qualifications, expertise, facilities, and time and support staff, to carry out the proposed research?		
10. Has a section on 'Ethical Considerations' been included in the protocol?		
11. Has the informed consent process been clearly explained in the protocol?		
12. Are issues relating to protection of privacy and confidentiality of data adequately addressed, especially if the study involves a retrospective review of clinical records?		
13. Has a waiver of informed consent been requested if the study involves a retrospective review of clinical records?		
14. Does the study involve collection of DNA/RNA and, if so, has consent been adequately sought for this?		

Appendix P

ETHICS COMMITTEE APPLICATION FORM

UNIVERSITY OF STELLENBOSCH

SUBCOMMITTEE A

2009

Application to the University of Stellenbosch SUBCOMMITTEE A

for clearance of new/revised research projects

This application must be typed or written in capitals

Name: Prof/Dr/Mr/Ms:
Position/Professional Status:
Affiliation: Research Programme/Institution:

Telephone and extention no.   **Code:**   **no.**
Fax: **Code:**   **no.**

Title of research project: (*Do not use abbreviations*)

Where will the research be carried out?

All the following sections must be completed (Please tick all relevant boxes where applicable)

1. **FUNDING OF THE RESEARCH: How will the research be funded?**

2. **PURPOSE OF THE RESEARCH:**

3. **AIMS AND OBJECTIVES OF THE RESEARCH:** *(Please list objectives)*

4. **SUMMARY OF THE RESEARCH** *(give a brief outline of the research plan – not*

5. **NATURE AND REQUIREMENTS OF THE RESEARCH**

5.1 **How should the research be characterised** *(Please tick ALL appropriate boxes)*

5.1.1 Personal and social information collected directly from participants/subjects
5.1.2 Participants/subjects to undergo physical examination
5.1.3 Participants/subjects to undergo psychometric testing
5.1.4 Identifiable information to be collected about people from available records
5.1.5 Anonymous information to be collected from available records
5.1.6 Literature, documents or archival material to be collected on individuals/groups

5.2 **Participant/Subject Information Sheet attached? (***for written and verbal consent***)**

YES	
NO	

5.3 **Informed Consent form attached?** *(for written consent)*

YES	
NO	

5.3.1 **If informed consent is not necessary, please state why:**

_____
_____
_____
_____

6.3 Are the participants/subjects subordinate to the person doing the recruiting?

YES	
NO	

6.3.1 If yes, justify the selection of subordinate subjects:

_____
_____
_____
_____
_____

6.4 Will control participants/subjects be used?

YES	
NO	

6.4.1 If yes, explain how they will be selected:

_____
_____
_____
_____
_____

6.5 What records, if any, will be used, and how will they be selected?

_____
_____
_____
_____
_____

6.6 What is the age range of the participants/subjects in the study?

_____

6.6.1   Was assent for guardians/consent for participants/subjects obtained?

YES	
NO	

If YES, please attach the appropriate forms.

6.6.2   If NO, please state why:

_____
_____
_____
_____

6.7 Will participation or non-participation disadvantage the participants/subjects in any way?

YES	
NO	

6.7.1 If yes, explain in what way:

_____
_____
_____
_____

6.8 Will the research benefit the participants/subjects in any direct way?

YES	
NO	

6.8.1 If yes, please explain in what way:

_____
_____
_____
_____

7. PROCEDURES

7.1 Mark research procedure(s) that will be used:

Literature	
Documentary	
Personal records	
Interviews	
Survey	
Participant observation	
Other (please specify) _____ _____	

7.2 How will the data be stored?

_____
_____
_____
_____

7.3 If an interview form/schedule; questionnaire or observation schedule/framework will be used, is it attached?

YES	
NO	

Possible complications	
Persecution	
Stigmatisation	
Negative labeling	
Other (please specify) _____ _____	

9.4 There will be financial costs to:

particant/subject	
institution	
Other (please specify) _____ _____	

9.4.1 Explain any box marked YES:

_____
_____
_____
_____

9.5 Research proposal/protocol attached:

YES	
NO	

9.6 Any other information which may be of value to the Committee should be provided here:

_____
_____
_____
_____
_____

Date: **Applicant`s signature**

Who will supervise the project?

Name: **Programme/Institution/Department:**

Date: **Signature:_____**

Director/Head/Research Coordinator of Department/Institute in which study is conducted:
Name:
Date: **Signature:_____**

Appendix Q: Screening Questions

WIE VRA U?
- **Alle vroue bo 18 jaar oud.**
- **Indien getroud, alle vroue bo 16 jaar oud.**

WAT VRA U INDIREK?

- **Hoe gaan dit met u verhouding?**

- **U simptome mag stress verwant wees. Baklei u en u vriend/man baie? Het u al ooit voorheen seergekry?**

- **Wat gebeur as u vriend/man kwaad raak?**

- **Het u vriend/man enige probleme met alkohol, dwelms of dobbel? Hoe affekteer dit sy gedrag met u en u kinders?**

HOE VRA U DIREK?

- **Soos u weet, is dit nie ongewoon vir 'n persoon om in dié tyd, iewers in 'n persoon se lewe, emosioneel, fisies of seksueel mishandel te word nie en dit kan 'n persoon se gesondheid later in sy lewe affekteer. Het dit al ooit voorheen met u gebeur?**

- **Ons vra alle vroue kliënte/pasiënte in die kliniek of hulle al ooit voorheen enige vorm van mishandeling ervaar het. Het u al ooit voorheen enige vorm van mishandeling ervaar deur u vriend/ man?**

- **Dikwels wanneer ek 'n besering soos die van u sien was dit omdat sy deur iemand geslaan was. Het dit dalk met u gebeur?**

- **Het u vriend/man of vorige man/vriend u al ooit voorheen geslaan of fisies seergemaak?**

- **Was u al ooit voorheen geslaan,geskop,geklap of gebyt deur u vriend/man?**

- **Het u vriend /man al ooit voorheen u lewe gedreig, u van u familie of vriende geïsoleer, of geweier om vir u geld te gee?**

WAT OM VOLGENDE TE DOEN:

- **As die persoon positief geassesseer is vir mishandeling, verduidelik soos volg: Ons evalueer huidiglik 'n nuwe diens om persone soos u te help. Sal u belangstel om met Sr. Abrahams te ontmoet sodat sy u ook kan assisteer?**

- **Verwys asseblief direk na Sr X**

SCREENING QUESTIONS FOR IPV

WHO TO ASK:
- All women over 18 years old
- If married, all women over 16 years old

WHAT TO ASK: Asking indirectly:
- How are things going in your relationship?
- Your symptoms may be related to stress. Do you and your partner fight a lot? Have you ever been hurt?
- What happens when your partner gets angry?
- Does your partner have any problems with alcohol, drugs or gambling? How does it affect his behaviour with you and the children?

Asking directly:
- As you may know, it's not uncommon these days for a person to have been emotionally, physically or sexually victimised at some time in their life and this can affect their health many years later. Has this ever happened to you?
- In this clinic we ask all women patients if they have ever experienced any form of abuse. Have you ever experienced abuse by your partner?
- Sometimes when I see an injury like yours, it's because someone hit them. Did this happen to you?
- Has your husband / partner or ex-husband / ex-partner ever hit you or physically hurt you?
- Have you ever been hit, kicked, slapped, pushed or bitten by your boyfriend / husband / partner?
- Has your boyfriend / husband / partner ever threatened your life, isolated you from your family or friends or refused to give you money?

WHAT TO DO NEXT:
- If patient screens positive for abuse, please explain as follows: "We are currently evaluating a new service to help people like you. Would you be interested to meet with Sr Abrahams so that she can assist you too?"
- Please refer directly to Sr X

Appendix R: Forensic Appendix for First Interview

Researcher: _____   *Patient Code:* _____   *Folder No.* _____

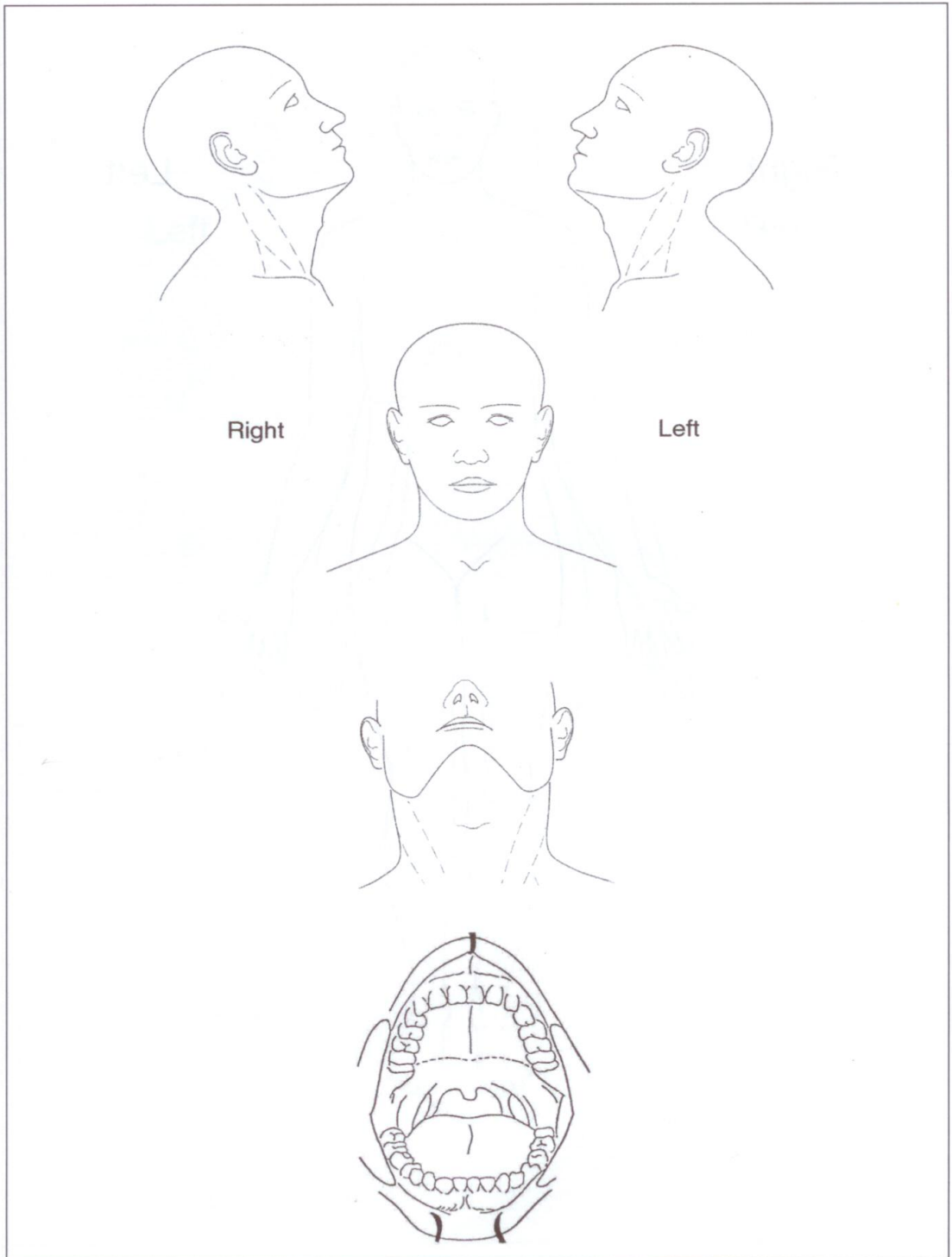**APPENDIX FOR FIRST INTERVIEW**

General Appearance:

_____

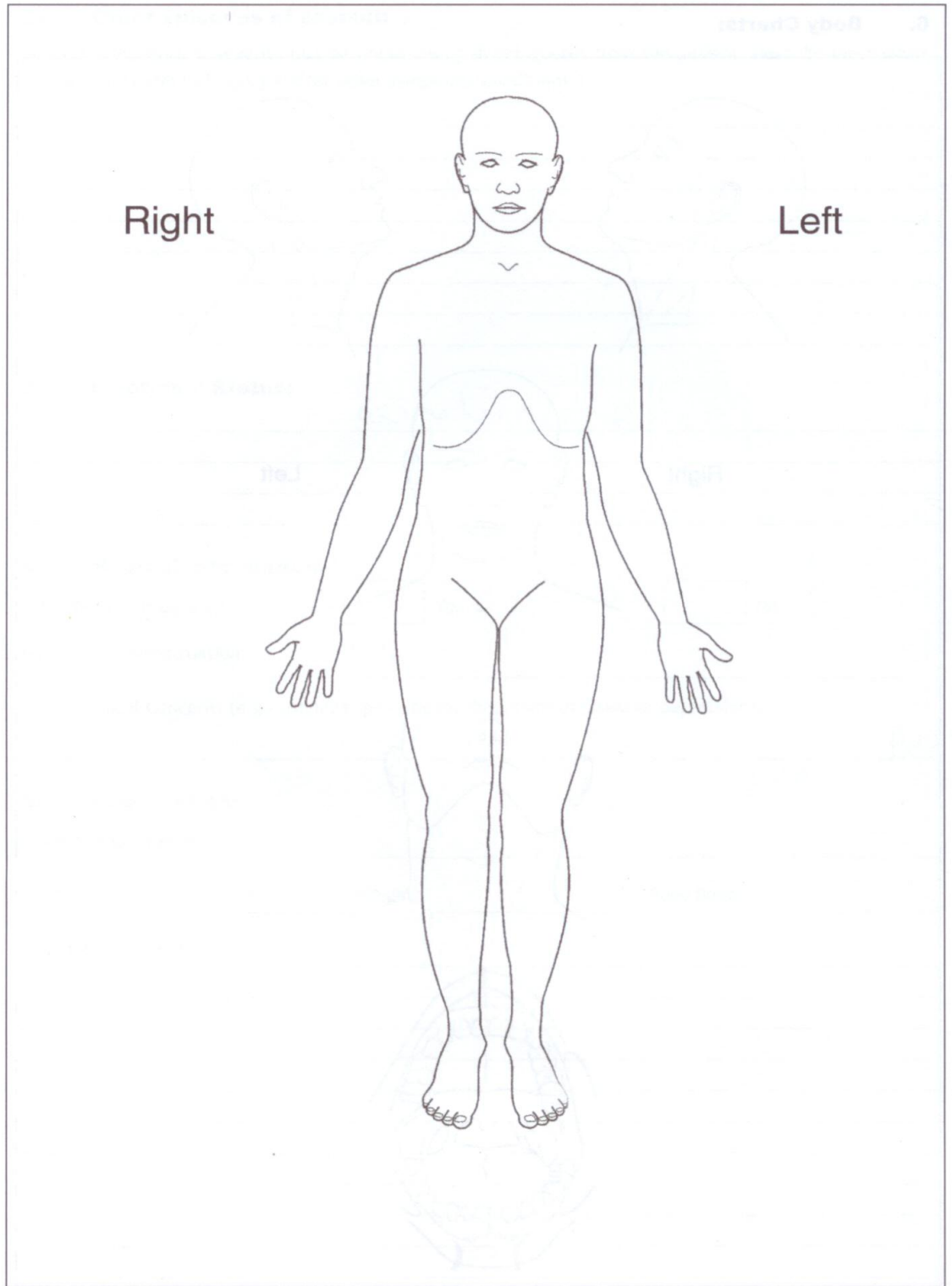Height: _____   Weight: _____

Body Build: _____

Description of Injuries:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____   Folder No. _____

6.   Body Charts:

Right   Left

Patient Name: _____   Folder No. _____

Right

Left

24

Patient Name: _____ Folder No. _____

Left

Right