EXPERIENCES OF NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE AT A COMMUNITY HEALTH CENTRE IN KHAYELITSHA

by

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TABLE OF CONTENTS

TABLE OF FIGURES

LIST OF ABBREVIATIONS

SANC: South African Nursing Council

PHC: Primary health care

CHC: Community health centre

DECLARATION

I declare that *the experiences of nurses caring for youth victims of violence at a community health centre in Khayelitsha* is my own work, that it has not been submitted for any degree or examination at any other university, and that all the sources have been indicated and acknowledged by means of complete references.

Harrite Achu Ekole-Chabanga   May 2013

Signed: _____

ABSTRACT

The introduction of primary health care in South Africa in 1994 marks a new beginning for the majority of the marginalised population in South Africa during the apartheid era. This introduction has improved access to health care in most communities. Health services are now more decentralised with community health centres that are primarily run by nurses. Violence continues to take its toll in post-apartheid South Africa and the youth remain the most affected group of most communities. It often leaves the youth shattered and traumatised with alarming psychological effects, including poor self-esteem. There is a steady increase of youths who are visiting community health centres to seek health care from nurses with a subsequent increased workload for the nurses at these centres. Previous research has dwelt more on either violence on its own, or the youth affected by violence but very little is known about the nurses caring for these youth victims of violence. It is unclear how nurses who are working at a community health centre experience caring for youth victims of violence.

The purpose of this study was to explore and describe the experiences of nurses caring for youth victims of violence at a community health centre in Khayelitsha and to develop guidelines for supporting nurses caring for youth victims.

A qualitative, exploratory, descriptive, and contextual design was used. The accessible population (N = 40) included all nurses who are registered under Section 31(1) of the Nursing Act No 33 of 2005 in order to practice nursing or midwifery, and who were working at a community health centre in Khayelisha. Purposive and snowball sampling were used. The data collection method comprised an individual unstructured interview while using an audio recorder and documenting field notes. Tesch's descriptive method of open coding was used for data analysis. Trustworthiness was ensured by means of applicability, dependability, transferability and confirmability. The findings from this study indicated that the experience of nurses who were caring for youth victims of violence was particularly related to a number of factors. These factors included challenges faced by the youth in the community, their socio-economic situation, violence and abuse, gangs, substance abuse, illiteracy, teenage pregnancy; as well as challenges face by nurses, under-preparedness, staff shortage, increase workload, rudeness, and verbal and physical abuse of the nurses. They also emphasised some rewarding experiences. There were some psychological effects on nurses and their emotional responses reported by these nurses. The study also revealed the different coping mechanism

these nurses were using and their need for support. Guidelines were developed to support nurses. Recommendations for future implementation are presented in the last chapter.

Key words: Experience, nurse, support, care, youth, victim, violence, trauma, primary health care, community health care centre, guidelines.

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CHAPTER 1:
OVERVIEW OF THE RESEARCH STUDY

1.1 INTRODUCTION AND BACKGROUND

The World Health Organisation (WHO) (2012) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, a group or a community that either results in, or has a likelihood of causing injury, death, psychological harm, mal-development or deprivation. For the purposes of this study, violence refers to an act or acts of force against another person. The World Health Assembly has declared violence a public health issue as far back as 1996. Countless people are injured while other people are suffering from fatal health consequences by being victims or witnesses to acts of violence. Countless lives are also destroyed and families are broken due to acts of violence (Krug, Mercy, Dahlberg & Zwi, 2002).

Victims of violence are people who have experienced one or multiple forms of physical or psychological violence that leave people helpless and powerless (Hamber & Lewis, 1997:17). A victim is also defined as a person who has experienced, is confronted with or witnessed an event or events that involve actual or threatened harm, death, serious injury or a threat to the physical integrity of self or other people that result in intense fear, horror, and helplessness (www.blaauwberg.net/cic/articles/general_psychology/gender.asp). Typical reactions to traumatic experiences include fear and anxiety, sleep disturbances, antisocial behaviour, depression, and sadness (Eckes & Radunovich, 2007). The youth are victims of violence at twice the rate of the general public (Buka, Stichick, Birdthistle & Earls, 2001; Rosenthal, 2000; Schwab-Stone, Ayers, Kasprow, Voyce, Barone, Shriver & Weissberg, 1995), they are especially vulnerable to the effects of trauma, which have a significant impact on their development (Eckes & Radunovich, 2007). If the youth are not guided to recover from traumatic experiences, they might engage in disruptive and self-destructive coping mechanisms, often without being fully aware of the nature or causes of their actions (www.arrivealive.co.za).

The impact of traumatic experiences on the health, well-being, and development of individuals has been recognised. The potentially devastating effects of child abuse, rape, domestic violence, disaster, kidnapping, torture and crime victimisation have led to the recognition that there is a universal reaction to overwhelming stress (Kluft, Bloom & Kinzie,

2000: 79-102). The provision of health care is an essential part of contributing to a healthy nation. People who are harmed by human rights abuse and violence of any kind should have access to good quality and appropriate care (Deogaonkar, 2004). Many victims in South Africa, especially the youth, are likely to struggle with their relationships with other individuals due to shattered trust, vulnerability, and feelings of grief (Hamber & Lewis, 1997), all of which adversely affect daily functioning (www.arrivealive.co.za). Traumatised youth should be supported to regain their proper functioning in society (Nader, 2010) and nurses can assist by empowering and caring for the youth by means of well-designed nursing care programmes or guidelines that enable greater autonomy (Blanchard, 2009:68).

Nursing care is influenced by context, culture, and individual differences among nursing health care providers. In spite of the current challenges in the nursing profession, most nurses transcend organisational problems and are motivated to serve and care for patients in spite of difficult circumstances. Nurses have to establish meaningful and caring nurse-patient relationships in increasingly complex health care organisational contexts (Moody & Pesut, 2006:16).

The nursing profession continues to struggle with multiple complex issues that affect nurses' efforts to be competent, caring health care professionals (Moody & Pesut, 2006:15). Caring is a process that is characterised by expert nursing, as well as interpersonal relationships and sensitivity. As a result of caring, a person can experience improved mental and physical well-being (Finfgeld-Connett, 2008:528). Caring implies that the receiver of the care does not get harmed (De Villiers, 2010:325).

Caring is a mutual relationship between individuals that involves giving attention to and taking responsibility of the need for care (Kohlen, 2007:103). Nurses have both a moral and ethical duty to treat patients competently in a caring and professional way (Moody & Pesut, 2006:15). Caring also requires the ability to deal with difficult situations without any immediate support and the consideration of other people's stated opinions and their personal experience of a situation (Lundgren, 2011:6). Caring, therefore, requires empathy, flexibility, support and advice of a caregiver for the needs of another person in a vulnerable situation, such as a youth victim of violence.

1.2 OVERVIEW

1.2.1 Trauma and violence

The emergence of non-communicable diseases is at an increase in urban and rural South Africa and it has increased the pressure on acute and chronic health services in the country (Mayosi, Flisher, Lalloo, Sitas, Tollman & Bradshaw, 2009). Increased drug abuse in South Africa over the past decades has led to an increase in the crime rate. It presents the most difficult challenge that is facing post-apartheid South Africa (Demombynes & Ozler, 2005). With half of its population under the age of 25 years, South Africa has crippling crime rates (Pelser, 2008). These high crime rates have led to a higher rate of youth victimisation with most of the crimes occurring at places we might consider safe: school and the home. Assault is typically reported to occur at schools (26%), in public places (21.6%), and at home (19.6%), while 92.9% of the victims are aware of the identity of the perpetrator (Pelser, 2008). It causes the crime to be even more traumatic, since the victim feels betrayed. Pelser (2008) also establishes that for a significant number of especially young South Africans, victimization, crime, and violence are very common experiences. These occurrences impact on the ways in which the youth are socialising and developing their identities. Struggling with the effects of trauma may lead to social isolation, declining school performance, behavioural problems, and issues that may impact on the current and future quality of life and functioning (Eckes & Radunovich, 2007).

Trauma produces lasting psychological and physical effects on most who are subjected to it and unfortunately the youth of our communities are not immune to its often devastating effects (DeNigris, 2008:211-244). A study in the USA shows that by the age of 11 years, 11% of the youth have experienced a traumatic event, and by the age of 18 years, the prevalence increases to 43% ("Identifying and addressing trauma in adolescents", 2007). Several studies in South Africa show that the youth are exposed to high levels of violence, and the victimised and / traumatized often experience delayed behavioural and psychological growth (Suliman, Kaminer, Seedat & Stein, 2005). The Western Cape Province has also noted a high rate of traumatisation among the youth (Suliman et al., 2005:2) with the youth in Cape Town, especially in the Cape Flats and Khayelitsha where most of the youth live, who are facing a range of hardships ,violence and violence related trauma (Samara, 2005:1).

For a significant proportion of young people in South Africa, crime and violence have become common due to consistent experience and exposure at the key institutions of their socialization: home, schools, and their immediate environment (Pelser, 2008). Although many people appear to recover from trauma without intervention, many do not, and they require continual attention to their distress and dysfunction (Kluft et al., 2000:79-102). Violence is an alarming problem in South Africa. Crime is used as a means to resolve problems and to achieve personal aims (Vogelman & Simpson, 1990). It is estimated that 50% of all crimes that are contested in South African courts are rape, while 60% of all cases in Durban and Mdantsane involve sexual assault (http://www.blaauwberg.net/cic/articles/ general_psychology/ gender%20violence. asp).

Sexual violence is one of the fastest growing crimes in the world (Smith, 2004) and many adults who are seeking mental health care report a history of child sexual and / or physical abuse (Courtois & Bloom, 2000). Studies have found that the percentage of individuals using mental health services are reporting child sexual abuse that ranges between 12% – 50% (Wurr & Partridge, 1996:867-872). It is quite a large number and indicates that most mental illnesses are rooted deeply in traumatic childhood experiences that have not been dealt with. Provision of care is important and has been recognised as necessary in providing quality health care to victims of trauma (Fredheim, Danbolt, Haavet, Lien & Kjønsberg, 2011). Unfortunately in the past, more emphasis has been placed on physical healing in relation to post-traumatic psychological healing of victims. Health care workers are the only people who are equipped and prepared to work with individuals who suffer from trauma and at community health centres, these services are provided mainly by nurses, since they are the first point of contact at primary health care facilities (Ciampi, 2011). There has been very little investigation to establish which factors / variables might either obstruct or encourage nurses' ability to care for victims (Ciampi, 2011).

1.2.2   Challenges working with traumatised victims

Since the early 1980s, there has been increased concern about how the challenging work environment affect professionals (nurses, social workers, counsellors, mental health workers, psychiatrists) who are working with traumatised victims of violence (Kanno, 2010. Studies show that these professionals experience occupational stress symptoms while attempting to assist these victims, (Boscarino, Figley & Adams, 2004; Bride, 2007; Bride, Jones & MacMaster, 2007) with secondary post-traumatic stress that is an inevitable consequence of supporting patients who are victims of crime and violence (Bride, 2004; Figley, 1983, 1995). Working with victims threatens emotional balance while creating overwhelming negative feelings. It is recommended that training programmes are implemented at workplaces to assist professionals and survivors with coping. Helping professionals at social service agencies, clinics, and hospitals has a higher probability of reaching traumatised populations, such as victims of violence and crime (Kanno, 2010).

1.3   RATIONALE OF THE STUDY

Violence is the leading cause of morbidity and mortality in South Africa (Doolan, Ehrlich & Myer, 2007). The major cause of violence in South Africa has not changed much since the apartheid era. According to a report from the Centre for the Study of Violence and Reconciliation (Hamber & Lewis, 1997), the current high rate of crime is equally related to economic and social marginalisation, while the youth remain the most affected group of this violence.

The youth are the backbone of any community; commitment to the youth has been especially pronounced in South Africa due to the contribution of young people during the anti-apartheid struggle, and also the sheer magnitude of the current youth population of 52% according to the national census of 2001 (Samara, 2005:1). Census 2012 results also confirm that South Africa has a young population with most of the nearly 52-million who are under 39 years of age with 28.9% aged between 15 and 34 years (Blaine, 2012).

Primary Health Care (PHC), a people-orientated health system, emerged in South Africa during 1994, soon after the election of the first democratic administration, with the purpose of meeting the needs of the majority of people who were marginalised during apartheid (Kautzky & Tollman, 2008). PHC is the first point of entry into the health system and provides services such as health promotion, disease prevention, health maintenance,

counselling, patient education, as well as the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. It is organised to meet the needs of patients with undifferentiated problems and is located in communities to facilitate timely access to health care (Academy of Family Physicians, 2012). PHC is gaining ground worldwide, since countries are seeking to deliver services that meet stated demands and changing needs (Lerberghe, 2008). With community health practice, there is a paradigm shift from a disease-orientated to a prevention and health promotion perspective; nurses are the key drivers of community health centres (CHCs) (Wilhemsson & Lindberg, 2009). Mental health problems constitute a burden to communities and, therefore, primary health care services need to be improved to ensure adequate recognition of and regard for these settings (Havenaar, Geerlings, Vivain, Collinson & Robertson, 2008). The adoption of the PHC philosophy by the South African Government in 1994 aims at community development and participation in the planning, provision, control, and monitoring of health services. The PHC blueprint adopted by the first democratically government in the White Paper on Health Services Transformation (1997) envisages a decentralised, nurse-driven system that made nurses the first point of contact for communities. Therefore, exploring and describing the experiences of nurses caring for youth victims of violence have informed the development of guidelines for supporting nurses in caring for this group of victims.

1.4   PROBLEM STATEMENT

Violence and crime are a daily reality in South Africa. More traumatised victims report to health care centres on a daily basis and receive care from nurses due to the limited onsite presence of physicians and social workers. Therefore, nurses have an extended role in assisting the traumatised youth before they are referred. Literature in South Africa contains no evidence of experiences of nurses caring for youth victims of violence.

It is unclear how nurses at health care centres experience caring for youth victims of violence, and what support is available to these nurses caring for victims. Violence initiates a vicious cycle. Victims of childhood abuse are more likely to present with aggressive and violent behaviour when they become adolescents and adults. Therefore, the health sector has an important responsibility in availing services to assist victims of violence and also for providing support to nurses (Krug, Mercy, Dahlberg & Zwi, 2002:1084). An understanding of the experiences of nurses caring for youth victims of violence is necessary. From their

experiences, guidelines have been developed for supporting these nurses caring for youth victims at that centre.

The research questions are:

- What are the experiences of nurses at a CHC caring for youth victims of violence?
- How can nurses be supported when caring for youth victims of violence who are visiting a CHC?

1.5   PURPOSE OF THE STUDY

The purpose of this study was to develop guidelines to support nurses caring for youth victims of violence at a community health centre in Khayelitsha.

1.6   OBJECTIVES

The objectives of this study are to:

- explore and describe the experiences of nurses who care for youth victims of violence who are visiting a CHC in Khayelitsha. (Phase 1); and
- develop guidelines for supporting nurses caring for youth victims of violence at a CHC in Khayelitsha. (Phase 2).

1.7   DEFINITIONS OF CONCEPTS

- **Violence:** includes diverse aggressive tactics that severally or collectively have the potential to cause significant emotional injury to those people who are victimised (Chappell & Martino, 2006:17). In this study, violence includes physical abuse, bullying, robbing, sexual harassment, and physical coercion.
- **Victim:** the national policy guidelines, (National policy guidelines for victim empowerment, 1997), defines a victim as someone who has suffered harm, including physical or mental injury and emotional suffering. In this study, the victim refers to an individual in the Khayelitsha area who has been subjected to physical violence.
- **Trauma:** includes sudden injuries, a recent diagnosis of HIV, car accidents, rape, kidnapping, abuse and natural disasters (Costello, Erkali, Farbank & Angold, 2002). For the purposes of this study, trauma refers to the result of acts of violence to which the victim has been exposed.
- **Support:** to give aid or encouragement to a person or cause (American Heritage Dictionary, 2009). For the purposes of this study, support refers to aid or encouragement that is given to nurses caring for victims of violence.

- **Caring:** Caring is characterised by expert nursing, interpersonal sensitivity and close relationships (Finfgeld-Connett, 2008:528). Caring is about giving attention to and taking responsibility for the need for care (Kohlen, 2007:103).

- **Care:** To pay attention to the needs of something or someone. It also refers to the act of providing treatment to someone. For the purpose of this study, care means the provision of health care that is defined as the prevention, treatment, and management of illness and the preservation of mental and physical well-being through the services that are offered by the medical and allied health professions (American Heritage Dictionary, 2009).

- **Nurse:** according to the Nursing Act No 33 of 2005, it is a person who is registered in a category under Section 31(1) to practice nursing or midwifery (Nursing Act, 2005). These categories include registered nurse, enrolled nurse, and enrolled auxiliary nurse.

- **Nursing:** practices with personal and professional knowledge that are based on a value system of holistic beneficence and patient empowerment (Finfgeld-Connett, 2008:527).

- **Youth:** the South African National Youth Policy defines youth as any person between the ages of 14 and 35 years of age (National Youth Policy, 2000).

- **Experience:** process or fact of personally observing, encountering or undergoing, something (Dictionary.com, 2012). For the purposes of this study, the experiences of nurses who care for youth victims of violence at a CHC in Khayelitsha are explored and described.

- **Primary health care:** essential health care made accessible at a cost that a country and community can afford, with methods that are practical, scientifically sound, and socially acceptable (WHO, 1978).

- **Community health care centre:** any institution that is providing primary health care; and 24 hour maternity, accident, and emergency services is referred to as a primary health care centre (Cullinnan, 2006).

- **Guidelines:** recommendations that are indicating how something should be done or what kind of action should be taken in particular circumstances (Encarta Dictionary, 2008)

1.8   RESEARCH DESIGN

A qualitative, exploratory, descriptive, and contextual design was used. A qualitative design was used because the researcher was interested in a better understanding of the experiences of nurses caring for youth victims of violence (Merriam, 2009). Qualitative research gives a rich understanding of the phenomenon under study, since it exists in the real world and is constructed by individuals in the context of that world (Polit & Beck, 2004:247). Qualitative research gives a voice to individuals who have not been heard before (Clark & Creswell, 2010).

An *exploratory design* was used to gain a deeper understanding of the experiences of nurses. Exploratory research is flexible, data-driven, and context-sensitive (Mason, 2002). The design is useful for examining new fields of interest or when the field of study is relatively new and it leads to insight and comprehension (Babbie & Mouton, 2001:79), which has made it suitable for this study. A *descriptive design* gives a detailed description of event processes or outcomes (Houser, 2011). This approach is used to provide a detailed description of the actions of participants and attempts to understand the participants' points of view (Babbie & Mouton, 2001: 271). A *contextual design* was used to gather intensive data for understanding needs, intents and processes (Margaria, 2010).

1.9   POPULATION AND SAMPLE

1.9.1   Setting

Khayelitsha is a township that is located to the South East of Cape Town, between the shoreline of False Bay and the N2 highway, and consists of formal and informal housing. It consists mainly of black indigents who remain more connected to the rural Eastern Cape Province than to the city of Cape Town in terms of their beliefs and culture (Nleya & Thompson, 2009). According to the crime statistics of 2006 / 07, Khayelitsha ranks among the areas in South Africa where murder, rape and aggravated robbery are most prevalent. It is one of the most violent settings in urban South Africa, and more than half of its population consists of the youth (Table 1.1).

Table 0.1: Khayelitsha crime statistics 2006 / 07

Crime	Number of incidents	Incidents per 100 000 people
Murder	430	106
Attempted murder	230	57
Rape	512	126
Drug related crimes	674	166
General theft	2 780	684

(Source: Cape Argus, 5 July, 2007)

It should be borne in mind that the statistics provided above are not entirely accurate, since sexual violence against women is frequently under-reported in South Africa (Luyt, 2008).

The accessible population in this study consisted of all categories of nurses who were working at a CHC in Khayelitsha (N = 40). Purposive and snow ball sampling were used because the researcher deliberately selected participants (Jooste, (Ed.) 2010). Purposive sampling is a type of non-probability sampling method in which participants are selected because they have knowledge and experience about the phenomenon being studied. Snowballing is the selection of participants as an offshoot of existing ones. During the course of initial interviews purposively selected, the researcher learned of other persons who could be interviewed. The researcher then followed such lead, which led to the new participants identifying yet other possible participants (Yin, 2011:89). The sample size was determined on the basis of saturation (the point during data collection when new data no longer bring additional insight to the research questions) (Brink, 2006). Initially, during the proposal stage eight (n = 8) interviews were envisaged to achieve data saturation. Sampling continued until data saturation was reached during the 9th interview (including the 2 pilot interviews). At that stage, the researcher did not gain any new knowledge about the phenomenon under study (De Vos, Strydom, Fouché & Delport, 2005:294).

The inclusion criteria for the study were nurses who were working at the CHC for more than a year, and who were caring for youth victims of violence during the past six months.

1.10   RESEARCH METHOD
PHASE 1

1.10.1   Data collection method

Individual unstructured interviews were conducted in a quiet room at the CHC. Unstructured interviews provide an opportunity for more probing, depending on the responses of interviewees. It helps to focus and guide an interview without recommending any particular format (Lindlof & Taylor, 2002). Unstructured interviews allow participants to express themselves more openly than they would during a structured interview (Flick, 2009: 150). A voice recorder was used, and observational field notes also formed part of the data collection process.

Pilot interviews were conducted by means of two individual interviews with nurses at the particular CHC. The pilot interviews helped guiding the researcher whether the research question was adequately structured for the study (Brink, 2006). The nurses were contacted in advance to explain the purpose of the pilot interviews, to obtain their permission for conducting the interviews, and to arrange appointments for the interviews at an appropriate time and venue. A digital audio recorder was used to record the interviews (Cohen, 2006). Bracketing was used to meet ethical and emotional challenges during the interviews (Rolls & Relf, 2006).

1.10.2   Data analysis

1.10.2.1 Phase 1

Tesch's method of open-coding was used for data analysis. Coding is the process of examining the raw qualitative data in the form of words, phrases, sentences or paragraphs, and assigning codes or labels to these elements (Strauss & Corbin, 1990). Firstly, the recorded interviews were transcribed. It required the immersing of the researcher in the data in order to gain insight into the phenomenon under investigation. The researcher then developed a data coding system, and with the assistance of an independent coder the codes were finally linked to form themes, categories, and sub-categories (Morse & Richards, 2002). Data triangulation was done; it required the consideration of different data collection methods, i.e. interviews, field notes, and journal entries in order to increase validity of the study (Guion, Diehl & MacDonald, 2011).

1.10.2.2 Phase 2

Guidelines were developed from the results of Phase 1.

1.11   RIGOR

Scientific rigor in qualitative research is measured by credibility, applicability, transferability, dependability, and confirmability (Lincoln & Guba, 1985). These concepts are thoroughly discussed in Chapter 2.

1.12   ETHICAL CONSIDERATIONS

The rights of participants in this research were guided and protected by required ethical considerations.

1.12.1   Right to self-determination

Individuals are autonomous beings and have a right to decide whether to participate in a study or not. Being autonomous agents, the participants have the freedom to choose either to be part of the research or not. They can decide to withdraw from a study whenever they choose (Brink, 2006:31). The researcher informed the participants of the purpose of this study and they had the choice to participate or not. Participants could withdraw from the study at any time when they felt uncomfortable.

1.12.2   Right to privacy and confidentiality

This right refers to the disclosure of information that is discussed or observed during the interaction between the researcher and the participants. The attainment of absolute privacy was difficult because the researcher had to report findings, and sometimes research quotations from participants were included in reports (Hennink, Hutter & Bailey, 2011:71). The researcher had the responsibility of preventing all data gathered during the study from being divulged or made available to any other persons. In cases where the information obtained was going to be published for the benefit of other researchers, the researcher made sure that the participants were informed and assured that they would remain anonymous (Brink, 2006:35). Participants had the right to anonymity. Audio recording of interviews and field notes were kept under lock and key. The data would be destroyed five years after the

completion of the study and publication of the results in accordance with the rules of the University of the Western Cape.

1.12.3 Right to anonymity

The right to anonymity is protecting the identity of participants to such an extent that they cannot be identified. It was important to inform participants that research information was collected, analysed and reported anonymously with the assurance that participants could not be identified in any of the research data (Hennink, et al., 2011:71).

1.12.4 Right to fair treatment

Participants had a right to fair selection and treatment. They were selected for reasons directly related to the study and were treated fairly. The agreement with participants as described in the information sheet was respected (Brink, 2006).

1.12.5 Right to protection from discomfort and harm

Participants had the right to be protected from harm or discomfort, be it physical, emotional or otherwise. Enquiries during qualitative research run the risk of exploring unresolved issues that can upset participants. If such situations arise, the researcher must organise support for the participant before releasing the participants (Munhall, 2001). The researcher limited any such harm and a counsellor was available to assist the participants when assistance was needed. Thankfully, the services of was counsellor required, since all issues that arose during the interview process could be resolved by the researcher and participant.

Harm could also be expressed in other forms like shame or embarrassment. Social harm could arise from the way in which an individual is viewed, or treated by other community members (Hennink et al., 2011:67). The researcher restricted any such harm from occurring.

1.12.6 Obtaining informed consent

Permission, according to Hennink, et al. (2011), must be sought at different levels. In this study, informed consent included:

- The researcher sought and obtained permission and approval from the Higher Degrees Committee at the University of the Western Cape (Ethical clearance registration number: 12/5/17).

- Written permission and approval for the study was obtained from the Department of Health.

- Written permission was obtained from the relevant authorities (unit managers) at the CHC.

- Permission was also obtained from the individual participants (nurses) at the CHC. Participants signed an informed consent form after they had read the information sheet. The researcher sought permission from the participants and provided adequate information for enabling participants to consider whether they were willing to participate in the study (Hennink, et al., 2011:66).

1.13   CONTRIBUTION OF THE STUDY

The youth experiences a range of challenges during their transition to adulthood. Empowering the youth empowers the nation (Ihenetu-Geoffrey, 2011:3). The youth who is experiencing trauma requires appropriate interventions in order to function in society without losing a sense of self. The nurses caring for the youth need to be supported in order for them to carry out their duties appropriately and while the physical and emotional wellbeing of these nurses is assured. This study seeks to contribute to the community health environment by developing guidelines for supporting nurses caring for youth victims of violence.

1.14   CONCLUSION

In this chapter, the introduction and background of the study, literature review, the rationale of the study, and the conceptual definitions of key words were discussed. It also described the purpose and objective of this research study with an emphasis on research design, ethical principles.

CHAPTER 2:
RESEARCH METHODOLOGY

2.1   INTRODUCTION

Research methodology refers to the systematic approach that is used to solve a research problem; it includes the various steps that are taken by the researcher during the research process. It also considers the logic of methods that are used during the research process (Kothari, 2008:8). The discussion in Chapter 2 focuses on the research design, population, sampling, data collection, analysis, and trustworthiness.

The aim of this study is to explore and describe the experiences of nurses caring for youth victims of violence that inform the formulation of guidelines to support these nurses.

2.2   RESEARCH DESIGN

A qualitative, exploratory, descriptive and contextual design was conducted in this study to gain an understanding of the phenomenon; and provided the researcher with an opportunity to seek answers to the research questions in a real world setting (Rossman & Rallis, 2012). In this study, experiences of nurses who were caring for youthful victims of violence were explored and described as it existed in the real world, i.e. a community health centre in Khayelitsha.

2.2.1   Qualitative design

Qualitative research is a systematic, subjective approach that is used to describe life experiences and to give them meaning. It encompasses a social enquiry that focuses on the way people are interpreting their experiences and the world they live in. It seeks to understand, describe, and interpret social phenomena as they are perceived by individuals, groups, and cultures. It is mostly used by researchers to explore the behaviour, feelings, and experiences of people (Holloway & Wheeler, 2010:3). Qualitative research takes into account that experiences of individuals are unique due to their subjective perspective and social background (Flick, 2009:16). Compared to a qualitative design, a quantitative research design is a traditional scientific research method that gathers data objectively in an organised, systematic, and controlled manner in order for the findings to be generalised to other situations / populations (Boswell & Cannon, 2011:172). In contrast, a quantitative approach

interrogates the cause and effect relationships of phenomena (Boswell & Cannon, 2011:172), and has objectivity and randomisation as characteristics.

Qualitative research designs offer an avenue for the subjective exploration and understanding of elements of humanity that are not possible with quantitative research methods (Boswell & Cannon, 2011:194). Qualitative research is inductive and interactive rather than deductive like in a quantitative design (Boswell & Cannon, 2011:195). In this study, the researcher conducted individual interviews to explore the participants' meanings and interpretation with regard to their experiences of caring for youth victims of violence (Holloway & Wheeler, 2010:3).

This study focused on the phenomena from the 'emic' perspective where participants, rather than the researcher, provided the source of meaning; a holistic approach that encouraged participants to share their values and life experiences that affected their perspective of the phenomenon. It stands in contrast with quantitative research that tries to minimise these effects (Boswell & Cannon, 2011:195). Since quantitative research methods require strict control, such as research findings that are representative of intervention, they therefore require the researcher not to deviate in the data collection process from one subject to another, while qualitative research embraces data from heterogeneous samples, since they allow the researcher to adapt his / her inquiry while the understanding of a phenomenon is expanding (Boswell & Cannon, 2011:195).

In qualitative research, the researcher's communication with the field and its members is taken as an explicit part of knowledge; the subjectivity of those participants who are being studied becomes an integral part of the research project. Observation in the field becomes data in their own right that are documented and are forming part of the interpretation of the research (Flick, 2009:16). Qualitative research is based on the principle that there is no single reality. Reality is based on perceptions that are different for each person and that change over time, while what we know only has meaning in a given situation and context. It offers the platform for exploring the depth, richness, and complexity that are inherently part of a phenomenon (Burns & Grove, 2005:52).

Given these characteristics and the purpose of this study, it is important to bear in mind that a qualitative research design would best answer the research question, hence the researcher's choice of a qualitative research design.

2.2.2 Exploratory design

Exploratory research design is a flexible research design that gets used when there is very little information known about the research phenomenon, such as the experiences of nurses caring for youth victims of violence. The main emphasis of an exploratory design seeks to discover ideas and insight about the phenomenon (Churchill & Lacobucci, 2009:61). Exploratory research aims at generating knowledge about a relatively under-researched topic or newly emerging subject (D'Cruz & Jones, 2004:17). No studies have been conducted about the experiences of nurses caring for youth victims of violence or related topics at a community health centre in Khayelitsha.

Exploratory research was used to form a better idea of the phenomenon being studied (Blaikie, 2010:70). This study also gathered information in a less structured manner (Russell, 2008:113) by conducting unstructured interviews with the assistance of one open question. The choice of using an exploratory design was informed by the fact that limited information was known about the topic of experiences of nurses who were caring for youth victims of violence, since it was a relatively new study phenomenon with no research done about this topic (Watson, McKenna, Cowman & Keady, 2008:269). Exploratory research is capable of generating concepts about a phenomenon could be tested in-depth during follow-up studies (Jooste (Ed.) 2009:459).

2.2.3 Descriptive design

A descriptive design seeks to present an accurate account of the phenomenon under study. It is more rigorous and narrower in its focus (Blaikie, 2010:71). A descriptive design attempts to portray a detailed picture of the phenomena, and it searches for a deeper understanding of the phenomenon (Russell, 2008:114).

It was an appropriate approach for this study because the researcher sought to paint a comprehensive picture of the phenomenon, i.e. the experiences of nurses who were caring for youth victims of violence. In this research study, a descriptive approach referred to the experiential meaning of caring for youth victims of violence and was adopted for collecting data about the experiences of nurses who were caring for youth victims of violence at a community health centre in Khayelitsha. Descriptive design provided an accurate picture of a phenomenon under study (Jooste, (Ed.), 2009:461).

2.2.4 Contextual design

A contextual design was used because the phenomenon had immediate and intrinsic contextual significance (Babbie & Mouton, 2001:133). Qualitative research was conducted in the natural setting for the proposed study and was based on the premise that realities could not be understood in isolation of their contexts. Participants were recruited and studied within their natural day-to-day environment (Lincoln & Guba, 1985).

This study is not representative of the larger nursing population who are working with youth victims of violence but is confined to a community health centre in Khayelitsha, hence this study was a contextual study. In qualitative research, a theoretical framework is not predetermined but derives directly from the data; it is context-bound; researchers must immerse themselves in the natural setting of the participants; and it focuses on the participants' views, perceptions, meanings and interpretation (Holloway & Wheeler, 2010:3).

Contextual designs are based on the principle that objective data do not capture the human experience. The meaning of these nurses' experiences emerged within the context of personal history, current relationships, and future visions, since individuals lived daily in a dynamic interaction with the environment (LoBiondo-Wood & Haber, 1994:257).

2.3   THE SETTING

Khayelitsha is the largest township in Cape Town of predominantly informal settlements (54.7%), and of a relatively young population with 75% of the population who are younger the 35 years (Lawson, 2005). Furthermore, fewer than 7% of its residents are over 50 years old, while over 40% of its residents are under 19 years of age (*www.socialentrepreneurcorps. Com/ /SouthAfricaCountry Overview.pdf*). It is reputed as the fastest growing township in South Africa. Today, Khayelitsha has an estimated population of about 900 000 residents, with a majority who are unemployed, and trapped in poverty that inevitably harbours social ills as a result of bleak socio-economic prospects (Ngxiza, 2011:5). It runs for a number of kilometres along the N2 highway. The approximate ethnic composition of Khayelitsha is 90.5% Black African, 8.5% Coloured and 0.5% White African, and isiXhosa is the most widely spoken language of the residents.

The Site B Day Hospital is one of the provincial government clinics in Khayelitsha with a Rape Care Centre that is offering a holistic service which includes counselling, medical

treatment, forensic examination, and follow-up nursing / medical care (Rape Crisis, Cape Town Trust, 2006).

The trauma unit at the Khayelitsha Community Health Centre (CHC) faces a compounded burden of disease intervention that includes trauma, alcohol abuse, and other infectious and chronic lifestyle diseases. It is the only 24-hour clinic serving patients from the Site B delineated area, while after hours it is also serving the Michael Mapongwana and Nolungile CHCs in Khayelitsha. With the opening of the Khayelitsha Day Hospital, there has been a significant workload reduction at this facility (Anonymous, 2012).

2.3.1 Population

The population refers to the entire set of individuals who meet the sampling criteria (Burns & Grove, 2005: 342); it refers to the whole group of persons who are of interest to the researcher (Jooste (Ed.), 2010:302). In this study, namely nurses who are working with youth victims of violence at a community health centre in Khayelitsha. The accessible population is the portion of the population to whom the researcher has reasonable access (Burns & Grove, 2005:342, Jooste (Ed.), 2010:303). The population also consists of participants who have the necessary knowledge about and experience in the phenomenon under study (Holloway & Wheeler, 2010:137). In Jooste (2009:463), an accessible population is also defined as members of the target population who the researcher can easily get hold of and meet. For this study, the accessible population referred to all levels of nurses who were caring for youth victims of violence at a community health centre in Khayelitsha. This community health centre was chosen, since it was one of the oldest in this region that was caring for youth victims of violence coupled with its high case load of about 21 000 – 27 000 patients per month, with trauma representing 30% – 40% (7 000 – 8 000 patients per month) of all cases (Jonga, 2009:1).

2.3.2 Sampling

Sampling refers to the selection of people with whom to conduct a study and the sample is the total number of people who are selected / included for participation in a study (Burns & Grove, 2005:341). In qualitative research, selection of a sample is guided by ethics and the opportunity to gain access to people whom the researcher can interview with the purpose of obtaining rich data. Non-probability samples do not permit generalisation from sample to general population, since there is no assurance that the sample represents the population. On the other hand, participants are easier and more cost effective to access (Connaway & Powell, 2010:117). Participants of the study were at first purposively selected. They were black, isiXhosa speaking nurses who participated voluntarily and spoke English as a second language. Snowballing followed purposive sampling as discussed in Chapter 1.

Purposive sampling was used, since the researcher used her own judgment to choose participants on the basis of knowledge about and experience in the phenomenon under study (Holloway & Wheeler, 2010:138). Purposive sampling is a non-probability sampling method that does not require the subjects to have the same chance of being selected to participate (Heavey, 2011:70).

Snowballing then followed which is a sampling technique in which the researcher uses chosen participants to identify additional participants by asking those already contacted to name others with similar characteristics (Lichtman, 2010:142). Snowballing is described by Holloway and Wheeler (2010) as a variation of purposive sampling where previously chosen informants are asked to identify other potential participants with knowledge about research topic who in turn nominate further participants for the research study. During the course of the initial contact with the possible participants, from the head of departments, the researcher was also advised to contact other departments. From the initial entry which was the youth centre, the researcher was redirected to the trauma, maternity and Simelela units. Also during interview sessions with participants, the researcher was informed of possible participants who could contribute to the study hence the researcher also followed a snowball approach in recruiting participants for the study.

The researcher selected information-rich cases or subjects from which much can be learnt about the phenomenon or purpose of the study. The researcher used personal judgment in selecting participants for the research (Jooste (Ed.), 2020:306). It comprised respondents who were most likely to provide information about the phenomenon under investigation (Burns &

Grove, 2005:352). Their participation also had to ensure that it would best assist the researcher to explore the phenomenon in terms of the research question (Creswell, 2009:178). In this study, the sample was targeted to represent nurses who had at least 6 months' experience in working with youth victims of violence at a community health centre in Khayelitsha (n = 9). The researcher wanted to nurses who have had enough exposure working with youth victims of violence. A six month period was decided by the researcher because the researcher felt it is an adequate time to get to understand your work environment as well as accumulate reasonable amount of experience that will serve the research purpose and as Felstead, Fuller, Unwin, Ashton, Butler, & Lee (2005:359-383). put it, most learning arises naturally out of the demands and challenges of everyday work experience and interactions with colleagues, clients and customers and in qualitative research, selection of interview participants requires purposive and iterative strategies to generate interview data of sufficient breadth and depth (Polkinghorne, 2005:137). This can only be done with nurses who have experience hence the 6 months working experience used as an inclusion criteria.

The sample is the elements of a population who are participating in a study. It is an important part of the study and has to be suitable for the research purpose (Holloway & Wheeler, 2010:137). There is no rule in qualitative research with regard to sample size, since it is largely dependent on the nature of the inquiry, the quality of the eligible participants, and the type of sampling strategy. Qualitative data focus on the quality of data collected, and since each participant is a source of a large volume of data, smaller sample sizes are reasonably common in qualitative research. A larger sample in qualitative research does not necessarily supply more new evidence (Boswell & Cannon, 2011:796).

2.3.3   Eligibility criteria

These criteria establish the boundary between those individuals who are included in the study and the ones who are excluded from the study (Holloway & Wheeler, 2010:138). The inclusion criteria are the characteristics participants must have in order to be eligible for participating in a study while the exclusion criteria are the elements that disqualify one from being a participant (Heavey, 2011:71).

The inclusion criteria in this study were:

- All nurses who were caring for youth victims of violence at a community health centre in Khayelitsha.

- Nurses who were working with youth victims of violence at a community health centre in Khayelitsha for a period at least 6 months.

Exclusion criteria

- A person who was working at a community health centre in Khayelitsha and who previously had been a victim of violence.

The initial recruitment of participants was done by the unit manager. On the basis of an explanation of the purpose of the study and eligibility criteria, she provided guidance about suitable candidates by taking into consideration their job responsibilities, employment position, and involvement in the subject of study. She gave some valuable referrals which simplified the recruitment process of participants for the study. Utilisation of the units' managers made it easier to access participants. On the same day, the participants were explained the purpose of the study and were given information documents about the study and follow-up appointments were booked. Participants were interviewed until data saturation was achieved.
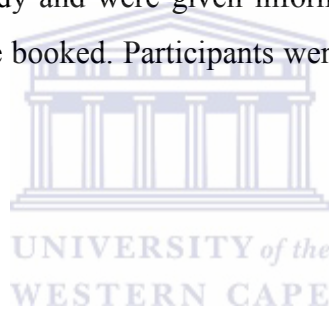
2.3.4 Data saturation

It describes the point at which data collection yields no new information and redundancy starts occurring. Saturation can be achieved with a relatively small sample if the participants are adequately informed about the research phenomenon and if they are able to reflect on their experiences and communicate effectively (Polit & Beck, 2008:357). Swanson and Holton III (Eds.) (2005:271) also define data saturation as the point in the data collection process where a valid and reliable pattern has emerged that does not require confirmation by collecting more data.

2.5   DATA COLLECTION

Data were collected at the community health centre during September 2012. After discussion with the manager in charge of the unit, the eligible participants allocated time among themselves to participate in the individual interviews.

2.4.1   Interviews

The principal method of data collection involved individual unstructured interviews of approximately an hour with each participant. Interviews involved verbal communication between the researcher and the subject during which information was provided to the researcher (Burns & Grove, 2005:396). Interviews provide a necessary and most often completely sufficient avenue of enquiry, given that the participants are consenting adults (Siedman, 2006:11). Interviewing permits behaviour to be contextually observed and, hence, provides access to an understanding of participants' actions (Siedman, 2006:10). It is a flexible technique that allows the researcher to explore greater depth of meaning than can be obtained applying other methods and yields a higher response rate. Patton (1990:196 in McClean, 2012:519) articulates it:

> *"We interview people to find out from them what we cannot directly observe… we cannot observe feelings, thoughts, and intentions. We cannot observe behaviours that took place at some previous point in time. We cannot observe situations that prelude the presence of an observer. We cannot observe how people have organized the world and the meaning they attach to what goes on in the world-we have to ask people about those*

things. The purpose of interview then, is to allow us to enter into the other person's perspective".

A questionnaire, on the other hand, tends to have less depth and subjects are unable to elaborate on responses or to ask for clarification of questions, while researchers are unable to use probing strategies. Unlike questionnaires that can be distributed to very large samples and that require a less time consuming process, interviews require much more time and hence sample size is usually limited. However, due to limited sample size, subject bias restricts the validity of findings (Burns & Grove, 2005:397-398).

Interviews could either be unstructured when the content is completely controlled by the participants, or structured when the content is similar to a questionnaire with possible responses to questions that are carefully designed by the researcher (Burns & Grove, 2005:396). An in-depth interview is a personal and intimate encounter when open, direct, and verbal questions are used to elicit comprehensive narratives and stories (DiCicco-Bloom & Crabtree, 2006:317). In case of this study, an unstructured interview was used, since the researcher was interested in understanding the experiences of other people, in this case the nurses and the meaning they were making of that experience, that is, their subjective understanding (Siedman, 2006:10). An open-ended question was used to initiate and explore participants' responses with the goal of participants to reconstruct their experience within the topic under study (Siedman, 2006:15). These unstructured interviews all started with one open question: "What is your experience of caring for youth victims of violence?"

An unstructured interview is used especially when the participants' experiences are not known, since it permits a wider range of responses, unlike a structured interview where the subject is limited to a finite number of responses that had been previously developed by the researcher (Burns & Grove, 2005:396). The weakness of unstructured interviews lies in participants who are approaching the interview differently. As a result, they are asked different follow-up questions that limit the comparability of responses, therefore, the outcomes produce a less systematic and comprehensive set of data. This process complicates the organisation and analysis of the data. Collecting data during unstructured interviews is also a time-consuming process (Klenke, 2008:126).

The researcher chose to conduct one-on-one interviews, rather than a focus group interview, because in a focus group sensitive topics are difficult to address and discuss due to the

emotions that are involved. It also increases the possibility that private thoughts or ideas are not revealed in the presence of a group of immediate colleagues (Holloway & Wheeler, 2010:129). A focus group comprises a group of people with common experiences or characteristics who are interviewed collectively for the purpose of eliciting ideas, perceptions, and meanings about the subject of interest (Holloway &Wheeler, 2010:125). A danger exists that some participants may dominate the discussion that will influence the outcomes by producing biases. The response of one participant may affect the responses of other members in the group and, subsequently, the true feelings of the individual may remain concealed (Holloway & Wheeler, 2010:133). On the other hand, a focus group may create a sense of "safety in numbers" to those anxious participants who are wary of researchers and the group dynamics can also assist participants to express and clarify their views in ways that are less likely to occur during one-on-one interviews.

2.4.2 Field preparation

Background research was conducted to determine how to recruit participants for the study (Babbie, 2012:327). One of my contemporaries who subsequently started working at this facility gave me information about the managers and the telephone numbers of the appropriate contact persons. He referred me to one of the managers of the community health centre who acted as a key information provider for introducing me to the various departments, specifically the units managers, who introduced me to potential participants. Some of the contact persons I was given did not satisfy the inclusion criteria but they assisted by referring and introducing me to potential participants. I made use of this opportunity by establishing contact with people who assisted me with acquiring my targeted population. The researcher communicated and created a friendly relationship with the people in preparation for the research interviews by explaining the research objectives to them.

A private room had been reserved at the clinic where the interviews took place. A private room ensured that participants could provide information confidentially without fear of being overheard by any other person. Furthermore, the familiar setting put the participants at ease while the sitting arrangement encouraged interaction and eye contact (McCaid & Dahlberg, 2010:137). A voice recorder in proper working condition was used during the interviews. The audio recording ensured the retention of valuable information while field notes taken during and after the interview were facilitating the analysis of the recorded information (Babbie & Rubin, 2010:470). Before commencement of the study, the unit managers of the day hospital

and the maternity ward were contacted with the purpose of explaining the purpose of the study and what was required during the research process. They were both provided with a copy of the research proposal, as well as letters of approval for conducting the research project from the university and the department of health. It served the purpose of clarifying any confusion and misunderstanding and for gaining their cooperation for the study. The nurses were subsequently notified by their different managers about the study and they also explained the purpose. The researcher then arranged appointments with suitable participants for possible interviews. The aim and objectives of the study and how the information obtained will be used were explained to the participants. Appointments were made and arrangements in relation to the time and venue for the interview were confirmed. An environment suitable for recording was arranged to ensure the satisfactory quality of the sound recordings with the purpose of proper transcribing and data analysis of the interviews (Chail, 2008).

Participants were contacted two days before their interviews to remind them about and to confirm their appointments. At the beginning of each interview; the researcher once again explained the purpose of the study, informed consent was signed by participants to confirm that they agree to take part in the research study, which included written consent to record the interview and to permit the researcher to take field notes. The participant had a clear understanding of the purpose of the interview, the institution, and the researcher provided full contact details. After the main question – what is your experience on caring for youth victims of violence – had been expressed, and following the interviewee's response, a combination of planned and unplanned questions were carefully considered for the purpose of continuing the conversation (DiCicco-Bloom & Crabtree, 2006:316).

From the responses of participants, probing questions followed to elicit more detailed information from participants. Further probing which is the use of prompts to search for elaboration, meaning or reasons (Holloway & Wheeler, 2010:92) was used by the researcher to assist the researcher with gaining a deeper and more comprehensive understanding of the information that was supporting the purpose of the study. The respondents were afforded an opportunity to speak freely until no new information was emerging (data saturation). The interviews lasted between 25 and 60 minutes. Participants were reassured of confidentiality of permitted field notes that were recorded while the interviews were progressing.

The researcher's essential role of reflexivity was taken into account, since her social role and the social role of the interviewees were equally important (DiCicco-Bloom & Crabtree, 2006:317). The important rapport that the researcher created with the interviewees included trust of and respect for the interviewees. It enhanced the sharing of as much information as possible, in their own words and with as little self-consciousness as possible (DiCicco-Bloom & Crabtree, 2006:317).

2.4.3 Pilot interview

Research designs are never complete, since they can always be improved. It comprises a practice run that is undertaken to identify any problems with the data collection methods. It should usually be completed before the commencement of the main study to determine the feasibility and reliability of techniques and instruments (Jooste (Ed.) 2010:300). It often provides the researcher with idea, approaches, and clues that may not have been foreseen that could increase one's chances of obtaining a more precise finding during the main research project (Collins, 2010:164). It helps the researcher to identify any flaws or limitations in the interview design and allows him or her to make necessary revisions prior to the implementation (Kvale, 2007). Another important reason for conducting a pilot interview is to develop an understanding of the impact of participants' view of concepts and theory on their interpretation of the phenomenon, or what meaning they ascribe to it (Maxwell, 2005:58).

A pilot interview was undertaken prior to the main study to ensure that the research method that was going to be used would adequately answer the research question. In this research, the pilot study consisted of two interviews with participants and the data that was collected during these interviews were included in the main research, since the collected data adequately informed the research question (Collins, 2010:166). After the pilot study, the researcher scrutinised the data and gained some valuable insight to reformulate questions in such a way that they would yield more applicable responses. It assisted the researcher to direct questions more freely to achieve the research objectives more precisely.

2.4.4 Notes

Observational field notes enable the researcher to systematically document their impressions, insights, and emerging hypotheses (Rossman & Rallis, 2002:195 in Bhatia, 2006:41). When added to interview transcripts, the observational field notes aid the interpretation of

interviews. It includes a description of the settings and activities, direct quotation or summaries of information, as well as the researcher's own comments (Bhatia, 2008:41).

Field notes were written from the beginning of data collection; certain occurrences or sentences of interest were written down, during and after the interview, since these notes reminded the researcher of events, acts, and interactions that triggered a particular thinking process (Holloway & Wheeler, 2010:185). The data included descriptions of nonverbal aspects of interview, as well as the researcher's feelings, experiences, biases, comments, and assumptions.

2.4.5   Role of the researcher

The researcher created a trusting relationship before the interviews started. She entered the participant's world of experiences of caring for youth victims of violence with sensitivity, an open mind, and created an environment that was conducive and reassuring to reflective empathy (Gorman & Clayton, 2005:65). While the researcher became a part of the setting, she remained sufficiently detached in order to observe and record information about responses and descriptive data. Like any other data collection instrument, the researcher endeavoured not to be swayed by emotions, beliefs, and personal views (Gorman & Clayton, 2005:65). The researcher merely provided the participants with an opportunity to speak their minds without directing or interpreting the encounter (Jooste (Ed.), 2010:311). This approach assisted the researcher to remain objective. The researcher also used bracketing to strengthen objectivity.

Bracketing: It refers to being aware of one's personal values and preconceptions with the purpose of transcending them during the research process to allows one an opportunity to see the situation in a new perspective. If bracketing is not done, the purpose of the research is defeated and one will instead perceive a mirror image of their own hopes, fears, and expectations. By keeping a daily journal, the researcher recorded personal feelings and reflections that empowered her to remain aware of them by bracketing their own values. The researcher was able to view the situation from the participant's perspective without prejudice (Denzin & Lincoln (Eds.), 2000).

Inductive reasoning or an inductive approach allows research findings to emerge from the frequent, dominant, or significant theme or themes inherent to the data (Thomas, 2006). Qualitative researchers allow research design to emerge or unfold during the research process

rather than constructing it prior to the study. They believe that what emerges from the data is a function of the interaction between the participant and the researcher which cannot be determined before the study (Lincoln & Guba, 1985). Inductive reasoning moves from particular observation and context to a general overview and the conclusion is only a tentative or possible generalisation (Jooste (Ed.) 2010:286).

2.5   DATA ANALYSIS

Data analysis began with data transcription, which is the production of written version of audio tapes followed by open coding which is the process of organizing the material into segments of text before bringing meaning to the information (Creswell, 2009:186). According to Strauss and Corbin (1998:102), open coding is a process where the researcher uncovered data by exposing the thoughts, ideas and meanings contained therein, and concepts were developed. The data was broken down into discrete parts, closely examined and compared for similarities and differences where similar themes were grouped together and termed categories.

The following guidance is described by Tesch for the coding process (Tesch, 1990:142-145):

- One needs to make sense of the transcribed data. The transcripts are read carefully while jotting ideas that come to mind.

- Read through one interview and try to get the underlying meaning of the interview while writing down your thoughts in the margin.

- When these steps above are completed for several interviews, make list of all topics that emerged. Cluster together similar topics and put them in columns arranged as major topics, unique topics and leftovers.

- Take the list and go back to the data, abbreviate the topics as codes and write the codes next to the appropriate segment of the text to see if additional categories and codes emerge. His helps to ensure all segments of data is coded.

- Find the most descriptive word for your topics and turn them into categories. Look for ways of reducing the total number of categories by grouping topics that are related to each other

- Make a final decision on the abbreviation for these categories and alphabetize these codes

- Assemble the data material belonging to each category in one place and perform a preliminary analysis.
- If necessary recode your existing data.

2.5.1 Data triangulation

It is the collection of data from multiple sources. It is the process where multiple approaches are used to answer a research question. These could include more than one research methods, investigator, data collection sources or multiple theoretical perspectives (Cowman, in Watson et al. (Eds.), 2008:269). In this case data triangulation meant the use of different data collection sources. These included observational field notes, transcribed interview and personal diary. Triangulation contributed to quality research because it produced knowledge at different levels and can overcame the deficiency that flows from a participant such as emotions of rage, anger or lukewarm attitude (Denzin, 1970 in Flick, 2007:42). Data triangulation has the potential to provide rich and productive data (Cowman, 2003 in Watson, Mckenna, Cowman, & Keady (Eds.) e, 2008:272).

2.5.2 PHASE 2: To formulate guidelines for supporting nurses caring for youth victims of violence

In this phase of the research, results of Phase 1 were used to develop guidelines for nurses who were caring for youth victims of violence at a community health care centre in Khayelitsha. These guidelines were developed from the findings of the study and supported literature. Each guideline indicated its rationale and the actions related to it (Muller in Booyens, 1998:607-608; 636-637).

2.6 SCIENTIFIC RIGOR

Rigor or trustworthiness is associated with the value of the research outcome and studies are critiqued by means of judging their rigor (Burns & Grove, 2005:55). It also refers to the honesty of the data collected. Scientific rigor in qualitative research is measured by credibility, transferability, dependability, confirmability, and applicability (Lincoln & Guba, 1985).

2.6.1 Credibility

According to Polit and Beck (2004:430), it refers to confidence in the truth of the data and the data interpretation. Credibility involves two aspects; firstly, by carrying out the study in a way that increases believability of the findings due to adherence to scientific principles, and secondly, by taking steps to demonstrate credibility to the target audience. In this study, credibility was achieved by requesting the participants' to review, validate, and verify the researcher's interpretations and conclusion (Brink, 2006). The following criteria were used to ascertain credibility:

- **Prolonged engagement:** Adequate time was invested in data collection with the purpose of gaining an in-depth understanding of the views of the participants (Jooste, 2010:319). Prolonged engagement also helped to build trust and rapport with participants (Polit & Hungler, 1997:305; Botes, 2003:180). Extended engagement during the unstructured interviews allowed participants to express their points of view (Brink, 2006).

- **Persistent observation:** This criterion was met, since the researcher continuously pursued interpretations in different ways. The researcher focused on the conversation that was relevant to the study with the purpose of gathering data of substantial depth (Jooste, 2010:319).

- **Member checking:** The researcher took the study back to the participants for critical discussion and to confirm the construction of data and interpretation (Polit & Hungler, 1997: 305; Botes, 2003:180). Member checking was further assured by the iterative comparison of statements, formulated meanings, and the exhaustive description (Martins, 2008).

2.6.2 Applicability

It is the extent to which research findings of an inquiry can be transferred to other contexts and settings (Jooste, 2010). This study was conducted in a specific context of a community centre.

2.6.3 Transferability

Transferability refers to the extent to which research findings are applicable to a different group or setting. Transferability is different from generalising because the focus is on

confirming that what has meaning in one setting is also meaningful in a different setting (Macnee & McCabe, 2008:170). According to Fitzpatrick and Kazer (Eds.) (2012), it is an indication of whether the findings or conclusion of the study fits other contexts.

2.6.4 Confirmability

Confirmability is achieved when results, conclusions, and recommendations are supported in the data and an audit trial (Fitzpatrick & Kazer (Eds.), (2012). It refers to the degree to which research findings are a product of the inquiry and not of researcher's biases (Babbie & Mouton, 2001:278). The researcher adhered to the academic and ethical requirements as stated in Chapter 1 during the entire research study. The locked voice recordings, transcripts, and journal would act as evidence that the conclusion and recommendations were the result of research findings and not of the ideas of the researcher. This work is the original product of the researcher's study. Proof of originality was achieved by the researcher who had bracketed pre-existing knowledge that might have clouded her position with the purpose of viewing the phenomenon from the participant's point of view. After each interview, the researcher kept a journal of her feelings and emotions in order to identify and omit bias during data analysis. Randomly selected sample interviews were also analysed by a different researcher (Martins, 2008).

2.6.5 Dependability

It refers to the confirmation that repeating the study with similar participants in a similar context will yield the same results (Babbie & Mouton, 2001:278). It includes the stability of data over time and conditions (Brink, 2006). According to Polit and Beck (2004), the concept of dependability and credibility in qualitative research are interdependent, hence all techniques applicable to ensure credibility also applies to dependability.

The following criteria are used to ascertain dependability:

- **Step-wise replication of the research method:** The researcher at all times describes all steps taken, supported by literature. This chapter outlines the whole research process; any additional steps taken as necessitated by the research will be outlined and described.
- **Code-recording of data:** All recorded data and the researcher's personal diary will be locked away as evidence of the research.

- **Dependability audit:** The research data will be coded by the researcher, supervisor, and an independent coder. The results will also be submitted to an external examiner.

2.7   LIMITATION OF THE STUDY

Since the onsite interviews were carried out during daytime, there was a missed opportunity of including nurses who were working night duty who also are experienced in caring for youth victims of violence.

2.8   CONCLUSION

The principal aspects discussed in this chapter include an explanation of the research design, the concepts of exploratory research, descriptive research, and contextual design. This chapter outlines the reason for using the particular research design for this study. The data collection process and analysis, as well as measures to ensure trustworthiness, are comprehensively discussed. The next chapter focuses on exploring the research findings, the process followed, as well as a description of themes and categories supported by verbatim quotations and a literature control.
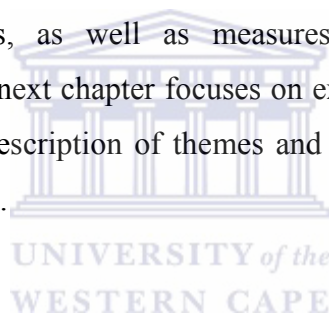
CHAPTER 3:
DESCRIPTION OF RESULTS

3.1   INTRODUCTION

This chapter answers the first research objective which is to explore and describe the experiences of nurses caring for youth victims of violence at a community health centre in Khayelitsha. This objective is achieved by analysis of the data obtained during the unstructured individual interviews.

Data analysis is a carefully planned and considered process of computing various summaries and derived values from a given collection of data. It is an iterative process during which the data are studied, and examined by using analytical techniques. Then the data are relooked from another angle and perhaps the data are modified in the process by transforming or partitioning the data with a view of restarting the analysis process by using another analytical tool; each technique probes the data from a slightly different angle (Berthoud & Hand (Eds.) 2007:3). Data analysis can, therefore, be referred to as a voyage of discovery.

Themes and categories emerged from the data analysis process (Table 3.1). These themes and categories emerged from the interviews and set of field notes of the experiences of nurses caring for youth victims of violence at a community health centre in Khayelitsha. The process of data analysis was inductive, since categories were selected according to the way in which they emerged from the collected data. As analysis continued, the process became more deductive, since the previous categories were tested against subsequent data to establish whether the results still held true for the naming of the categories congruent to the purpose of the study (Merriam, 2009:184-185). Data analysis began informally during interviews, listening to the voice recordings, reading of transcripts, reading observational field notes, and writing memos. The process continued until the categories were developed (Maxwell, 2005:96).

Coding was the main analytic tool used to arrive at themes and categories. Coding is the fracturing and rearrangement of data into categories to facilitate comparison between things in the same category and to aid in the development of theoretical concepts (Maxwell, 2005:96). The coded data were categorised and from these categories, major concepts and

constructs were developed. The researcher then searched for major themes that connected ideas with a view of finding a core category for the study (Holloway & Wheeler, 2010:176)

Data were collected through nine in-depth one-on-one interviews that included the demographic data for each participant, followed by the main research question: What is you experience of caring for youth victims of violence? There was no guide for the interview, since providing data was directed by the participant with the aim of allowing participants to talk freely and comprehensively about their experiences without any restrictions (Kaar, 2007:2). It is one of the most successful methods for researchers to investigate a phenomenon, since it yields data that is steeped in participants' attitudinal level about the research topic to the highest extent (Stokes & Bergin, 2006:33). Tesch's eight step approach as described by (Creswell, 2003) was used for data analysis.

3.2   BACKGROUND OF THE PARTICIPANTS

The following table shows the biographic data of the different study participants.

Table 0.1:   Biographical information

Participant	Gender	Age	Marital status	Department
*1	Female	39	Married	Sexual violence
*2	Female	52	Married	Trauma
3	Female	36	Married	Trauma
4	Female	34	Single	Trauma
5	Female	55	married	Trauma & Maternity
6	Male	34	Single	Trauma
7	Female	48	Single	Trauma
8	Female	49	Married	Trauma
9	Female	54	Married	Sexual violence

*Pilot interviews

This study had a total of nine participants who consisted of eight women and only one man working at a community health centre in Khayelitsha who were all isiXhosa speaking and who spoke English as a second language. The nine interviews include the pilot run. Every information serves as a valuable source of data during an interview, hence the inclusion of the pilot interviews. In qualitative research, everything is potential data (Kaplan & Maxwell, 2005) This study was conducted during daytime, hence the participants were nurses who were working day duty at this community health centre.

The biographical data also included marital status and the results indicated that it contributed to some extent to the way in which these nurses experienced their caring for youth victims of violence. The community health centre in Khayelitsha has different departments and the departments represented were the ones that directly cared for youth victims of violence. Purposive and snowball sampling also guided the researcher to particular target departments where she could obtain data that directly answered the research question. The gender distribution was not purposefully targeted at women, however, these departments had only two eligible men and only one of them agreed to participate in the study.

3.3   INTERVIEW SETTING

This research took place at a community health centre in Khayelitsha. The centre has different operational departments. It houses a trauma unit where most trauma and violence-related injuries are attended to. In addition, there also are an outpatient department, a midwife obstetric unit, and the Simelela Centre that is an affiliate of the hospital where mostly victims of sexual and domestic violence are treated. According to the nurses working at this facility, the trauma unit attends to acute cases, stabilises the patients, and then refers them to a secondary facility according to the severity of the incident.

3.4   RESEARCHER'S OBSERVATIONS DURING THE INTERVIEWS

It is worth noting that this particular CHC is situated in an isiXhosa community; hence, communication between researcher and participant was conducted in English which is the second language of most of the participants. Since the researcher was familiar with the isiXhosa language due to interaction with friends, understanding and relating to certain slang expressions during the interviews were possible and the researcher complimented this with field notes.

Some participants were very shy at the beginning of the interview, unwilling to disclose by providing very general rather than specific responses in their dialogue. As the interviews were progressing, it became easier to explore their world, since they were more willing to talk and express their experiences. One could gather from their tone of voice and physical reaction that they were deeply connected to the views that they were expressing. However, some were actually too aware of the voice recorder and concentrated more on being recorded than on the views that they were expressing. After a while during the interview, the researcher succeeded in distracting them from the recorder by telling them something funny. Their reaction of laughter managed to distract their attention from the recorder that enabled them to fully immerse themselves in the discussion. It was quite challenging at times, since the participants pretended not to understand what the researcher was asking. This came through when the researcher asked a question, they will laugh at first, attempt to answer, and then sit quiet for a while before indicating that they did not understand the question. At some points, it was frustrating, since it felt that the participant had planned responses to some questions. Other participants attempted to answer questions according to their assumption of what the researcher preferred to hear. It was evident by the questions they asked after responding, like "*Is that what you want to hear?*" or "*Am I answering you correctly?*" Some even felt compelled to apologise for certain emotional responses. They were not comfortable with the emotive nature of the responses, since these responses resulted from the close relation between them and caring for youth victims of violence. Some felt ashamed to express their feelings that were evoked by particular experiences. The researcher took great care to reassure them of the confidentiality of the information.

The researcher found it interesting to observe that after the voice recorder was switched off and the participants were thanked for their time, they continued to express their experiences. Fortunately, the researcher took notes during and after the interview as permitted by the participants in their signed consent forms. The researcher did not discourage further conversation, since these conversations were recorded in the journal afterwards.

On the other hand, some of the nurses were quite excited to take part, since they viewed the interviews as an opportunity to voice their opinions, experiences, and feelings. They actually thanked the researcher for initiating a research study about their experiences. A few were extremely outspoken and could not stop talking about their experiences.

From the study, the researcher realised that there were a lot of emotive experiences of nurses who were caring for youth victims of violence. A combination of negative and positive responses about caring for youth victims of violence was reported. Some participants, however, expressed their coping by referring to their work as just doing a job that included a range of experiences.

During the interview process, the researcher recorded participants' verbal and non-verbal behaviour; such as interactions, gestures, routines, interpretation, and social organisation. Sometimes, it was strange to observe that a participant laughed while expressing rather painful and scary experiences, for instance when a youth would swear at and threaten the nurses. It felt like they were trying to either impress the researcher or to create a front of courage. From their composure, the researcher could observe beyond the spoken information by noting their non-verbal communication. Sigmund Freud expresses the power of non-verbal communication as *"he that has eyes to see and ears to hear may convince himself that a mortal cannot keep a secret. If his lips are silent, he chatters with his fingers. Betrayal oozes out of him at every pore"* (Calero, 2005:90). This point of view convinced the researcher that the participants were more scared than they cared to admit of the situation they were talking about. Communication necessary skills of exploration, clarification, and validation were used to encourage a free flow of communication.

3.5   PRESENTATION AND DISCUSSION OF RESULTS

The results of this study are presented according to the themes and categories that emerged. The experiences of nurses who were caring for youth victims of violence at a community health centre in Khayelitsha are categorised in an emerging central theme, categories and sub-categories, following Tesch's method as illustrated in Table 3.2.

Table 0.2:   Themes and categories

Themes	Categories	Sub-categories
Personal experience: Both challenging and rewarding	Challenging	**Victims:** • Socio-economic situation • Violence and abuse • Gangs • Substance abuse

Themes	Categories	Sub-categories
		• Illiteracy • Teenage pregnancy **Nurse:** • Under-preparedness • Staff shortage • Increased workload • Rudeness and verbal & physical abuse toward the nurses
	Rewarding	• Increased personal awareness • Personal empowerment • Victim empowerment • Job satisfaction
Emotive responses in relation to caring for youth victims of violence	• Demotivation • Fear • Sadness • Anger	
Psychological impact on nurses caring for youth victims of violence	Nurses caring for youth victims of violence experience a negative psychological impact on their wellbeing	
Coping mechanisms that are used by nurses caring for youth victims of violence	• Faith in God • Self-motivation • Support from colleagues • Rationalisation • Suppression	
Nurses caring for youth victims of violence need	• Counselling and debriefing • Appreciation	

Themes	Categories	Sub-categories
support		

3.6   RESEARCH FINDINGS

Caring for youth victims of violence is a personal experience that can be both challenging and rewarding. A number of personal characteristics of the nurses who were working in this field were emphasised; such as passion, love, internal motivation and care, strength, and tolerance. The experiences of nurses who were caring for these youth victims was also largely related to the external working environment, the population distribution, level of literacy, and community resources. Caring for youth victims of violence, as seen in this study, has its challenges and nurses use different coping mechanism to mitigate these challenges. To every action there is a reaction, hence, nurses who were caring for youth victims of violence have verbalised some emotive responses and psychological implications of caring for these youths. The emotive responses of the nurses; especially the negative feelings of anger, fear, frustration, disappointments, and other psychological impacts; had never really been attended, therefore, coping with these issues had become a way of life for these nurses. They were also employing various coping mechanism in order to carry out their duties. Nurses are expected to provide a service by means of physical care, emotional support, and victim empowerment.

3.7   THEME 1: CHALLENGING AND REWARDING PERSONAL EXPERIENCES

Caring for youth victims of violence is a personal experience, hence, the researcher was very satisfied when the participants were able to acknowledge that and it emerged as one of the themes. A *personal experience* refers to the process of generally observing, encountering, or experiencing things as they occur in the course of time and the collection of past and present characteristics that epitomise a particular quality of a person (Collins English Dictionary, 2009). Most of the participants acknowledged that by caring for youth victims of violence had contributed to the persons who they were, for example one participant expressed an opinion about this issue:

"...I saw myself like as a person who has a passion né a passion of getting to know people, getting to know because beside knowing somebody it also help you to know who am I" (P-2).

"...I don't know how to put it... but for me to be here and to work with them, ..err sometimes at the end of the day I feel like that I have done something for the youth" (P-4).

From the data, it was evident that caring for youth victims of violence was regarded as a rewarding experience for nurses too, since they felt empowered and satisfied.

On the other hand, caring for youth victims of violence at a community health centre in Khayelitsha, in as much as it was a rewarding experience, most often took its toll on the nurses due to the complexity of the environment and multiple stressors in the work environment with very limited opportunities to express the impact of the many daily interactions they were experiencing (Davidson, Ray & Turkel, 2011:174-175).

A *challenging experience* refers to any experience that is requiring great physical or mental effort to accomplish, comprehend, or endure (Collins English Dictionary, 2009). During a challenging encounter, stress develops that causes wear and tear of our bodies and minds while we are trying to adjust to the situation. Unlike physical trauma, nurses caring for youth victims of violence need practical information, inspiration, and hope (Lerner, 2012). Unfortunately, what nurses receive – debriefing for specific incidents, educational offerings, and individual counselling – are appropriate but not adequate, since these interventions do not provide a sustainable forum (Davidson, et al., 2011:175). Some nurses expressed their challenging experiences in relation to caring for youth victims of violence:

"...You don't see him here you see your son, your relative, you know.... you know, it is painful really... it's painful" (P-5).

"...the worse thing is the DOAs (dead on arrival) the people who came dead, those whom I cannot help, they were gun shot and the they die on the scene, they were stabbed and then the die on the scene is what make me sad because if those people can come here alive it means that I can help them anywhere" (p-7).

"...my lowest point, the lowest point for me is that, when am looking at them, it reflects back to me that am having same age like this because one time there was a young teenager pregnant, who did know who pregnated [sic] *her and then she had this little baby, she is HIV positive and she was 17 years old, same as my... my child and it was so painful"* (p-8).

3.8   CATEGORY 1: CHALLENGING EXPERIENCES OF CARING FOR YOUTH VICTIMS OF VIOLENCE

The category "challenging" as a personal experience of nurses caring for youth victims of violence at a community health centre in Khayelitsha gets discussed according to two sub-categories: external challenges related to the youth victims of violence, and internal challenges of the nurses.

3.9   SUB-CATEGORY 1: CHALLENGES RELATED TO THE YOUTH VICTIMS OF VIOLENCE

3.9.1   Socio-economic situations of victims

Social scientists use the word socio-economic as an umbrella term to describe a wide variety of social (age, gender ratio, educational level) and economic factors (income level, unemployment) that might enable the explanation of an observed phenomenon, event, or set of events (World Economic Forum, 2005:2-6).

The socio-economic conditions of victims were viewed by the nurses as influencing their experiences while they were caring for youth victims of violence. The nurses felt that the incidence and prevalence of violence in that community were perpetrated by the socio-economic situation of the people. Khayelitsha is a poor community; hence, in an attempt to survive and to make ends meet, the youth were involved in violence. It explained the increased number of youth victims who were attended to at the community health centre as reported by the nurses. Ugur (2012:2), in his research, states that violence happens more commonly in societies that are unequal and fragmented; these conditions are true for the Khayelitsha community. Fox and Hoelscher (2010:3) support the notion that economic deprivation and opportunities are motives for individuals to become violent. Khayelitsha is a poverty-stricken township with high levels of unemployment, low household income, under-development, and a lack of an economic base due to spatial dislocation and historical neglect

(Ngxiza, 2011:2). Therefore, these conditions are main contributing factors to the increased incidence of violence in the area. Like all post-apartheid disadvantaged youth, the youth in the Khayelitsha community aspire to upward mobility and they will do whatever it takes to achieve this goal. While some of them achieve it by acquiring education and realising their potential, the majority of the youth resort to what they call the *ikasi style* (Swartz 2010 in Swartz, Harding & De Lannoy, 2012:28). It refers to the ways in which the youth try to rationalise their participation in unacceptable behaviour with the view of creating a sense of belonging. This style comprises sex, violence, as well as alcohol and substance abuse (Swartz et al., 2012:28). This notion was shared by most of the participants in the community as some participants stated:

"...they just go around, some follow the sun when it goes to another direction they follow to the other direction because there is nothing that they can do" (P-1).

A nurse reported about a youth "...if I want to go somewhere he gives me money and my mum doesn't give me all... all of those things, sometimes we will go to bed hungry and if am with that man, there is always food in the fridge, there is always food in the cupboard" (P-8).

It can also be interpreted that these youths, especially the girls, present their bodies to obtain favours from men, including basic necessities like food. Unemployment is a major challenge, hence, the youth get involved in whatever sustenance activities. Young girls get into abusive relationships with older men. Their quest for survival has exposed the youth to challenging and risky behaviour. The girls are willing to succumb to abusive men simply to afford their daily bread.

3.9.2   Violence and abuse

According to the Newfoundland Labrador Canada (2012), violence and abuse are seen as a pattern of behaviour that is intended to establish power and to maintain control over family, household members, intimate partners, colleagues, or groups. The Khayelitsha settlement is no exception to the experience of everyday violence with many of these instances occurring in public places where people conduct their daily activities (Ugur, 2012:3); e.g. schools, streets, as well as areas of entertainment (like shebeens) as stated by participants:

"...shebeens... you see, it all starts there... its where they enjoy themselves and the fight starts there and they will come here (sigh) pause..." (P-1).

"...Because may be they are stabbed on their way back from work or school" (P-6) Note.

With the omnipresence of violence, people feel very insecure wherever they are or whatever they are doing.

According to the participants in the study, there were lots of instances of violence in the area; especially during weekends, and in cases where people have part-time jobs, or people who get paid either weekly or fortnightly. They indulged in activities that most often end in violence. Especially youth girls become more vulnerable, since they yearn to be part of the weekend fun without actually having their own money. They will, therefore, do whatever it takes to be part of the fun and to join the rest of their friends. They end up being abused by men. These events are rampant in the township.

"...especially weekends they are drunk, so the most cases honestly they are drunk... the weekend is like 2 times what we see in the week. And always there is a stab and gunshot here and there" (P-3).

"...we have to attend a client that is out, out, out, a person that doesn't even know that she is been raped, the amount of alcohol that has been consumed by the client, it demotivates me, it kills me because most of our young clients, or young female clients when they are raped, its either they were drunk or its either they were at a party" (P-6).

3.9.3   Gangs

Gangs have existed since time immemorial. According to Miller (1975:9), a gang is a group of recurrently associating individuals with identifiable leadership and internal organisation that are identifying with or claiming control in a territory in the community and that are engaging, either individually or collectively, in violent or other forms of illegal behaviour.

From the experiences of nurses who were caring for youth victims of violence, one of the things that they pointed out was the level of gangsterism in the area. Little gangs in the area that are fighting one another contribute to the number of youth victims of violence. Most of

the time, violence erupts due to differences that have arisen among the different gangs. It is of great concern, since most of these gangs are led by youths. They fight against one another and sometimes these fights end with fatalities. According to the nurses, attending to a victim who is a gangster is hampered because other members of the gang accompany the victim to the community health centre as escorts and demand immediate assistance from the nurses. They are very impatient and rude to the nurses and the whole area at the CHC become chaotic. In her study, Allen (2009: XII) points out that gangs present a powerful challenge to emergency departments, since when one member is injured; the other members follow that member into the emergency department. Once they are in the community health centre, some of these gang members even threaten the very nurses who are attending to them.

> *"...some are coming with gun, threatening that am going to shoot you if you don't see my friend... they come here with their colleagues or whatever, and they shout the whole place"* (P-7).

> *"The escorts come and shout you must see my friend now"* (P-2).

Participants stated that gangsterism is a great challenge in the community. Gang related incidences have contributed to the increased amount of youth victims who are being cared for at this community health centre. One participant mentioned.

> *"...there is this thing now that worries us a lot... gang or what, where the other section is fighting the other, like Site B is fighting Khayelitsha"* (P-5).

3.9.4 Substance abuse

Abused substances include the excessive use of alcohol or other drugs that produce some form of intoxication that alters judgement, perception, and attention of physical control (Dryden-Edwards, 2013:1). In the community of Khayelitsha, the main substance frequently abused is alcohol. According to the narratives provided by nurses, most of the cases of the victims who are seeking treatment at the community health centre are more often than not related to alcohol abuse. Either victims arrive there drunk, or they have passed out and are unable to recall a single event related to the trauma experience.

"we... we have to attend a client that is out, out, out, a person that doesn't even know that she is been raped, the amount of alcohol that has been consumed by the client" (P- 6).

Some of the violence actually begins at places that sell alcohol (shebeens). Sometimes, victims who are brought to the community health centre are not orientated in place and time and only after a while do they realise the extent of their injury and why they are there.

"... Sometimes I feel very bad because sometimes, there is alcohol involved, they normally come in like at night after hours" (P-4).

"... for the fact that they are youth, they like, sometimes I feel very bad because sometimes, there is alcohol involved" (P-3).

The community health centre is very busy at night and during weekends when most people are out drinking and indulging themselves. Nurses attribute the escalated level of violence and the number of youth victims who are attending the community health centre to the presence of shebeens at every corner in town.

Drinking is widely seen as behaviour associated with violence and excessive drinking is a cause of violence; alcohol increases aggression and prompts violence (Seekings & Thaler, 2011:14-15). Alcohol abuse is, therefore, compounding the problem.

3.9.5   Illiteracy

Illiteracy in any country, city, or town is an added burden in society. According to the nurses, because many of the youth were either illiterate or school dropouts, getting a job to provide for themselves became a challenge. Sometimes the youth even were unable to communicate in English and most jobs required fluency English. It exacerbated matters. Illiteracy was leading to unemployment and forced most of the youth to become involved in violence. A study by Ackerson, Kawachi, Barbeau and Subramanian (2008:507) suggest that the level of education is an independent determinant of a woman's likelihood of experiencing intimate partner violence.

From the data collected, nurses at the community health centre to illiteracy attributed the treatment of victims to the high level of violence.

"most of them, they are dropouts from school" (P-3).

"...some think that if someone abuses me it means that the person cares for me and the person loves me... and when you say you love somebody, what does that mean? and when you say that you care for somebody what does that mean? u know because it seems as if love is interpreted in a negative manner" (P-1).

It emphasised that nurses ascribed the inability to distinguish between genuine love and getting battered by their partners to the lack of education. The young women needed to be educated in order to be able to distinguish between love and abuse.

> *"It is where by abuse takes place because you have to be submissive at all times, you cant express yourself, you cant find yourself a job, you cannot do anything, so what do u do? Then it is only to give men love so a man can do whatever to you so that you can gain something at the end of the day, you can clothe yourself and also you can feed your stomach. Do you see?"* (P-7).

Lack of education leads to difficulties in securing employment and women are likely to be victims of violence, since they rely on men for support, hence they will succumb to any circumstances for survival. Literature further supports that illiteracy, like unemployment, is a factor that marginalises the youth, and it makes some of them vulnerable to exploitation and involvement in criminal and deviant behaviour (Adedokun, Osakinle & Falana, 2010:25).

3.9.6   Teenage pregnancy

Teenage pregnancy is an international problem with South Africa and other countries experiencing an increase in teenage pregnancy with many of these teen mothers-to-be are still at school (James, Van Rooyen & Strumpher, 2011:190). Nurses report teenage pregnancy is one of the problems that plague the youth in society. It was a challenge in this community for a while and it most often results from cases of rape and youth who are pursuing men for money. After physical and verbal abuse, they end up being pregnant with the man no longer present to support their own children. It places a great burden on the youth, the families, and the community in general; hence, the nurses caring for the youth are indirectly affected. They attend to cases of not only rape and / or physical abuse, but also to pregnant youth who cannot even look after themselves. The use of contraception has increased globally, however,

teenagers have inadequate protection, and contraception use among teenagers is still low. Teenage pregnancy has subsequent health and social outcomes due to unemployment, poverty, and discrimination (Harden, Brunton, Fletcher & Oakley, 2009). The study participants confirmed these observations.

> *"...because youth have a lot of challenges né, there is teenage pregnancy"* (P-1).

> *"...they are falling victims of pregnancy"* (P-5).

> *"What I can say is that caring for the youth, especially in this community for me is a challenge, is a challenge, there are so many challenges, gangsterism is a challenge, teenage pregnancy is a challenge, drug abuse is a challenge"* (P-3).

> *"She is not supposed to be there, its adults who are supposed to get pregnant"* (P-6).

3.10   SUB CATEGORY 2: CHALLENGES RELATED TO NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE

3.10.1 Under-preparedness

According to the participants, it seemed to be obvious that newly qualified nurses did not know what to expect from caring for youth victims of violence. They pointed out that they were actually scared of and surprised at what they experienced while they were caring for youth victims of violence. According to the nurses, they viewed nursing as the caring for sick people and did not really understand the treatment of victims of violence; hence, it was challenging working with youth victims of violence.

> *"... my motivation for doing nursing was because I was always interested in what are the nurses and the doctors doing to someone who is sick, I never thought about caring for youth victims of violence, I don't know why I never think about it, but I was concentrating on what are they doing on someone who is sick that is why most of the time I did not know what is the different between someone who is sick and someone who is a victim of violence"* (P-6).

"... honestly, for the time I was choosing to join this career, I didn't know, how broad this career is, I was not much exposed on hospital, so it was just to look for a job" (P-3).

From the nurse's responses, it was evident that this aspect of nursing was never taken into consideration or even considered as a part of nursing, since nursing was only viewed as curative care. It shows that the public still perceive nursing just in terms of wound care, and bed baths of patients who are ill, and taking care of ill patients. Therefore, caring for victims of violence is a relatively new aspect of the profession that makes it challenging for nurses. It is evident in literature that health education is based on the biomedical model of health which aims at curing and preventing of diseases. Hence, nurses feel obliged to perform this task – caring for youth victims of violence – on a daily basis. This carting is not only physical, but emotional as well, and sometimes with psychological impacts for which they have not received formal training (French, Du Plessis & Scrooby, 2011:2). The nurse, therefore, is realistic when he mentions that his whole idea about nursing is caring for the sick.

Fortunately, with the emergence of a health promotion model encourages a holistic approach to health, and views a person as a bio-psycho-social being who is in permanent interaction within him / herself and his / her environment, including other human beings (Carvalho, Dantas, Rauma, Luzi, Geier, Caussidier, Berger & Clement, 2007) which include caring for youth victims of violence.

Nurses observe that irrespective of the department they are working in, the same orientation happens during recruitment. It is generalised and not specific to the department in which the nurse will be working. Nurses most often are given the do's and don'ts with regard to legal matters with an emphasis on patient's rights. The remainder of the orientation is supposed to be done by the ward staff members who seldom have the time to do it also due to their workload. The newly appointed staff members, therefore, have to adapt as time goes by to accept the customary way of doing things. This unpreparedness contributes to the frustration of nurses to the extent that they sometimes feel the urge to retaliate to patients, to quit.

"...I feel like O my God I don't wanna [sic] *be here... in the beginning, I could not even stand it but now, its three years working here so, so it's fine"* (P-2).

"...Sometimes they come here drunk and they start talking, to shout at us and sometimes I feel like O my God I don't wanna [sic] *be here because they can be very rude"* (P-4).

"...Sometimes I run away from situation, I don't want to see" (P-3).

3.10.2 Staff shortage

According to Oulton (2006:34), nursing shortage is defined as the imbalance between demand for employment and the available supply. Nursing shortage is a global issue that impacts on the health systems around the world. An inadequate number of staff members does not only place a risk on the patients but also has a negative impact on the wellbeing of the nurses (American Nursing Association, 2007).

> *"Sometimes you feel guilty because one other day there were 4 resusces* [sic] *(resuscitations) here and there were 4nurses that must resus* [sic]*, so we resus* [sic] *them and the other one resus* [sic] *this side and the other one we just put the drip on they have to wait until.."* (P-2).

From this response, it is also evident that the shortage of staff members makes it really difficult to perform nursing duties adequately. It presents a challenge, since staff shortages impede the nurses' ability to render quality care (Bégat, Ellefsen & Severinsson, 2005:222)

The current shortage experienced is dependent on the type of nurses (registered and enrolled nurses) and the geographical location, since some nurses are not willing to work in certain places. It impacts on the nurses' ability to meet the needs of the community (Oulton, 2006:35).

> *"Most of the youths are rude, most of the times, they will shout at you, maybe its not the patient but the escorts. Even you are busy on the other side they don't care about that they hmmm, so they shout at us and you feel like you don't want to be here"* (P-8).

The threatening attitudes of youth victims of violence towards nurses sometimes discourage them and one will most often find that nurses at these medical facilities are residents of that area, since other nurses are too scared of working in that violent environment. These circumstances also affect the nurses' ability to provide quality care because they are a source of stress for nurses (French, et al., 2011:5).

3.10.3 Increased workload

Increased workload refers to volume and level of nursing services (Arthur & James 1994 in Morris, MacNeela, Scott, Treacy & Hyde, 2007:465). The community health centre in Khayelitsha supplies health services around the clock and serves a vast geographical area, therefore, the increased workload increases even further, especially at night when the day hospitals are closed. Although the Khayelitsha District Hospital also provides health services 24/7, it is a referral hospital and patients get treated at the community health centre first before they are allowed to be sent to the district hospital (Wallis & Twomey, 2007:1276).

> Nurses at the community health centre also feel that they are doing more work, since victims of violence do not attend their nearest clinic but rush straight to the Khayelitsha Community Health Centre. *"There is short of equipment and the heavy workload, we see many patients"* (P- 3).

> *"The youth* passes *Michael Mapongwana Clinic and also now there is big hospital in Khayelitsha, she pass the hospital and come straight to site B. Feel like as if the work load now, they are adding on me because they are supposed to be helped that side, so those situations they also make me to feel like what are we doing here, why we have to have more work"* (P-6).

Different sections in Khayelitsha are allocated a day hospital that operates 9 hours a day and victims of violence are required to attend their nearest day hospital. Their insistence to be treated at the CHC, however, unduly increases the workload of nurses at this centre.

> *"Eish* [sic] *its sad, sometimes you are very busy with a patient that you cannot leave that patient. Then another one comes in and because of the staffing we are not able to help immediately. Then say for instance that one passes on. but they say we killed the patient, we didn't take care of the patient whereas we were busy with another"* (sad tone) (P- 8).

Situations like this example leave the nurses frustrated, since they are unable to give of their best during particular situations due to the many people they need to attend to. The situation also leaves them with feelings of guilt when a particular case they attend to – or do not attend to – results in dead. Bégat, et al. (2005:228) confirm that the less time a nurse has to

complete a task, due to workload, the more physical symptoms of stress are evident or experienced.

3.10.4 Rudeness and abuse towards nurses

Working with youth victims at the community health centre in Khayelitsha is a challenge for many of the nurses as verbalised by almost all the respondents in the study. The youth are ill-mannered, some due to the effect of excessive alcohol consumption, and some due to getting impatient when they have to wait their turn to be attended to, while the escorts who accompany the victims also threaten nurses at the centre. Abuse refers to people who are screaming at somebody, calling one names, or threatening other people (Nazarko, 2007:384).

> *"Most of the patients are coming... are coming with rudeness sometimes, I can say rudeness. They shout the whole place, but we didn't talk to them like that we just calm down. So we manage to see all the patients, all kinds of behaviour we see here"* (P-2).

> *"...the relative is fighting with what you are doing. They swear at you, they shout at you. They don't see what you are doing"* (P-5).

> *"...most of the youths are rude, most of the times, they will shout at you, maybe its not the patient but the escorts. Even you are busy on the other side they don't care about that they hmmm, so they shout at you"* (P-8).

It seems that the youth have nothing else to offer but being rude, even to their elders. Nurses of advanced years are working at this community health centre and they consider these youths as their own children, however, their responses to the nurses are disrespectful.

> *"...there are challenges their behaviour, there is disrespect, sometimes and sometimes they come drunk, hmmm yes sometimes"* (P-3).

The quotations in this section illustrate that the nurses at the community health Centre in Khayelitsha are not working in a conducive environment. It is critically important that one is comfortable in the working environment in order to provide excellent services. The working environment of nurses is an essential issue with regard to job satisfaction and staff turnover. It plays a role in patients' outcomes and respect of persons is an ingredient of

communication, collaboration, and valuing contributions of people (Ulrich, Lavandero, Hart, Woods, Leggett & Taylor, 2006:46-47). Abuse at the workplace decreases job satisfaction, causes low self-worth and burnout, and compel nurses to quit their job in response to repeated verbal abuse (Truman, Goldman, Lehna, Berger & Topp, 2013:7).

3.11 CATEGORY 2: REWARDING EXPERIENCES OF NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE

Participants also confirmed that working with youth victims of violence was not only challenging but it's also was fulfilling. They pointed out that the opportunity to treat these victims made a valuable contribution to their lives and they considered these health interventions as rewarding. There are lots of things one learns from caring for other people, especially victims of violence. At training institutions, nurses are taught technical skills and in the working environment they learn to refine those skills and it is during their working life that they realise they enjoy working with patients (victims of violence). Virtues like compassion, nurturing and endurance are not taught at training facilities but develop during a life path of caring (Johnson, 2006:335).

3.11.1 Increased personal awareness

Self-awareness is an inwardly-focused evaluative process during which individuals make self-standard comparisons with the goal of better self-knowledge and improvement (Greg & Roni, 2012:2). Participating nurses also stated that caring for youth victims of violence was also an eye-opening experience. They became more aware of themselves and the world of the victims and, hence, their view of health, illness, and victims of violence changed. There was an overall sense of achievement and turning from a novice into a true professional.

> *"It is a passion of getting to know people, getting to know because besides knowing somebody it also helps you to know who am I"* (P-1).

> *"It gives you opportunities to self-reflect and try to understand your feelings and emotions"* (P-5).

3.11.2 Personal empowerment

It is also rewarding and empowering when victims acknowledge the little acts of care by the nurses during their time of need. Nurses feel they are having an impact and it also boosts personal morale. Just like the acknowledgement that has been given by a cancer survivor *''I've been touched by the smallest gestures – a squeeze of the hand, a gentle touch, a reassuring word. In some ways, these quiet acts of humanity have felt more healing that the high-dose radiation and chemotherapy that hold the hope of a cure"* (Schwartz, 1995). Statements like like this one help to build the strength and confidence of nurses with the knowledge that they have an impact in the lives of their patients. It also holds true for the nurses caring for victims of violence at a community health Centre in Khayelitsha.

> *"I feel so empowered né and when you see people coming in, seeking information you know that you have made an impact, directly or indirectly because that shows that at least something is happening in the community because people are coming forward"* (P-3).

> *"...I don't know how to put it... but for me to be here and to work with them, ...errr sometimes at the end of the day I feel like that I have done something for the youth"* (P- 9).

These statements affirm the fact that sometimes we actually discover who we are or what we are capable of when we expected to do things that align with our inner passion. In performing a task, we get to identify our own qualities, our strengths, and our weaknesses. Mullai (2011:246) states that the real process of strengths discovery begins with self-reflection and people begin to reflect regularly on the things they do that make them feel strong, they develop a new way of thinking. Thinking about one's strengths becomes part of daily life and eventually part of habits.

Caring for youth victims is deemed to offer personal satisfaction to the nurses; they experience it as a rewarding event that is affording them satisfaction and adding value to their lives.

3.11.3 Victim empowerment

Victim empowerment refers to all actions that are geared towards reducing stress, giving support, education, and encouragement of the victims (John, 2012:24) to take actions that improve their lives. Nurses who participated in this study shared a vision that caring for youth victims was a great pleasure, since they felt that they made an impact on the lives of the victims by empowering victims to take ownership of their lives, while some of the victims are having a sense of achievement after they have recovered from the event.

> *"What I love is and also share né the information that I have with regards to sexual and domestic violence, like to help, young women, young men to be more respectful for their peers and for their partners and to understand where does love come from né."* (P-1).

> *"I feel great and I feel empowered when somebody picks up the phone and says , you know what, I have been a victim but now I am a survivor"* (P- 2).

> *"But for the few that we have impact on, we say halleluiah, it encourages me to do more"* (P-5).
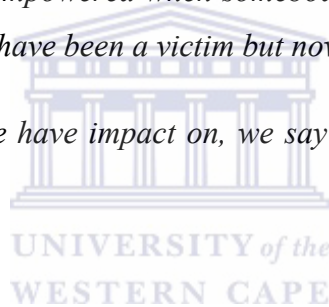
3.11.4 Job satisfaction

Job satisfaction is defined as the effective orientation that employees have towards their jobs and can be considered as either a general feeling about their jobs, or as a related constellation of attitudes about various aspects or facets of the job (Lu, Barriball, Zhang & While, 2011:1018). Many of the participants expressed their satisfaction while working with youth victims of violence, since they felt they were contributing to society. One realises that despite the many challenges they face, like in any other job, they enjoy doing what they do.

It is worth noting that, like with any other job, there are aspects of nursing that are satisfying; nursing is a wide discipline that provides different speciality services. The participants stressed the fact that they gained job satisfaction from caring for youth victims of violence, since they were making an impact in the lives of the youth. This impact is an extremely worthy course because the youth are the backbone of any nation. Professional commitment has also been viewed as a benefit that contributed positively to job satisfaction (Lu et al.,

2011:1028). Nurses, in the study, reiterated their pledge and commitment to nursing as one of the reasons why they were compelled to do their job.

"I love my job, I really love what am doing here..." (P-9).

"...but I told myself I must work in my community and to help the patient here" (P-2).

"...is I like to help those that cannot help themselves, so that's why am here and am here for my community" (P- 4)

3.12   THEME 2: EMOTIVE RESPONSES OF NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE

An emotive response is the ability to acknowledge, accept, and express one's own emotions appropriately while accepting personal limitations (French, et al., 2011:3). There were many subjective emotional consequences experienced by nurses who were caring for youth victims of violence at the community health Centre, which in turn, affected their personal wellbeing. These responses included demotivation, fear, sadness, and anger.

3.12.1 Demotivation of nurses

Demotivation refers to specific external forces that reduce or diminish the motivational basis of a behavioural intention or a continuing action (Dörnyei & Ushioda, 2011:138-139).

There are many factors that demotivate nurses who are working with youth victims at this community health centre. These factors range from disrespect and abuse from the youth victims, their relatives and escorts to undue pressure from the nursing management. Salary issues have also been a main concern for many nurses and nurses who are working with the youth victims view the additional care as another added burden that needs to be compensated.

"They shout at us, some of them they make you see as if you work is not appreciated. Some of them come in a very bad state and not orientated, we struggle and put up the drip and when he wakes up and is conscious, he ask where am I is it B? They sigh ...aah, and just pull out the drip and walk away (Laughs, but a kind of frustrated laugh). They take all the drip, put them on the floor" (P-8).

Every individual loves to be appreciated; demonstrating appreciation brings out the best in people and it motivates them to work better and it improves their self-esteem (Guiliana, & Ornstein, 2011:221). Subsequently, the nurses feel their services are not appreciated.

"...Those that are trauma trained, they have trauma allowance. Being traumatised, they get paid for that. Trauma situation is always traumatizing. I don't get paid in this situation but am also traumatised….if we get paid of working in this situation, it won't change the situation, but that motivating something that you are compensated, working in this condition helps (P-6).

"...my dear honestly as I join this career, I though it's a really, a career that is respected, honestly it's not a respected career because the wages we earn compared to ward clerks as I gave you the examples, I don't see myself like am respected. How wish I can demand that to be respected in terms of salary" (P-7).

Nurses also feel that that extra compensation for nurses who have an additional training certificate is comforting. However, it demotivates those nurses who are missing out because they have not had the opportunity to get additional training. Though financial rewards alone are not sufficient to retain the workforce; financial incentives importantly help maximising health workers' motivation (Mathauer & Imhoff, 2006:2). The salaries of nurses have always been an issue to nurses because they feel that they deserve more and according to Mathauer and Imhoff (2006:2), the problem of low salaries must be addressed, especially in situations where income is insufficient to meet even the most basic needs of health professionals and their families.

Nurses add that they do not feel motivated due to the way they are being treated by the governing bodies.

"We feel unsecured and it seems the government is not helping us. They not are caring for us. And even if they run an investigation about a certain case, they don't come back to us with feedback about that case so we l just sit in doubt… they come to us for information, what happened, then we have to write a statement but they don't come back with the feedback, we are disappointed" (P-8).

Additionally, the nurses feel that they do not get enough support from government, since they do not receive feedback, for their own peace of mind, about any matters investigated.

3.12.2 Fear

It is a distressing emotion that arises from, e.g. impending danger, evil, and pain; whether the threat is real or imagined; the feeling or condition of being afraid (Collins English Dictionary, 2009). Ekman and Friesen (1976) define fear as a feeling of apprehension caused by perception of danger, threat or infliction of pain. Given the violent nature of the youth who are attending the community health centre in Khayelitsha, there is a sense of fear among the nurses who are working there. It is really not a good thing when one's place of work becomes a place one fears. If one is not secure at work, productivity is hampered and subsequently the quality of care drops. Nurses are also scared, since they are afraid of becoming secondary victims in the hands of these youths. They also need to consider their families. Some have children who are of the same age as some of the victims and, hence, they live with a constant sense of panic: what if it's my child?

> *"Sometimes if you came across, the patient like that you can't even think well because you think this person can shoot me, how about my family…"* (P-5).

> *"…I feel very sad and scary man... in the beginning, I could not even stand it but now, its three years working here so, so its fine"* (P-4).

> *"…sometimes they come and they become rude you become scared also, may be now you go out, you go to the shop, what if I meet this person… sometimes you think oh… am not safe"* (P- 3).

Their responses emphasise the difficulty of concentrating on their jobs and giving of your best when they are worried about their own safety. Under these circumstances, it is not easy to take care of another person. Some nurse even feared that they might be attacked too when they are outside of the facility.

3.12.3 Sadness

Ekman and Friesen (1976) define sadness as a feeling of unhappiness or sorrow. It is characterized by feelings of disadvantage, loss, despair, helplessness and sorrow. An individual experiencing sadness may become quiet or lethargic, and withdraw themselves from others. Participants expressed sadness while they were caring for youth victims of violence. They really felt unhappy about what is happening with the youth. Some of the participants had young children; it escalated their worries about their own children and the youth victims they treated.

> *"Sometimes you feel... you don't feel nice"* (P-9).

> *"You don't see him here you see your son, your relative, you know... you know, it is painful really... it's painful"* (P-5).

It is difficult for a parent to see another child in pain that is caused by inflicted violence. From an African perspective, a child belongs to the community and a neighbour's child is your child too (Jegede, 2009). This cultural background saddens the nurses even more, since they view every young victim as a concerned parent. The following narration expresses the sadness of some participants:

> *I can take it like if it was me. It can be me, maybe am coming from work and then, the station and then somebody can come and... and stab me or gunshot me or it can be my child that is why I feel sorry for them, I sympathize with them as it can be my child and it can be me also"* (P-7).

> *"My lowest point, the lowest point of me is that, when am looking at them, it reflects back to me that am having same age like these"* (P- 9).

Participants also verbalised disappointment when abused ladies still decided to return to their perpetrators. Unfortunately, the victims had the final say and sometimes they made wrong choices. It really affected the nurses, since their hands were tied.

"It was painful for me, looking at her, looking at the bruises, looking at the scars (sigh), because she was not only stabbed underneath but she had cuts and the bruises also and the face was swollen né, eyes blue, but eh the lady wants to go back to the man and in that kind of case you can't side" (P-7).

3.12.4 Anger

Participants voiced a feeling of anger when they were getting faced with very disrespectful youth victims. They displayed no respect for elders.

> *"When you look yourself you say am a mother but they you don't have that respect… They are these young and you are this old, sometimes you just want to clap"* (P- 5).

Another thing that worried the participants was the fact that the victims were very knowledgeable about the law and sometimes used their knowledge to their own advantage but to the disadvantage of the nurses. They sometimes tauntingly told the nurses what their rights were and what the nurses were obliged to do. When they were brought to the facility under duress, they might get up; gather their things and leave – sometimes during the course of treatment - with the excuse that they had a right to refuse treatment. Such action made all the efforts of the nurse worthless.

> *"Some of them come in a very bad state and when hey recover though your effort, they later say they don't want to be here and its their right to go"* (P- 7).

3.13   CATEGORY 3: PSYCHOLOGICAL IMPACT ON NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE

Nurses caring for victims of violence are routinely exposed to verbal and physical aggression and repetitive exposure to traumatic events with inevitably serious psychological consequences (Adriaenssens, De Gucht & Maes, 2012:1411). Participants also verbalised that caring for youth victims of violence affected their personal lives. This dynamic was caused by its daily occurrence and, therefore, it became part of the nurses' life. Participants expressed how this dynamic affected their relationships at home. One participant even mentioned how caring for youth victims of violence, especially abused young women, had affected her relationship with her husband. Due to experiences at work, nurses might approach their spouses very cautiously; it unintentionally caused tension at home.

"You can be a victim and you can me mobbed also, so my main worry I always say what if it happens to me né and do you know what, it affects my relationships, am very careful, each and everything my partner does, I always analyse I" (P-1).

"It is because of the experiences that we are getting, that makes us scared of our men, and always on the alert, the cases that we listen to" (P-4).

Due to caring for victims of violence, nurses are indirectly traumatised. In his article, Rueden (Rueden, Hinderer, McQuinllan, Murray, Logan, Kranner, Gilmore & Friedman, 2010:191) says that nurses who care for critically ill, injured, or traumatised patients on a daily or near daily basis are subjected to traumatic stressors that may result in the development of troublesome effects, such as post-traumatic stress disorder or post-traumatic stress symptoms. From what the participants said, the researcher gathered that fear and mistrust were taken home due to the frequent exposure to women who had been abused by men.

It is possible to be traumatised by indirect exposure during interaction with trauma victims. This is referred to as secondary traumatic stress or vicarious trauma that includes emotions and behaviour that a person experiences as a result of being exposed to another person's traumatic experience (Rueden, et al., 2010:191). It was confirmed by a participant who mentioned traumatic experiences at work affected the way she handled her own children. Due to the violence in the area, she was becoming very strict with her children as an attempt to protect them.

"...And also your kids, you are overprotective... silence... you see. It affects you at the end of the day (P-1).

"It affects me but, I do not cry with the situation, but I just err, it becomes stressful" (P-3).

"..., its the stabbing that affects me at home really, I don't even want my children to go out, more especially when its dark, I don't want them, so they think maybe they think mama is crazy" (P- 5).

3.14 CATEGORY 4: COPING MECHANISM EMPLOYED BY NURSES CARING FOR YOUTH VICTIMS OF VIOLENCE

Coping mechanisms are strategies used by individuals to modify personal perception and behaviour in respect of conflict that arises from the external environment (Liu, Pan, Wen, Chen & Lin, 2010:145). It is also defined as the cognitive and behavioural efforts exerted to manage external and internal stimuli that are perceived as taxing on the individual with the aim of minimising, tolerating, accepting, or ignoring a demand (Hays, All, Mannahan, Cuaderes & Wallace, 2006:186-187). The participating nurses were using a variety of coping mechanisms to perform their daily activities. Coping strategies could either be problem-focused, i.e. attempting to manage or change the problem that is causing the stress or emotion-focused, i.e. using strategies to alleviate emotional distress (Bidewell, Chang, Daly, Hancock, , Johnson, Lambert & Lambert, 2006:31). In many studies, the former strategy is viewed as a more beneficial strategy (Ceslowitz, 1989; Chiriboga & Bailey, 1986, Chang et al, 2006:31). However, most of the stressors experienced by the nurses are not amendable to change by the attempts of individual nurses, hence; changing one's attitude towards the stressor forms an important aspect of coping (Boyle, Grap, Younger, & Thornby, 1991 in Chang, et al., 2006:31). Some coping strategies are described according to the sub-categories.

3.14.1 Faith in God

Faith is a philosophical element or an approach of coherence to support activities that find meaning in one's world and is identified as the most powerful force in human nature. It also involves making sense of the experiences and situations life presents (Dyess, 2011:2724). Faith in God is one of the strategies used by nurses as a coping mechanism. Evidence is also found in similar research conducted by French, et al. (2011:6) that proves faith fulfils an important function in the lives of nurses. Believers use their belief in God to mitigate the stressors of life. Many of the participating nurses confirmed that their faith and trust in God had helped them to cope with the many challenges at the community health centre.

Faith is an evolving pattern of believing that grounds and guides authentic living and gives meaning in the present moment of inter-relating (Dyess, 2011:2728). This pattern of believing seems to be a pillar that supports the strength of nurses by assisting them to persevere with their work of caring for youth victims of violence. It is a source of strength and inspiration for them.

"...hmmm, you just pray to God and say oh dear God just stake me through" (P-6).

"...am a very religious person, I think that also helps me because there quotations from the Bible I use every day and there are stories in the Bible né , there were Josephs then and there are still Josephs today né, there were Elijahs then and there are still Elijahs today né, some may be the Samsons, some may be the Delilahs, but we are one né, so I have to choose one character that I have to live with from those heroes and the heroines" (P-1).

Prayers and faith in God, therefore, provide a source of support for nurses caring for the youth victims of violence.

3.14.2 Self-motivation

Nurses often use self-motivation to remain focused. It implies that individuals draw from their inner strength while performing their duties. According to Ntoumanis, Edmunds and Duda (2009:250), a person who faces a stressful situation will compare the potential personal relevance in terms of its impact on valued personal goals. In this case, the goal of the nurse is the desire to care; hence, they make that conscious decision to care for the youth victims of violence despite the accompanying challenges. The desire to care acts as a driving force and motivates the nurses in carrying out their duties.

"...Am motivating myself from inside because I don't know what awaits me at the centre where am going to" (P-1)**.**

"I think its still up to me of telling myself each and everyday I wake up from my house, its still in my heart to tell me let me go see who needs help" (P-6). Self-motivation is a very strong tool that enables one to reach one's destination or ultimate goal, and if one does not fully understand what one is doing, then commitment becomes impossible (Harnsberger, 2013:1).

3.14.3 Support from colleagues

Support from colleagues was also mentioned as one of the ways the participating nurses used to cope in their work environment. This support among the staff

members serves as a motivational factor in a stressful work environment (French, et al., 2011:6).

> *".. like working with people am working with... you have a room to go and share whatever even if it is a personal experience. Their ears are always listening" (*P-1).

> *"Sometimes our senior colleagues really help us, they treat us as family especially during difficult situations at work"* (P-4).

Aucamp (2003:4) confirms that support among colleagues serve as an important aid in managing stress in the workplace.

3.14.4 Rationalisation

Many nurses use rationalisation as a coping mechanism when faced with the stressful situations that are arising from caring for youth victims of violence. They think it is part of the job and, hence, have to accept it without any reason to complain. After all, if they don't do it, who will? At the same time, no matter what situation they find themselves in, providing rationales for the stresses they are exposed has little effect on their emotional wellbeing. They feel they are dealing with the situation without realising that the effects are projected at home on their families and partners.

Rationalisation is a coping mechanism used when one's choices do not bring about desired satisfaction, hence, the need to reduce the psychological state that is created by this discrepancy. In cases where decisions cannot be easily reversed, this discrepancy is reduced by adjusting attitudes to align with decisions (Jarcho, Berkman & Lieberman, 2011:460). Nurses often rationalise; this coping strategy gets used because becoming a nurse requires a large investment that necessitates this method of coping in order to remain content with nursing and its trials and tribulations.

> *"...you know you are a nurse and you have to serve the patient because you have to see the patient"* (P-2).

> *"...it is not nice to work here with this situation but we have to work because am a nurse and I promise to do my work* (laughing) *so I have to do it, have to. I have to tolerate and I have to take this, I have to accept as it is"* (P-4).

71

"...its very bad but we have to tolerate them, just as it is, its not like its really, we have to admit because we said we are going to, we have to care for the patient no matter what. we are here for the patient so we don't have to refuse that" (P- 9).

Rationalisation is also used to justify one's behaviour by and explaining it in a favourable light. Conduct or, more frequently, misconduct gets defended by resorting to "rational, logical, socially-acceptable" explications and excuses and it is also used to re-establish ego-syntonic behaviour (Vaknin, 2007).

3.14.5 Suppression

It is the removal from consciousness of forbidden thoughts and wishes. The removed content does not vanish and it remains as potent as ever, fermenting in one's unconscious. It is responsible for creating inner conflicts and anxiety, and provoking other defence mechanisms to cope with these experiences (Vaknin, 2007). Nurses use suppression as way of coping with the stress they encounter. Nurses are reluctant to talk about their work experiences at home; they attempt to deal with these issues at work the next day. Studies have shown that suppression leads to the development and maintenance of post-traumatic stress disorder (Amstadter & Vernon, 2005:517).

"...no it doesn't affect, because am working long hours, mos [sic] *né. Sometimes I just arrive at home and it has disappeared"* (P-3).

"When you get home and sometimes I don't feel even like talking and you just wanna [sic] *go and sleep"* (P-5).

"Yeah, I try to hide those emotions" (P-9).

3.15 CATEGORY 5: NURSES NEED SUPPORT WHILE THEY ARE CARING FOR YOUTH VICTIMS OF VIOLENCE

3.15.1 Debriefing / Counselling

Nurses expressed their need for support in coping with the challenges they were encountering at work. This support should be readily available to nurses, especially when their experiences are taken into account. Debriefing is defined as a group meeting arranged for the purpose of integrating profound personal experiences on the cognitive, emotional and, group level in order to prevent or mitigate adverse reactions. The aim of debriefing is to explore intense feelings and reactions to a potentially traumatic event with the view of assisting with coping or mitigating these issues (Magyar & Theophilos, 2010:500). The participating nurses did not mention any form of formal debriefing they were offered after exposure to traumatic events. Most of them relied on other colleagues for support when they faced challenging situations or they dealt with it as they saw fit. Introducing or enforcing proper and professional debriefing will make a difference to the coping of nurses.

> *"it is so traumatising to me, I think we need err to be counselled sometimes at least twice a year"* (P-5).

> *"I was very traumatised that day, all of us cried… We were so traumatised"* (P-2).

> *"It affects me but, I do not cry with the situation, but I just err, it becomes stressful"* (P-3).

3.15.2 Appreciation

Appreciation is defined as the acknowledgement of the values and meanings of something, someone, an event and experiencing a feeling of positive emotional involvement with it (Adler & Fagley, 2005 in Fagley, 2012:59).

Nurses provide an invaluable service and there work experiences could never be compared with any other, since theirs' is a life changing and lifesaving profession. It is one of the selfless professions focuses on caring for fellow human beings. Nurses should be applauded

for their treatment of youth victims of violence. However, it rarely happens, since most of the time nurses go unrecognised and unappreciated.

"...The relative is fighting with what you are doing. They swear at you, they shout at you. they don't see what you are doing" (P-5).

"Someone who comes drunk on you and you must help, you just feel frustrated, not appreciating at all" (P-6).

"They shout at us, some of them they make you see as if your work is not appreciated" (P-8).

The attitudes of these youths towards the nurses do not show an iota of appreciation. It is important that nurses are appreciated, since it leads to increased personal affect and life satisfaction (Fagley, 2012:60).

3.16   CONCLUSION

From the analysis, caring for youth victims of violence at a community health centre in Khayelitsha is a challenging and rewarding experience for nurses. The challenges are enormous and most frequently impact on the physical and emotional wellbeing of the nurses. Despite these challenges while caring for youth victims of violence, the nurses are dedicated in their job. They do, however, need support to provide quality care while coping with these challenges encountered by means of motivation and recognition of their work.

CHAPTER 4:
GUIDELINES, CONCLUSIONS, AND RECOMMENDATIONS

4.1   INTRODUCTION

This chapter aims at answering the second research objective which is to develop guidelines with the purpose of supporting nurses who caring for youth victims of violence at a community health centre in Khayelitsha. After having explored and described the experiences of nurses caring for youth victims of violence, guidelines has been developed according to the research themes with the purpose of supporting these nurses. The last part of this chapter also includes an account of the strengths and limitations of the study, as well as recommendations for future study.

The previous chapter has highlighted the challenges that are faced by nurses caring for youth victims of violence, as well as challenges facing these young members of society. All these factors have contributed to the nurses' experiences. Work related stress negatively affects workers and there has been an increased concern about health professionals, especially nurses (Chang, et al., 2006:30). Nurses experience a plethora of emotions when they are caring for these victims and many nurses experience these emotions intensely traumatic. They also employ ineffective coping strategies in an attempt to counteract the consequences of these emotions (Maguire, Morgan & Reiner (Eds.), 1997: 577 – 612). The data analysis of this study necessitates a structured support regime for nurses caring for youth victims of violence. The development of the guidelines in this study attempts to address this issue. Odendaal and Nel (2005:96) define support as giving strength, and encouragement to help the sourcing of material and immaterial aid. The guidelines for nurses caring for youth victims of violence at a community health care centre in Khayelitsha are now explained.

4.2   ADDRESSING THE CHALLENGES OF CARING FOR YOUTH VICTIMS OF VIOLENCE

From the data collected, the nurses expressed lots of challenges they were encountering while caring for youth victims of violence. It is very encouraging to know that nurses did not only view these challenges as concerning them directly, but emphasised that the victims too were facing a lot of challenges in the community. Therefore, it is important that the guidelines

address the challenges faced by the youth of this community, as well as those challenges faced by the nurses.

It is important to acknowledge that the health of a population is also affected by extrinsic factors that are beyond the control of the individuals (Casey, 2006:1040). That is why an understanding of the challenges that are faced by youth of the community is important.

4.2.1 GUIDELINE 1: NURSES SHOULD UNDERSTAND THE CHALLENGES THAT ARE EXPERIENCED BY THE YOUTH OF THIS COMMUNITY

Rationale: Nurses need to understand the challenges faced by youth victims in this community. The youth of this community have numerous challenges that are evident from the narratives. An understanding of these challenges will assist the nurses to understand the people they are dealing with, and once one understands what one is dealing with, one will approach the issue differently which will subsequently bear more successful outcomes. Nurses should also realise that violence in this community cannot be dealt with in isolation. A comprehensive and integrated approach needs to be followed that involve the different sectors and community members to ensure that the negative impact on victims and the nurses is reduced.

4.2.1.1 Understanding the socio-economic challenges of the Khayelitsha community

This community is a previously disadvantaged community. The history of this community exposes it to a higher risk of violence. According to Krug, et al. (2002:1085), there are lots of biological and personal factors that influence how individuals behave and that increase their likelihood of becoming either victims or perpetrators of violence. These factors include demographic characteristics (age, education, income), personality disorders, substance abuse, as well as a history of experiencing, witnessing, or engaging in violent behaviour. Since Khayelitsha is a community that is susceptible to violence, nurses are required to understand the challenges that this community face. Therefore, nurses need to focus on the care and support of the victims and engage the various sectors to assist with addressing these challenges.

- Primary health care should be linked to the communities they are serving (Walley, Lawn, Tinker, Francisco, Chopra, Rudan, Bhutta, Robert & Alma-Ata Working Group, 2008:1002). This means that nurses should be directly or indirectly

connected to the community, since it will facilitate a better understanding of the community they serve: "Not knowing doesn't change anything. It only makes us more vulnerable… the choice we make is influenced by the knowledge we possess" (Christie, 2011).

- Nurses should be knowledgeable about their community. Knowledge is empowering; the more one knows the more powerful one becomes (Christie, 2011). It implies that nurses' understanding of their community provides them with more power to care for the youth victims of violence.

4.2.1.2 Addressing illiteracy in the community

- The major challenge of illiteracy in this community can be overcome by engaging the community.

- Community programmes can be organised by involving the parents. Parents should be educated and informed about the important role education plays in empowering the youth. The more the youth are informed and feel a sense of belonging in the community, the less likely their chances are of getting involved in violence. Wegner, Garcia-Santiago, Nishimura and Hishinuma (2010:791) also mention that community organisations and activities plays a positive role in reducing school dropouts, substance abuse, behavioural problems, and in improving performance at school.

- Community health care workers should be trained to assist nurses in the communities by arranging health promotion activities that aim at transformation of attitudes and behaviour (Walley, et al., 2008:1004).

4.2.1.3 Addressing substance abuse

- Substance abuse by the youth can be controlled by involving the local community. Community engagement programmes can be used to sensitize the community about the effects of alcohol, especially in relation to the youth. Community members need to support the limiting of alcohol consumption by the youth, e.g. the non-sale of alcohol to the youth at certain times and banning unsupervised alcohol consumption by youth. Community leaders need to be elected for conducting routine visits at shebeens and any owner who allows unlawful consumption of alcohol by youths needs to be dealt with accordingly by applying community laws.

- By providing statistics about youth victims of violence that are related to alcohol abuse, nurses can also demand the implementation of legislation that will prevent alcohol consumption by the youth, and they can also promote the control of alcohol purchasing by involving local enforcement authorities (police, community members) to identify, reprimand, and even close shebeens that sell alcohol to unauthorised persons (the youth).

4.2.1.4 Curbing gang violence

- During the interviews, it was mentioned that the taxi driver association used to cooperate with the community to curb gang violence in the area with the result that such violence ceased. When associations like the taxi driver association can also assist to reduce incidence of gang related violence, their efforts will significantly reduce the number of victims who are attended to at the clinic.

- Weekly community forums with members of the public need to be conducted to discuss gang violence in the area and ways of addressing the issue. Members of other communities should be invited to share their ideas about curbing gang violence.

- Peace keeping teams should be elected by the community to engage with the youth in the community with the purpose of addressing issues of gangs and violence.

- Nurses should organise regular events at the community health centre to disseminate information about the effects of violence on the youth and community. They could arrange a violence awareness day in the community where previous victims give an account of the impact of violence in their lives to the rest of the community.

- Primary health care includes community engagement and involving relevant parties with the purpose of realising set community goals Primary health care involves the general integration of the community, inter-sectorial collaboration with the department of education and social services to rehabilitate the youths, as well as the empowerment of the community (Walley, et al., 2008:1001) through job creation.

4.2.1.5 Reducing teenage pregnancy

- School-based contraception programmes should be implemented with the view of encouraging the youth to prevent teenage pregnancy by providing them with properly informed choices. Programmes that are aimed at reducing the rate of teen pregnancy need to include a myriad of approaches; encouraging abstinence, providing education about birth control, promoting community service activities, and teaching skills to cope with peer pressure (Bennett & Assefi, 2005:72).

- Despite the shame and stigma that are attached to rape, parents and their children should be encourage to report cases of rape, to seek emergency medical care, and to prevent unwanted pregnancies due to rape. Early screening should be encouraged and emergency contraception should be readily available.

- Studies also show that failure of the youth to use contraception, especially teenagers, is largely caused by parental influence (or lack thereof), and the attitude of nurses at community health centres (Wood & Jewkes, 2006:111). These causes should be interrogated and teenagers should be encouraged to make use of the services available to them. The youth should be empowered to make informed decisions about preferred methods of contraception.

- Parents should also play an active role in the sexual education of their children. Parents also need to be educated about the use of contraception methods. The more the community is involved, the better the chances of success. Nurses also need to be readily available to provide more information to the youth about the available methods of contraception, their side effects, and how to manage those side effects (Woods & Jewkes, 2006:115).

4.2.2   GUIDELINE 2: ADDRESSING THE CHALLENGES THAT NURSES ARE FACING

Rationale: The challenges that are faced by nurses caring for youth victims of violence need to be addressed in order for the nurses to provide appropriate care to these victims. Nurses cannot provide their services effectively without adequate preparation and human resources? Therefore, assisting nurses in meeting these challenges will improve the outcomes of the services provided by nurses to the youth victims of violence**.**

4.2.2.1 Addressing staff shortage

- Staff shortages are a universal burden and there is no quick fix to this problem. Nurses should acknowledge this reality by working effectively as a team to minimise the effects of staff shortages. Nurses should also acknowledge the boundaries of their own capabilities. No nurse needs to feel guilty while caring for youth victims as long as everyone supplies such care to the best of their ability. Staff should at all times apply their skills and abilities fully to achieve inner job satisfaction.

- Management should motivate the appointment of permanent nurses. Recognition of the need to train and retain competent staff members also leads to more effective implementation of primary health care services (Walley, 2008:1001) and human resource management is crucial for high-quality care (Hassan-Bitar & Narrainen, 2009:154). The fact remains, adding more nurses to the health system results in more people live longer, irrespective of whether the nursing work is preventative or curative (Renfrew, unpublished) (Opportunities should be created for the auxiliary and staff nurses who have been working at the facility for more than five years to upgrade to professional nurses with the purpose of meeting the workload demands of the professional nurses. This will also help to reduce the stress and burnout of nurses, since they will be equipped to manage the work environment. Professional nurses should also be afforded the opportunity to attend post-basic education in trauma and victim management.

- The study results also necessitate the integration of nursing staff. While most of the staff members in the community are of an isiXhosa background, non-isiXhosa speaking nurses could also be deployed during community service deployment. The staffing issue can further be addressed by deploying nurses with different cultural backgrounds at the same health facility. Since nursing uses one language of caring for patients, the workforce can easily be increased by deploying nurses from different cultures to work in this centre. Nurses should embrace one another and create a common platform of cooperation to reduce the burden of every nurse.

4.2.2.2 Reducing the problem of under-preparedness

- Once a part of the team, every nurse should be able to support any new staff member to become fully productive in the shortest possible time. In-service training is particularly important to empower nurses. This will build confidence that results in

better performance. Each newly appointed staff member should work under the direct supervision of an experienced staff member. Since the one nurse acts as a mentor, the morale and confidence of the inexperienced nurse is developed quickly and effectively.

- It is also important to adjust the curriculum with the purpose of addressing future expectations of nurses, who are going to care for victims of violence, while they are still at the training facility. Nurses caring for youth victims of violence need to be better orientated about ways of identifying and handling stress by attending self-help workshops and training interventions from time to time (Jonsson & Halabi, 2006:95).

- Caring for youth victims also involves emotional stress, hence, appropriate training should be provided to nurses about topics related to emotional wellbeing, since formal and informal training provide practical advice for coping with stress (French et al., 2011). Muller (2005:141) confirms that nurses should receive the necessary training to ensure competent performance.

4.2.3 GUIDELINE 3: NURSES SHOULD FOCUS ON CARING FOR YOUTH VICTIMS AS AN EMPOWERING AND REWARDING EXPERIENCE

Rationale: Nurses should focus on the bright side of their job by identifying the empowering and rewarding aspects of their work. It should be considered as an opportunity to gain more experience while they are caring for youth victims who are involved in different kinds of violence. In general, nursing is a career that offers job security, mobility, and career variety (Mooney, Glacken & O'Brien 2007:385).

4.2.3.1 Nurses should know that caring for youth victims of violence is a special duty

- Nurses caring for youth victims of violence do not only attend to physical injuries but most often there are emotional and psychological factors involved. Therefore, working in such a complex and challenging situation requires professional development and personal growth. Working in a multi-skilled setting provides an opportunity for learning additional clinical skills, professional development, broadening one's scope of practice, and improving efficiency by coordinating clinical services (French, et al., 2011:5).

- Nurses should regard the experience as a possibility of broadening their scope of practice. According to French, et al. (2005), working in such an environment also prepares the nurse for the possibility of specialty when pursuing further studies.

4.2.3.2 Alleviating fear by creating policies and procedures that protect nurses

- Clear guidelines should be available to nurses who are working at a community health centre to protect nurses from any advances they consider as threatening to their wellbeing, e.g. the national health system that regards any incident of a patient, service user, or member of the public makes any unnecessary, unwarranted, or uninvited physical contact as an intentional act of assault even when they are under the influence of alcohol (Hampton, 2007:539).

- An established reporting system supports the protection of nurses, and alleviates fear that is associated with victims of violence, escorts, or family members.

- Abusive relatives should be asked to leave the premises and when they refuse to do so, the police should be called.

4.2.3.3 Ensuring nurses are motivated while they are caring for youth victim of violence

- Nurses should stand together and learn to address their concerns when they arise in order to provide positive motivation and to create a willingness to continue working in the unit.

- Regular meetings should be organised by nursing unit management to discuss possibilities of career advancement and to provide feedback. Creating positive motivation is the responsibility of management to ensure that nurses feel valued and experience a sense of belonging.

- Demotivation that results from a lack of feedback to nurses should be minimised by the nursing management who take responsibility for following up investigated cases and giving feedback to the nurses. Responsible management provides the nurses with peace of mind.

- A trusting relationship should be developed between the nurses and management and management should pay attention to nurses' concerns and try to address these concerns as soon as possible to eliminate feelings of mistrust.

4.2.4   GUIDELINE 4: NURSES SHOULD EMPLOY POSITIVE COPING MECHANISMS WHILE THEY ARE CARING FOR YOUTH VICTIMS OF VIOLENCE

Rationale: The use of positive coping mechanisms will enhance emotional and physical wellbeing of nurses. Positive emotions support good health, contribute to physical and emotional wellbeing, and make effective coping possible (Tugade, Frederickson & Barrett 2004:1161). The use of positive coping strategies help individuals emerge from crises with additional coping skills, closer relationships, and a richer appreciation of life (Tugade et al., 2004:1165).

4.2.4.1 Debriefing and counselling

- It is very necessary for nurses to have debriefing sessions after every stressful or traumatising situation and also to deal with those emotions that arise during the caring for youth victims of violence. Debriefing meets the needs of those people, like the nurses caring for youth victims of violence, who are not directly affected (Raphael, Meldrum & McFarlane, 1996:65).

- It is also important that staff members are supported timely and comprehensively when a crisis arises as well as a 24-hour service for nurses. The sooner an intervention occurs, the better the outcomes for the nurses.

- Nurses should not resort to speaking only to families and colleagues but also to professionals. It is common practice for nurses to look after other people while neglecting their own health. Nurses should remember that if one does not take care of oneself, it will be difficult to efficiently take care of any other person.

- Psychological guidance and counselling are important to nurses after they have been exposed to traumatic events (Adriaenssens, et al., 2012:1420), hence, management should assume the responsibility of ensuring that the nurses have access to these services. It is also important for management to understand their staff members individually and high risk individuals should be identified for follow-up purposes.

- It is necessary to create a favourable environment where nurses can talk about stressful experiences and gain perspective in order to function effectively in the workplace at all times. Peer support and open communication channels support such an environment.

- An internal employee assistance programme should be established for debriefing personnel after a traumatic incident. It is important that it is an internal programme, since research shows that external programmes might have limited value to the employees (Magyar & Theophilos, 2010:503).

- Discussions and professional debriefing methods should be taught to student nurses during induction and regularly thereafter during their academic programme to prepare them for the future challenges.

4.2.4.2 Support structure

- Having a strong supportive network and being able to talk to colleagues have been found to help with the strong emotions that are experienced (Adriaenssens, et al., 2012:1413).

- Reliable professional relationships are necessary due to the daily stressors that nurses are exposed to at work. Once a great team cooperates, they are able to rely on one another.

- Provision of a multidisciplinary forum where nurses are able to discuss difficult emotional and social issues that arise while caring for youth victims of violence should be encouraged.

- Nurses should endeavour to create a work-life balance. Create opportunities for de-stressing by means of team building programmes and having confidence in one's own abilities.

4.3   REFLECTION ON THE STUDY

This study aimed at exploring and describing the experiences of nurses caring for youth victims of violence and describing guidelines to support the nurses caring for these youths. The sample of this study was nine nurses who were working at a community health centre in Khayelitsha. This study was highly contextual and represented the views of the nursing who were working at this facility. It does not depict the view of all nurses caring for youth victims of violence at every community health centre in the Cape Town Metropolitan area. Cape Town is a very diverse region in terms of ethnic distribution, socio-economic conditions; hence, the results of similarly studies conducted at different suburbs will yield different results. However, some guidelines can be applied to a larger group, since some of the challenges that nurses face are generic, e.g. staff shortages.

4.3.1 Strengths

This study explored and described the experiences of nurses who were caring for youth victims of violence and described guidelines to support nurses who were caring for these youths. This was done by using unstructured, in-depth one-on-one interviews. This study showed the challenges faced by nurses who were caring for youth victims of violence and illnesses that were plaguing this community which further increased the burden of violence in this area. The emotional and psychological wellbeing and the consequent health implications of these nurses also surfaced in this research. The researcher expects that this study will facilitate further research about the experiences of nurses caring for our youth in the community and that those nurses in positions of authority will consider the suggestions of this study with the purpose of enhancing and empowering nurses caring for youth victims of violence while taking the current challenges into consideration.

4.3.2 Limitations of the study

This research was conducted at a community health centre in Khayelitsha, where most of the nurses working there speak predominantly isiXhosa with English as a second language. The researcher is a non isiXhosa speaking person hence communication with some participants was slightly strained, since they found it challenging to fully express themselves in English which is their second language. Many studies have been carried out about experiences of nurses caring for terminally ill people, cancer patients, and a host of other conditions. However, this is a fairly new study topic with very little published material about nurses caring for youth victims of violence and, therefore, not enough information exists for the purpose of comparing findings.

4.4 RECOMMENDATIONS

- Nursing practice is a well-established profession and it is important that nurses are treated well in order to provide quality care to their patients, including the youth victims of violence. Nurses should strive to understand the community they are working in by engaging with the community at all levels possible to make practice easier and less of a burden. Integration of personnel is vital and personal and professional growth should be enhanced in practice. Proper in-service training is needed for newly appointed staff members for preparing them for the challenges and expectations.

- Further research should be carried in this area, given that there is another facility in this area that provides a similar service to compare findings and strengthen research work in this field.

- The researcher suggests that with a nurse researcher with an isiXhosa background will be of great value to explore any unexplored feelings that could not be expressed as a result of language barriers, especially the emotive responses of caring for youth victims of violence. Researchers in mixed suburbs and non-isiXhosa areas like the southern suburbs of Cape Town will greatly contribute and provide a broader context of the nurses' experiences caring for youth victims of violence. This is the first study and should pave the way for more in the Western Cape and beyond.

- Nursing education should also prepare students for community health and how it differs from treatment at tertiary institutions. The expectations and impacts on health at community health centres are unique to the community it serves. Education should not focus on the ill only but also the emotional and psychological burdens of patients that impact the nurses and, hence, equip them with vital coping strategies.

4.5   CONCLUSION

This study explored and described the experiences of nurses who were caring for youth victims of violence at a community health centre in Khayelitsha. The purpose was to develop guidelines to support these nurses and to prepare future nurses who plan to work in the communities. There were many challenges as outlined by the nurses. It also emphasised the emotional and psychological impacts on the lives of the nurses. Despite the plethora of challenges nurses were experiencing while caring for youth victims of violence, they also found their care as rewarding. Nurses needed support to carry out their duties and to improve the outcomes of their care.

The researcher hopes that the guidelines developed will be interrogated by the different parties involved with the view of improving the physical, moral, and psychological wellbeing of these nurses. Their wellbeing will improve the health outcomes of the youth in their care and invariably will benefit the general health of the community and the nation.

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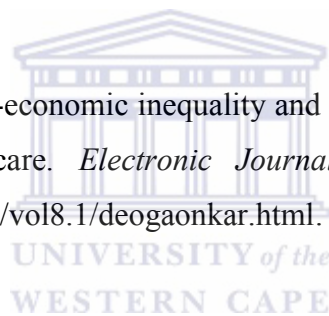
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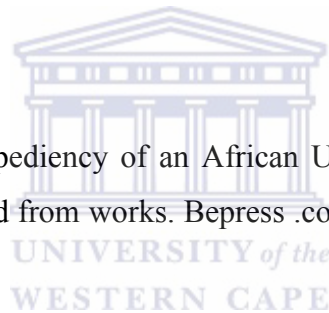
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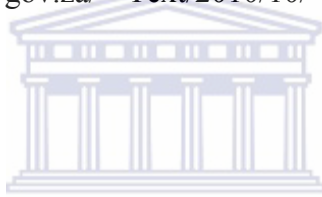
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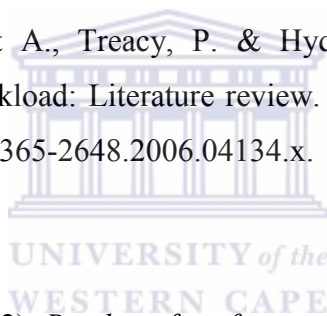
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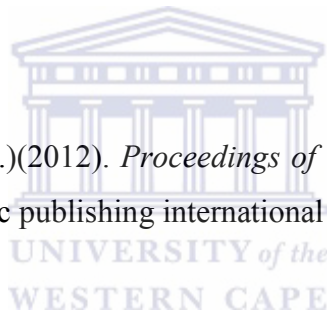
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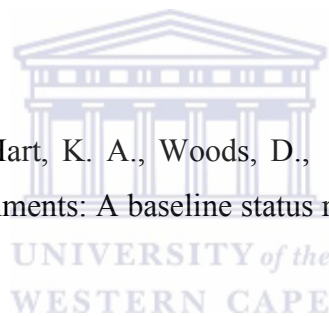
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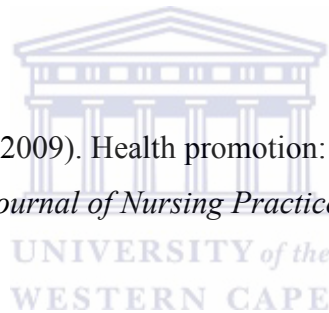
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UNIVERSITY *of the*
WESTERN CAPE

ANNEXURE A: LETTER OF APPROVAL FROM THE UNIVERSITY

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

UNIVERSITY *of the*
WESTERN CAPE

13 June 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Ms H Ekole-Chabanga (School of Nursing)

Research Project: Experiences of nurses caring for youth victims of violence at a community health centre in Khayelistha.

Registration no: 12/5/17

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

A place of quality,
a place to grow, from hope
to action through knowledge

ANNEXURE B: LETTER OF APPROVAL FROM THE DEPARTMENT OF HEALTH

Western Cape Government

Health

STRATEGY & HEALTH SUPPORT
healthres@pgwc.gov.za
tel. +27 21 483 9907; fax. +27 21 483 9075
14 Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8000
www.capegateway.gov.za

REFERENCE: RP 87/2012
ENQUIRIES: Dr Sikhumbuzo Mabunda

39 Bremer Hof
Couch Crescent
Oostersee, Parow
Cape Town

For attention: Ha Ekole-Chobenga
Prof. Karien Jooste

Re: Experiences of nurses caring for youth victims of violence at a Community Health Centre in Khayelitsha.

Thank you for submitting your proposal to undertake the above mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact the following people to assist you with any further enquiries.

SITE B Community Health Centre   Ms Nolsho   (021) 361 4835

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (heo_hres@pgwc.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR NT Maledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 23/08/2012

CC   DR G PEREZ   **ACTING DIRECTOR: KLIPFONTEIN/MITCHELLS PLAIN**

Page 1 of 1

LARGE CAPS: UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail:haribabes@gmail.com/ 2649882@uwc.ac.za

Information sheet

To: Participant

Project title: Experiences of Nurses Caring for Traumatized Youth Victims of Violence at a Community Health Centre in Khayelitsha

What is the study about?

This is a research project conducted by Harrite Ekole-Chabanga, a master's student at the University of the Western Cape. We are inviting you to participate in this research because you will be given the opportunity to describe your experiences with traumatized youth victims of violence. The purpose of this study is to explore and describe nurse's experiences with traumatized youth victims of violence.

What will I be asked if I agree to participate in the study?

You will be asked to share your experiences supporting traumatized youth victims of violence. The researcher will schedule an interview with you in a private and quiet room within the hospital. The one on one interview will be conducted with you by the researcher and it will take not more than an hour. The interviews will be audio-taped with a digital

recording device and field notes will also be taken so that the researcher can go back and verify what you will share. You will be asked open ended questions regarding your experiences in supporting traumatized youth victims of violence. This will be followed by further questions depending on the answers that you give? There will be no right or wrong answer.

Would my participation in the study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, the audio-taped interviews will be stored in a compact disc which will be stored in a locked and safe cabinet where no one will be able to access it except the researcher. Your name will not be mentioned or identified in the report. Identification codes will be used instead of names. e.g. participate 1 or participant A. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no risks involved in this study. However, there researcher understands that during the course of the interview, you may recall experiences that may have disturbed you while working with traumatized youths. But should this be the case, you will be referred to the appropriate counseling services.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the researcher to learn more about your experiences of supporting youth victims of violence. We hope that, in future, other people might benefit from this study through improved understanding of your experiences caring for traumatized youth victims and what may be done to improve the situation.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may not take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose anything.

Is any assistance available if I am negatively affected by participating in this study?

Yes. If are negatively affected through participating in this research, you will be referred to the counseling services via the Occupational Health and Safety officer.

What if I have questions?

This research is being conducted by Ms. Harrite Ekole-Chabanga from the School of Nursing (SoN) at the University of the Western Cape. If you have any questions about the research study itself, please contact her at: 073 749 3069

Address: No 79, Parow East,7500

Email: haribabes@gmail.com or 2649882@uwc.ac.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
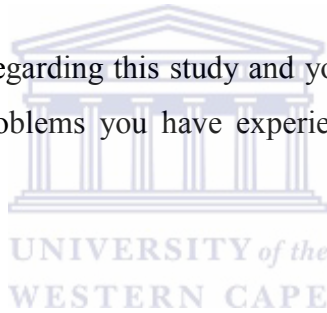
University of the Western Cape:

Dean of the Faculty of Community and Health Sciences:

Prof. Jose Frantz

021 959 2746

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Head of Department

Prof Karien Jooste

021 959 2274

Email: kjooste@uwc.ac.za

Private Bag X 17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee

APPENDIX D: CONSENT FORM

University of the Western Cape

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail: haribabes@gmail.com/2649882@uwc.ac.za

Consent form

I ………………………………………………………………………………….hereby give my permission to participate in the research project stated above. I have read and understood the information sheet and I am fully aware of the nature of the study. I understand that my participation in the proposed study is voluntary and I that I can withdraw from the study anytime I wish. I understand that all the information that I will share will be kept confidential and anonymous. I agree to be interviewed during the research process and that the interviews will be audio-taped and kept in a safe place where no one will be able to access them except the researcher.

…….I further agree to be give permission to be audio-taped during my participation in the study

…….I do not agree to be audio-taped during my participation in the study.

I further understand that there are no compensations that I will receive from participating in the study and I am participating out of my free will and I was not forced to participate.

Participant's Signature…………………………………………………………………..

Date……………………………………………………………………………………..

Place……………………………………………………………………………………

Witness 1…………………………………………………………..

Witness 2…………………………………………………………..

APPENDIX E: INTERVIEW QUESTIONS

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959, Fax: 27 21-959

E-mail: haribabes@gmail.com/2649882@uwc.ac.za

Interview questions

1   Would you please describe your experiences on caring for traumatized youth victims of violence?

2.   Is there anything else that you would like to share with regard to your experiences in caring for traumatized youth victims of violence?

The researcher will use the following for the purpose of probing:

3.   What do you mean by?

4.   In what ways?

5.   Anything else?