HEALTH CARE RESPONSES AT RETREAT COMMUNITY HEALTH CENTRE TO CASES OF DOMESTIC VIOLENCE

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ABSTRACT

Abused women are confronted with many issues when seeking medical advice and when living in abusive relationships. The aim of this study was to ascertain how health care givers respond to and provide treatment to cases of domestic violence. Furthermore, I also looked at how abused women experiences intimate abuse and how they experience the health care services provided to them. Qualitative methodology was utilized with the focus on in depth interviews and participant observation. In depth interviews were conducted with ten abused women and seven health care givers at Retreat Community Health Centre and Steenberg police station.

The study showed that abused women, as well as health care givers, perceive domestic violence as a private matter. Dealing with domestic violence in health care facilities is made more complex by the fact that it needs to be treated, while also staying confidential and a potential intrusion on the privacy of the women who seek help. Despite all the state and public discussions on domestic violence as a health problem, it was in actuality still regarded as falling in the private and the social sphere. The study also indicates that to enable them to deal with constant violence, abused women develop various coping strategies. Women staff learned to cope with community violence, often by behaving in what is normally considered to be masculine ways, by 'performing' a toughness they felt might protect them. Abused women on the other hand use protection orders against their abusive partners.

DECLARATION

The author declares that this thesis, unless specifically indicated to the contrary in the text, is her own work.

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Jeanine Heili Mathison

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CHAPTER ONE
INTRODUCTION AND BACKGROUND

1. Introduction

The study of the abuse of women is currently an area of increasing research. Anthropologists in South Africa, for example, (Becker 2001; Campbell 1996; Glanz and Spiegel 1996; Gibson, et al 2002; Salo 2000) have begun to pay more attention to family and gender violence. Domestic violence against women nevertheless remains a ubiquitous problem in South Africa with the position of women and men historically structured around male possession and control over females (Simpson, 1993).

A study of 83 women in the Western Cape found that 12 percent of the women experienced sexual assault at the hands of their male partners (Maconachie, Angless and Van Zyl, 1994). About 44 percent of males admitted abusing their female partners in a study of 1394 men working in three Cape Town municipalities. A survey of a selected group of women in Cape Town indicated that 43% of the women interviewed had experienced battery and marital rape (Vetten, 2000:51). A study of women attending a community health centre in the city had similar findings. A further study by Marais (1998) in South Africa found that 21.5% of female adult patients visiting their general practitioner reported a history of domestic violence.

Quantitative studies make the extent and urgency of dealing with gender violence clear. However, understanding the dynamics of domestic violence calls for more in-depth studies, which cannot be done through quantitative research (Babbie and Mouton, 2001). Therefore, a qualitative (in depth) study was appropriate to gain insight into women's experiences of domestic violence, their experiences of the health care services, as well as how health caregivers respond and provide treatment to abused women.

This study is an assessment of institutional responses to cases of domestic violence and in particular the health care responses. It examines how health caregivers respond and provide treatment to cases of domestic violence. Furthermore, the research provides an understanding of how abused women experience the services provided to them by health caregivers. In addition it provides further insights into how abused women experience domestic violence and how they cope in abusive relationships.

My own need to conduct the research arose out of my deep concern for the high incidence of violence against women in Lavender Hill and Vrygrond, which are areas I know particularly well. In particular, this concern stems from the high occurrence of gang violence and abuse against women that is currently affecting the community. By focusing on the responses of health caregivers to cases of domestic violence, women's experiences of the services provided to them and the abused women's own experience of domestic violence, I hoped to gain a better understanding of how our society could control and deal with domestic violence. Thus the study aimed to contribute to a greater understanding of the occurrence of domestic violence against women in the greater Retreat area. The research took account of the multiple interpretations of domestic violence by women.

Baer *et al.* (1997:28) stress that historical events, such as the legacy of apartheid, contribute to health and social problems, disease and suffering. At the same time, political and economic forces contribute to the development and persistence of a particular health problem, such as violence against women. The area where the two target locations are situated, the Cape Flats, was in a sense 'created' by virtue of the Group Areas Act of 1950. During the 1960's and 1970's it increasingly became the 'dumping grounds' of black and, specifically, 'coloured' people (Jensen, 1999:76).

In this area, state and personal violence was commonly used to resolve problems and conflicts, and these forms of violence in turn led to a rise in violence against women, children and the elderly (Motsei *et al.* 1993). This has also been the pattern in Lavender Hill and Vrygrond, which are served by the Retreat Community Health Centre.

The interviews conducted with the female respondents in this study revealed that women constitute the true workforce of these areas. Even when they have no official job, they do odd jobs such as managing households, looking after children, and are involved in all kinds of projects in the community. In contrast, the men have not learned to carry out any significant activities when they are unemployed. It seems that women are trying by all means to build the community, while the men, especially in poorer areas with a high rate of male unemployment, are breaking it down through violence and other related activities. This situation also contributes to violence in as well as outside the household.

In the area where I did my research, violence has become entrenched in the local worlds and worldviews of men and women. Efforts to deal with domestic violence are being complicated by the increasing perception that the health care system should somehow address it, thereby making it a medical problem rather than a societal one. At the same time shortcomings in the health care system itself makes this task very difficult. This study further reveals that health caregivers are resisting efforts by the state to make domestic violence a medical issue. This is in contrast to trends in Brazil among people of the Alto do Cruzeiro where a variety of societal 'problems' like hunger, violence and suffering have been medicalized (Scheper-Hughes 1992).

The study also reveals that abused women, as well as health care givers, perceive domestic violence as a private matter. Dealing with domestic violence in the health care facilities is made more problematic by the fact that it needs to be treated.

At the same time, the treatment needs to remain confidential and avoid being a potential intrusion on the privacy of the women who seek help. The study also shows that abused women develop various coping strategies to enable them to deal with constant violence. For the purposes of the study, in-depth interviews were conducted with 7 health caregivers and 10 women who have been abused by their intimate partners. The validity and reliability of the interviews were supported by taped-recorded versions, and verbatim transcriptions by the researcher.

Because women from Lavender Hill and Vrygrond use Steenberg Police Station and Retreat Community Health Centre when they seek assistance, I focused on these sites to find abused women who would be willing to take part in the study.

1.2 The Structure of the thesis

Following the introduction and background provided in Chapter One, the thesis has the following structure:

Chapter Two provides a literature survey on domestic violence and summarises the main points that arise from the literature.

Chapter Three outlines the methodological approaches employed in the study, the interpretation of the data as well as the ethical considerations.

Chapter Four provides an analysis of the results in terms of the demographic information of the health caregivers, their interpretation of domestic violence, as well as their responses to, and treatment of, abused women.

Chapter Five also analyses the results, but in terms of the demographic information of the abused women, how they interpret domestic violence, their experience of the health care services and lastly their experiences of domestic violence.

Chapter Six summarises the findings drawn from this study, and draws a number of conclusions from these findings.

CHAPTER TWO
LITERATURE REWIEW

2.1 Introduction

Male violence against women has been a feature of society since time began. However, the manner in which the violence has been perceived, has differed with changes in societal norms over the years. Under patriarchal marital systems and laws in South Africa, the male's position as the household authority and the woman's as the property of either her father or husband was sustained as correct and normal (Simpson, 1993). Although women were battered by their husbands in the past, their calls for assistance were ignored or minimised, and labelled as domestic disputes. These cases were rarely treated as criminal and the efforts of the authorities were directed at the protection and privacy of the family. It was largely in response to pressure from feminist movements that legislative changes were made which aimed to protect women from domestic violence. In South Africa the Domestic Violence Act of 1998 was passed to protect women in married and cohabitating relationships from domestic violence. The current state also politicised domestic violence and extended the responsibility for dealing with it to the legal and health domain. This strategy does not really address the inequalities in society, for example the lack of work, poverty and community violence.

2.2 Defining the abuse of women

The abuse of women seems difficult to define as it covers a variety of actions and substantially skewed components. Women may define themselves as abused at different stages during an abusive relationship (Maconachie, Angless and Van Zyl, 1993).

According to Maconachie *et al.* (1993) studies on violence against women indicate that it occurs along a continuum that ranges from hitting or slapping to femicide. Motsei (1993) defines the abuse of women as any repeated acts of physical or psychological force or reported threats thereof, used against a woman by her partner.

The Domestic Violence Act of 1998 defines domestic violence as including physical abuse, sexual abuse, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, entry into the home without the complainant's permission, and any other abusive and controlling behavior. However, it can also refer to violence against children, elderly people, and people involved in a same sex relationship (Vetten, 2000).

2.3 Factors contributing to violence

As already noted in Chapter One, the Cape Flats was in a sense 'created' by virtue of the Group Areas Act of 1950 as a 'dumping ground' for Black and especially Coloured people. This historical legacy of South Africa has increased the prevalence of poverty, ill health, social suffering and to some extent has played a contributing factor in the escalation of violence.

Domestic violence has various causes including biological, individual, psychological influences as well as societal norms and values that guide how people should behave towards one another. Historical circumstances also play a role (Vetten, 2000). In order to understand domestic violence, one has to take into account South Africa's colonial and apartheid history as well as the recent transition to democratic government (Vetten, 2000). Segal (1998) and Labe (1990) surmise that the cruelty of the previous apartheid system has serious implications for the social conditions of South Africa's disadvantaged people. It has added to poverty, ill health, hardship and divided families - all conditions under which violence can increase.

According to Kelly (1988), there is an increasing affirmation, internationally as well as in South Africa, of the fact that poor people bear most of the impact of violence in society.

This does not inevitably mean that increased levels of violence and crime in communities are always the result of high levels of poverty. Mercy *et al.* (1993) argue that many factors affect high levels of community violence. These include over-crowding, family disruption, weak social structures, high population concentrations, population transience and social norms that encourage the use of violence to cope with difficulties. While there is a correlation between poverty and violence, domestic abuse has multiple causal factors in South African society, which extend beyond mere statistical relationships. The various manifestations of violence against women in South Africa have been influenced by social, cultural and political history and by racial, class and gender divisions (Vetten, 2000). It is argued that within an oppressive patriarchal system like *apartheid* South Africa, women, especially black women, had the least power and were the most oppressed and exploited.

2.4 Patriarchy and domestic violence

Over time men, as a group, have occupied a higher status of power prestige and credibility than women as a group. Women and girls resultantly learn that they are less powerful, prestigious and credible (Lorber, 1997). In South Africa, the fact that the occurrence and acceptance of violence have been supported culturally by patriarchal structures and ideologies, legal condonation and the rejection of interference in family matters from outside agencies, made violence a very complex issue (Gamache, 1991). As a result, women became trapped in violent relationships by policies, practices within religion, social, political and legal institutions (Gamache, 1991).

Changes in relationships between men and women were further influenced by migration patterns; the breakdown of traditional family structures, urbanization or modernization, which some men found extremely threatening. Therefore they responded to these threats to their gender identity and power with violence (Kelly, 1998).

While women still suffer from inequalities borne out of patriarchal norms and practices, there have been some recent changes. The upsets in conventional gender norms can result in violence as some men attempt to hold on to their male identities and to their power (Vetten, 2000). The situation is exacerbated by inadequacies in the criminal justice system, because it heightens the impression of an environment where gender violence has relatively few consequences. Gender violence is often typically treated as much less serious than other crimes, and therefore accompanied by symptoms such as low criminal conviction rates, evasion of arrest, open harassment and intimidation of the victim, lack of witness protection services and lenient sentences where convictions are procured (Gibson *et al.* 2002).

2.5 Anthropological studies on domestic violence against women

Cross-cultural anthropological and ethnographic studies of violence against women, such as that of Levinson (1989), and the review of 14 cultural groupings by Counts, Brown and Campbell (1992), identify the role of social and cultural mores, including those around gender relations, in the acceptance and promotion of violence against women. Counts *et al.* (1992) have found that the occurrence and brutality of wife beating varies from very frequent to almost non-existent, although the physical punishment of wives is accepted and even seen as necessary in most societies. Counts *et al.* (*ibid.*) report that the following elements are linked with low levels of violence against women: the existence of 'sanctions' against violent behavior or 'sanctuary' for women experiencing violence, for example the family and community being able to intervene in marital disputes or

violence.

Cultures with a 'macho' concept of masculinity coupled with dominance, toughness or male honor were found to have generally higher levels of violence against women (Campbell, 1985). The socialization of boys and girls often mirror related cultural norms and values that add to male dominance. For example, a study that was done among the San people in Namibia shows that the division of labour becomes fixed between boys and girls because of the different ways in which they are socialized (Becker, 2001).

According to this study, women used to take part in public decision-making on an equivalent basis with men. Becker states that the participation in military culture brought a change in male hierarchies among the San people of Schmidtsdrift in Namibia, which resulted in a division of labour. The gendered nature of lives on farms also contributed to gender violence because women became dependent on men (Becker, *ibid.*). The study also indicates that men gain increased power and influence with access and control over resources and the domestic sphere. According to Gibson *et al.* (2002) it is often assumed that as a result of the institutional occurrence of violence, many men experience a sense of powerlessness and perceived emasculation. The high prevalence of domestic and sexual violence are attributed at least in part to displacement of aggression, taking the form of assertions of power over the weaker (Gibson et al. 2002).

The anthropologist Peggy Reeves-Sandy (1989) identifies construction of a tough violent masculinity as one key component in creating a 'rape-prone' society. Large numbers of South African men have learned to be more aggressive and get their own way by force if necessary. This is often a result of men's experiences in arenas of tough violent masculinity such as the South African Defense Force, the Police, the army of the ANC to mention only a few (Vetten, 2000). Innermost to this process of being made a man are the exclusion of femininity and the promotion of a tough, aggressive, brutal, and competitive masculinity (Cock, 1991:56).

Men are believed to be physically and emotionally strong, to take risks and to have frequent sexual intercourse, often with more than one partner.

Studies on masculinity show that in every society, the conduct of men and women is determined at least in part by widely held beliefs on both sides as to how both men and women should behave (Morrell, 1998). According to anthropologists such as Cornwall and Lindisfarne (1994), and Becker (2001), genders are fluid and multiple identities. Fluidity means that gender differences such as femininities and masculinities are frequently created, altered and challenged in everyday interactions.

The manner in which men act differs from context to context. However, these actions are not spaces of open debates between equals. Unequal relations of power are crucial parts of male interactions. According to Morrell (1998:608) masculinities are often bound together by their domination of women, but he also cautions that a sole focus on male-female domination makes it difficult to understand important differences between masculinities. Ideas of being male and female differ according to cultural settings, which can include differences in language or historical background, class and so forth, as well as masculinities that are seen as normal in terms of how men should behave. There may also be opposing forms of masculinity within the same society or cultural setting (Back, 1994:175).

2.6 Gender and Social practices

Gender is embedded in the major social organization of society, such as the economy, the family, politics, the medical and legal systems, and it has a major impact on how the women and men of different social groups are treated in all sectors of life, including health and illness (Lorber, 1997). Gender is thus one of the most significant factors in the transformation of physical bodies into social bodies. For instance, beating a woman fits the ideal of masculinity while women have to be submissive to fit with the feminine ideal.

According to Shilling (1993:112) embodiment can serve to justify and legitimise the original social categories and the ways in which women are oppressed as the weaker sex. However, bodies can sometimes change in ways that support the validity of original images and practices, although these changes are not usually programmed from birth but are contingent on social practices. For example women may develop a taste for sport after their teenage years (Shilling, 1993).

One of the separations between public and private spheres has been that of economic separation (Fineman and Mykitiuk, 1994). Women generally earn less than men and experience higher rates of unemployment (Budlender, 1997). As a result, men frequently control how the household money is spent as well as who spends it, and men usually own the house in which the family lives. It is precisely this male control of wealth and property that emerges as a major correlate of wife beating from a cross-cultural survey of wife beating in 90 societies (Levinson, 1989). Smith (1989) explicitly points out that the 'taken for granted assumption' about marriage and the role of the family shape the way in which the roles of women are defined and the way in which domestic violence is perceived. Therefore, violence is just one of a variety of controls that men try to exercise over female partners. Other forms of control are anger and psychological abuse, economic, sexual control and religion (Dobash and Dobash, 1997).

Poor women who experience domestic violence at the hands of their partners often face the added pressure that they cannot leave the relationship not only owing to their economic dependence but also to what is called the have-hold discourse, the desire of heterosexual women to attract and keep heterosexual men (Hollway, 1984; Mama, 1996). Though dependence does not only include economic benefits, women are often dependent on their intimate partners for shelter (Bowker, 1983).

Despite the belief of spousal equality in contemporary marriage, feminists claim that marriage still institutionalises the control of wives by husbands through the structure of husband-wife roles. As long as women are responsible for domestic work, child rearing and emotional and psychological support, and men's primary identity is that of provider and revolves around work, the husband has the more important status and also controls the majority of issues and decisions in the family.

However, failure to live up to these expectations can also result in violence and control. It is through such a system, coupled with the acceptance of physical force as a means of control, that in the words of the Dobashes (1992), the wife becomes an "appropriate victim" of physical and psychological abuse. Feminists challenge the dominant views of battered women as helpless victims by proposing that battered women be seen as survivors of violent experiences, who have many adaptive capacities and strengths (Yllo and Bogard, 1988). This critique provides an important contribution in the present study exploring women's strengths and coping strategies when they are involved in abusive relationships.

2.7 Feminist theories on the abuse of women

Feminist theories uphold that the difficulty with violent relationships is not the violence *per se* but that the batterer uses violent behavior to gain and maintain dominance and to demonstrate power (Harway et al. 1993). Men control women structurally and systematically within a cultural setting, which is designed to meet the needs and the benefits of men (Kirkwood, 1993). According to Maconachie (1994), violence directed towards women is premised on the understanding that it happens to women because they are women and because of the unequal power relations between men and women. Such acts are described as 'gender violence'.

Feminists assert that, in order to understand abuse against women, it is important to take into consideration the dimensions of race and class (Mama, 1996). Furthermore feminists and other scholars have identified unequal gender relations as a cornerstone of domestic violence against women (Yllo and Bogard, 1988).

2.8 The Private and Public notions in understanding domestic violence

The above approach explains the position of men and women in society. Historically, the binary oppositions of "private" and "public" have been seen as significant components for understanding gender as well as why society regards issues such as domestic violence as private issues. Women's work revolves around the domestic sphere of child rearing while men dominate the public spaces (Fineman and Mykitiuk 1994). The approach is important in understanding the responses of health caregivers to domestic violence as well as women's experiences of domestic violence and the health care services. Furthermore, this approach explains why , in this study, health caregivers and abused women themselves were hesitant to talk about domestic violence. Domestic violence itself is regarded as a private issue and is rarely discussed in the public. On the other hand, health caregivers are expected to deal with domestic violence cases but they may not intrude on the privacy of the women or what women as well as health caregivers regard as private.

2.9 Critical medical anthropological approach

Medical anthropologists such as Scheper-Hughes (1992) and Helman (2000) have criticized biomedicine for its failure and individualistic approach to health and illness. In biomedicine, health and illness are understood to be the core problem of the individual and other aspects such as culture and socio-economic characteristics are ignored. As a result, the illness aspects of human distress are being medicalized and individualized, rather than politicised and collectivised (Scheper-Hughes, 1992).

Medicalization results in a misidentification between the individual and the social bodies and has a tendency to transform the social into the biological (Scheper-Hughes, 1992). According to Scheper-Hughes (1992), the failure to view the experience of suffering and ill health from an integrated perspective has been influenced by the Cartesian legacy of body and mind. Various efforts have been made to address the issue of domestic violence in South Africa. Medical anthropology can raise awareness and give better insights into the problem of domestic violence by taking into consideration factors such as culture, poverty and unemployment.

Different theoreticians have portrayed the body as multi-faceted and multiplex. Some of this analysis has separated the physical body from the social. Douglas (1970) differentiates between two bodies, namely the physical and social, which inform one another. At another level, Douglas (1970) indicates that bodily symbolism and cultural constructions of the body pervade and support societal views and relations. Scheper-Hughes and Lock (1987) expand approaches of the body to three, namely individual body, social body and body politic. The individual body refers to the phenomenological, lived experienced body-self. The social body on the other hand refers to aspects of the body and ways in which it can be instilled with symbolic meaning.

The body politic refers to the individual and collective regulation and control of bodies and involves post-structuralist epistemology. The work of Scheper-Hughes and Lock (1987) is useful in analysing the research carried out for this thesis in terms of the individual body, social body and the body politic. The individual body refers to the lived experience of the body itself. The manner in which the body is received in and experienced in health and sickness differs. At the second level of analysis is the social body, which refers to the representational uses of the body as a natural symbol with which to think about nature society and culture. And thirdly, the body politic refers to the regulation, surveillance and control of bodies individually and collectively in reproduction and sexuality in work and in leisure, in sickness and other forms of deviance and human difference.

2.10 CONCLUSION

From the literature it can be seen that domestic violence seems to be a major concern in South Africa and over the world. The various manifestations of violence against women in South Africa have been influenced by social, cultural, and political history and by racial, class and gender divisions (Vetten, 2000). It is argued that within an oppressive patriarchal system like *apartheid* South Africa, women and especially black women had the least power and were the most oppressed and exploited. As a result women became trapped in violent relationships by policies, practices within religion, social, political and legal institutions (Gamache, 1991). Medical anthropologists such as Scheper-Hughes (1992) and Helman (2000) have criticized biomedicine for its failure and individualistic approach to health and illness. In biomedicine health and illness are understood to be the core problem of the individual and other aspects such as culture and socio-economic characteristics are ignored. As a result the illness aspect of human distress are being medicalized and individualized, rather than politicised and collectivised (Scheper-Hughes, 1992).

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Methodology

Qualitative methodology was employed in the study. Qualitative methods are more suitable for sensitive topics such as HIV/AIDS and domestic violence (Schoepf, 1991). Through the use of the qualitative paradigm I was able to study domestic violence cases in terms of their own definitions of the world (the insider perspective). Qualitative methodology also focuses on the subjective experiences of individuals, and is sensitive to the contexts in which people interact with each other. Instead of focussing on counting and quantifying patterns in behaviour, the emphasis is on a rich detailed description of actions. Geertz (1973), refer to it as "thick description". A thick description is a lengthy description that captures the sense of actions as they occur. Through the use of qualitative methodology I could take an inductive approach. Instead of beginning with an existing theory, I was able to begin by engaging in the natural setting, describing events as accurately as possible as they occurred (Babbie and Mouton 2001). Adopting qualitative methods allowed me to establish a rapport with the informants and to be flexible in the ways in which the interviews were conducted.

3.2 Research Design and methodology

The specific design selected was an ethnographic study with an emphasis on in-depth interviews and participant observation. This approach was adopted because it allowed me to give a full account of women's experiences of domestic violence as well as the health caregivers' responses to the injuries caused by domestic violence.

Through participant observation I was able to observe how health caregivers interact with the abused women as well as record the complaints of the patients who frequently had to wait for two hours or more to be helped. During both familiarization and observation key role-players and gatekeepers at the Retreat Community Health Centre played an important role in establishing social networks that I could utilise. The security guards became gatekeepers who at times refused to allow me on the hospital's premises.

3.3 Gaining Access

During my first visit to the Retreat Community Health Centre, the security guard asked me to report to the sister in charge. I had to explain my purpose for being at the hospital. I also had to show the sister in charge a copy of my proposal and a letter from the head of my department. At times it was required from me to sign a hospital register but it did not ensure me access at all times. Due to the changes in shifts by the security guards as well as the health caregivers, I had to renegotiate access at times, which robbed me of valuable time. Some guards would allow me in without signing the register.

On my arrival at the Centre on Friday 15 February 2002 at 10 o'clock in the morning, I saw the security guards with guns on the inside of the gate. Two of the security guards were wearing bullet-proof vests. My car was parked outside the hospital gate and I went to ask the guard if I could park inside the hospital premises like I normally did. I explained to him that I was doing research and that the sister in charge knew about me. I went back to the car and wanted to enter but another security guard, who was standing at the gate, refused to open the gate. I had to explain to the security guard who I was and what I was doing there and I told him that the first guard had said that I could go inside.

Only then was I allowed to enter the hospital premises. On entering, I noticed that only a few people were standing outside - three males, one of whom worked at reception, and two females. It was very unusual because normally you see people entering the hospital premises and other sometimes sitting outside to smoke. I asked one of the women what was going on. She explained to me that a gangster had been there earlier and was threatening to shoot the nurses. He (the gangster) said he was coming back and one of the doctors said the hospital should be closed during weekends because of the violence.

Van Dongen (1997), in her study in a psychiatric hospital in the south of the Netherlands, states that the use of time and space is an undecided and an unsure issue. Thus I would say that the perception of the Retreat Community Health Centre as a fairly safe place changed into that of a dangerous space because of the gangsters who threatened to shoot the nurses. Before I could get inside, one of the men working there came from inside and said: "dit gaan nou enige tyd kom" (It's going to happen any time now). Then he urged us to get inside because the bullets could hit us. Taussig (cited in Scheper-Hughes 1992:232) refers to this as a state of doubleness of social being in which one moves in bursts between somehow accepting the situation as normal, only to be thrown into a panic or shocked into disorientation by an event or a rumour, or something said.

On my way in, I decided to stand where the people normally wait for their files. I observed that the people were calm as if nothing unusual was happening. Some of the women asked for the doctor but were told no one was available. The women said that they did not mind about themselves as long as the doctor could see the children. I decided to go to the trauma room to fetch the referrals. There were none available, and the only doctor still present told me he was leaving. On my way out I saw three registered nurses – the only other health care staff I noticed that day.

On each visit to the hospital I was referred to the sister in charge, who was often out of her office. This process delayed my progress but also gave me the opportunity to observe what was going on in the hospital.

On 26 February, 2002, I went to the Retreat Community Health Centre and on my arrival I wanted to park inside like I normally did. I was approached by one of the security guards who told me that I was not allowed to park inside because only the staff members could do so. I explained to him that I normally parked inside and that the sister in charge and the some of the staff members knew about me. I explained to him that I was doing my research there and that I had permission to do so. The security guard refused to let me in and told me that he was just doing his job. He told me that I had to sign the register but that I could not park the car inside. I asked him if all the people entering the hospital premises had to sign, because I had never observed them doing so. After a long argument I realized that only by signing the register would I be allowed in. The problems in gaining access to health care facilities are not atypical to this hospital. Gibson (2000) refers to similar experiences in her paper "The Problematics of Research in Particular Medical Spaces: A Case Study of a Training Hospital". During the time of my study, gangsters threatened to shoot the nurses and the hospital was closed for the weekend. This probably explains why gaining access at the Retreat Hospital at the time of the study was such a complex one.

3.4 Dilemmas of Interviewing: researcher, researched and research techniques

The dilemmas I encountered during the interviewing process not only made me aware of my position as a Coloured student and woman, negotiating my 'Otherness' with the health caregivers, but also of the importance of social context in shaping narratives. In the initial stages, the question of how to conduct the interview had to be resolved.

I was soon convinced of the non-feasibility of a pre-planned questionnaire. An informal conversational approach proved to be more fruitful as it encouraged women to discuss certain key moments of their lives that even the most thoroughly planned questionnaire might have overlooked. While conducting the interviews, I always felt that I was an outsider approaching an unknown terrain. This involved both an intrusion in the respondent's space as well as the dilemma of interacting in that space.

Interaction with each respondent was on the basis of being accorded a certain status. For example, in some cases I was seen as a social worker, as a researcher and as someone trying to improve the lives of the women. In other cases I was given the status of a newspaper reporter trying to investigate what was going on at the Centre. I had to comply with the wishes of the respondents that they could only speak for 20 to 25 minutes because of their 'busy' schedules at the hospital. At the Retreat Community Health Centre, it was also common for other health care providers to invaded our privacy continuously by entering the room where the interviews were being conducted.

At the Steenberg police station the voluntary workers entered the room where the interviews with the women were being conducted, or at times they stayed on in the trauma room. Through these small acts, the voluntary workers and the health caregivers seemed to be exercising a silent authority over the participants and over me, because I was an outsider and had no right to intrude on the women's privacy. Another reason could be that the voluntary workers wanted to protect the women who seemed to be vulnerable to the manipulation of someone who was not part of that community.

I realized that I was frightened by domestic violence. Confronted with reality, I wanted to get away. Listening to women's harrowing stories, their cries, their desperateness to change their lives made me helpless and I did not like that feeling.

While in my own room I could read about domestic violence at a safe distance, far from people's suffering, far from a woman with a child on her lap, with bruised black eyes, scars on her face, a wound on the head and desperateness to put something on the table for her children. It made me realize that many of the articles I read were quite impersonal, as if they were not about 'real' people, but merely statistics.

At times I wanted to cry with the respondents and I would feel extremely angry because of the manner in which their husbands treated them but I had to control my emotions. I found it extremely difficult to distance myself and at times I would find myself giving women advice and giving them money to buy food for their children. I constantly wanted to do more to make their lives bearable and felt guilty because I could not do so. According to Van Dongen and Fainzang (1998), when doing research work 'at home' or locally, the chances are that one is confronted with emotional involvement and its painful consequences. This situation can also arise elsewhere, but usually lessens when one leaves the research site. In this case, I felt responsible, helpless, sad, angry and distressed, particularly since it all was so close to home.

3.5 Selection of cases

Health caregivers who worked at the Retreat community health centre and who attended to the cases of domestic violence were interviewed. Snowball sampling was used to select the participating women. Snowball sampling is appropriate when the members of a special population group are difficult to locate (Babbie and Mouton, 2001). This procedure was used to collect data on people I could approach in the existing facilities, and then I was able to ask those individuals to put me into contact with other abused women.

Abused women between the ages of 18 and 45 years, who attended the community health centre, were referred to me. Their names were written on the referral list as well as their telephone numbers and addresses and this list was put up on the dressing room's notice board. This approach had its limitations because there were no proper addresses or telephone numbers where the participants could be contacted. And in the case where there was a telephone number, the phone often went unanswered or the person who answered did not know the name of person I asked for.

Some of the women were not willing to take part in the interviews because they feared that their husbands might hear from others that they were talking to a stranger and that it could result in a beating. Other women said it was not safe for me to come to their houses because they were afraid that their husbands might hear from people that someone was visiting them. Some women also feared for my own safety. When asked if we could meet elsewhere, women preferred not to go because of their fear.

3.6 Data collection techniques

3.6.1 Observation

A period of time was spent at Retreat Community Health Centre as well as at the Steenberg Police Station. Comprehensive field notes were documented throughout the period and broad questions were asked about domestic violence. At the Retreat Community Health Centre, the refusal rate among the health care providers was very high. Most of the time when a health caregiver was approached for an interview, they would tell me that they were very "busy" and that I should come on Saturdays. From my observation, nurses would rather stand in the dressing room conversing with one another with no patients to attend. On one occasion the issue of HIV/AIDS was raised and discussed and they were actively taking part in the conversation.

As soon as they were approached on how they responded to cases of domestic violence they said they did not get any cases of domestic violence or they said that they had a lot of work to do.

However, from my observation I could see that they were not busy because patients complained and said: "These people are very lazy no wonder the gangsters wants to shoot them". Another remark from one of the women waiting to be seen was: "Ek wag al va veoggend af die goed is baie gevrek". (I have been waiting since this morning, these people are very slow) or "Ek is al meer as vier ure hier" (I've been here for more than four hours now). On such occasions one would assume that there were many patients or that it was very busy. It nevertheless seemed to me at such times as if only a few patients were waiting for health caregivers to assist them.

Security guards were quite bossy and rude, saying, "Here mevrou, tjy kan nie da in gaan nie" (Lord, mrs, you cannot go there). Patients obeyed the instruction without objecting. I noticed that most of the women preferred to make use of the police service rather than the hospital. At the hospital there was no privacy for women. All the patients had to stand in a queue in order to be assisted by the health caregivers. This could perhaps be one of the reasons why women were not open about what happened to them.

At the Steenberg Police Station, the police were very cooperative. When people came to lay a charge they were very quick to assist them - this could also have been because of the fact that I was around. It was easy for the police to notice that I was not part of the community. Although I tried to blend in and to wear informal clothes, my accent was different from that of the people living in Retreat. They asked me several times if I had already been assisted and if I was waiting for someone. At times they told me that I could come back because the person I wanted to see was not in. The police station had windows where people could stand individually, and it provided some form privacy. There was also a trauma room with two volunteer workers who assisted the women who had been abused.

3.6.2 Interviews

This study utilised qualitative interviews as described by Rubin and Rubin (1995:31). Their model of interviewing emphasises the relativism of culture, the active participation of the interviewer, and the importance of giving the interviewee a voice. In-depth interviews were conducted with ten women who have been abused and who were in married or cohabitating relationships. Semi-structured interviews were also conducted with health care providers.

3.7 Interviews with abused women

3.7.1 Description of the women

Most of the women who were interviewed and who attended the community health centre or came to the police station had scars in the face, bruises on the arms, scars on the lips, scratches in the neck and a few of the women were under the influence of alcohol during the interview session. To some extent the women seemed dishevelled and somehow neglected. The women came to the police station with uncombed hair with only one shoe on the foot or without shoes. However, it needs to be mentioned that some of the women were well groomed.

The interviews with the women took place at two sites: Retreat Health Centre and Steenberg Police Station. The majority of the women were interviewed at the Steenberg Police Station and only a few women were interviewed at the Retreat Health Centre. Interviews at the Health Centre took place while women were waiting to be seen by health caregivers. The women were taken to a place where other people could not hear what we were talking. In such a case the woman would ask a friend to listen when her name was called in order to keep her place in the queue of patients.

Most of the women were accompanied by their children or in some cases by their husbands. This was a way of preventing women from talking about the abuse. In some instances children were sent to accompany their mothers to hear what they told the health care providers or the volunteer workers so that they could tell their fathers. Other reasons why children accompanied their mothers was that there was no one to look after the children at home and could also be indicative of a woman's role as caregiver. The interviews with the women ranged from 30-60 minutes.

Most of the women did not mind that the interviews were tape-recorded. They saw me as someone who could help them, or just someone they could tell about the abuse. Others would say, "Ek wil dit net van my chest af kry". (I want to get it off my chest). The women were fairly open and willing to discuss their painful and harrowing experiences. The interviews at the Steenberg Police Station took place in the trauma room, which is reserved for abused women, rape cases and problems that mothers experience with their children such as drug abuse. The trauma room consists of comfortable chairs and there are a lot of teddy bears. There are also pamphlets on domestic violence posted on the wall of the trauma room.

3.7.2 Interviews with health caregivers

Locating an informant does not guarantee the success of the interview. At the Retreat Health Centre I was continuously shown away by the health caregivers with excuses that that they were "very busy". Some health caregivers would tell me to come on Mondays or during weekends. Others would simply say that they did not get any domestic violence cases. The interviews with the health caregivers took place in the office of the sister-in-charge, the trauma room and the injection room.

It proved very difficult to have private interviews with the health caregivers. Other health caregivers would come in to see what I was doing and would leave after some time. I hardly ever conducted an interview where only the respondent and I were present. As a result, respondents were reluctant to give information or some would take a long time to answer a straightforward question. The presence of the other health caregivers negatively influenced the flow of the conversation. The interviews took place while the health caregivers were merely standing around to indicate that they did not have time and that they were in a 'hurry'. Most of the interviews with the health caregivers were tape-recorded. They tended to be very cautious about answering the questions.

3.8 Description of the study sites

As previously noted, the research was conducted at the Retreat Community Health Centre and Steenberg Police Station. Retreat, Steenberg, Cafda and Lavender Hill are coloured sub-economic areas that were historically created as a result of the Group Areas Act. It is one of a number of communities living on the sandy area called the Cape Flats. The residential areas of Retreat and Steenberg are divided into two sections, the working class and middle-class areas.

The people who reside in the working class are from the lower social and economic classes compared to the people who are living in the middle-class area. The houses of the middle-class people are more spacious and you hardly find "shanties" in the yards of these houses. Most of the working class live in small blocks of two or three-roomed flats, which are generally in poor condition and overcrowded as a result of the housing shortage. It is common to find slogans written on the walls of the buildings like the 'home boys' or the 'twenty eights', which refer to particular gangs. This is also indicative of the space that the particular gang occupies in the area.

During gang fights, I found that outsiders like myself, who do not live in that specific space of the gang that is fighting, cannot enter that territory. For example, if you are residing in the 28's territory and the station is in their territory, you may travel through the area, but if you are residing in the Americans' territory, you are not allowed to make use of that route to get to the station. On the other hand, if the shopping complex is in the Americans' space, people residing in the 28's territory are not allowed make use of that particular shopping complex.

The merchants and taxi drivers have to pay tax to the gangsters in order to ensure that they will look after them. Some people live in their own houses or others rent houses from owners. These houses are either made from corrugated iron or some are referred to as "wendy houses" which are made of wood. "Smokkelhuise" or shebeens are also common where the lower class is staying. The 'smokkelhuis' owners sell beer, liquor and in some instances dagga and mandrax.

According to respondents the norm in the flat is that a man has to smack his wife every week just to show that women should fear men. It is common to find both parents drunk on Fridays and Saturdays and children have to look after themselves. The men beat their wives or the wives beat their husbands. On Sundays many husbands go to the moneylenders to borrow twenty or thirty rands because there is nothing to eat in the house. It is common to see men and women playing games like dominos outside. Respondents mentioned that, although there is a lot of violence, people still care for one another in times of sickness but it is not like it used to be in the past.

The shebeen owners play loud music that attracts young people. Most of the women live with their husbands and other siblings either in the mother-in law's house, or rent one room inside the house with the husband's relatives. Women share the kitchen with the rest of the family or other people who are also renting from the owners.

It is very common to find a woman on the street corner or close to busy places such as the hospital or shops selling sweets, cigarettes, chips and cold drinks to generate income. Women also do odd jobs to gain more money by cleaning other people's houses, doing the laundry or looking after children. On the other hand I often found men hanging around on the street corners or visiting shebeens. Sometimes young children were also present on the corners of the streets, making remarks when people or women passed by, or asking for money from strangers. Most of the people residing in the working class use public transport such as trains and taxis. It is common to hear loud music playing in the taxis.

3.8.1 Research sites:

The Retreat Community Heath Centre was the initial site but due to difficulties in getting women to interview, I also interviewed women at the Steenberg Police Station. The street in which the Health Centre is situated, is very narrow and has a lot of speeds bumps. This is probably to control the speed of drivers. It is very difficult to locate the clinic from the outside because there are no clear landmarks that indicate that it is a health centre. From the outside it looks more like a school than a clinic.

Yet members of the community know where the hospital is and because it serves a particular population it is probably not necessary to identify it clearly. There are also tuck shops in the street of the health centre. Further down in the street of the health centre is a scrap yard where they dump old buses and cars. The taxis sometimes park in front of the hospital and the main road is further down where the taxis stop to pick up people. The noise of the taxi guards can be heard when you are on the hospital premises, as they call out the different names of the places that they go to.

For example, I could often hear a taxi guard call "Retreat Station, Steenberg," very loudly. The health centre, which includes a maternity unit, provides health services to people living in Retreat, Cafda, Steenberg, Lavender Hill, Grassy Park and Vrygrond. According to some of the staff,

violence-related injuries are the most common problems among patients. There are two entrances at the health centre - one that is mainly used by staff members, and the main entrance used by all. The gates are mostly closed and are guarded by security guards because of violence-related crimes.

Patients and visitors are searched before they can enter the health centre. As previously noted, the centre was chosen because most of the abused women come from areas such as Lavender Hill, Vrygrond, and Steenberg where there are high levels of community and domestic violence. It was also assumed that the abused women would make use of the health care facility after being beaten. However, most of the women make use of the police station.

The Steenberg police station is situated in the middle-class area. There are clear landmarks on the outside that indicate that it is a police station. Opposite the police station is a church and further down is a big shop. Unlike the street in which the health centre is situated, the police station appears to be in a much quieter area. The health centre and the police station serve an estimated population of 270 000. It is 45 minutes' drive from the University of the Western Cape. The main road divides Lavender Hill, Steenberg and Retreat.

3.9 Ethical Considerations

Written consent was obtained from the participating health institution, and written informed consent was sought from the informants. I explained in detail the purpose and possible benefit of the research findings during both the familiarization with the study and the data collection period. Participants were informed that their names would not be used. The participants were assured that all matters would be treated with strict confidentiality and that the researcher would observe high levels of ethical

conduct. Free will to participate in the study was adhered to. It was made clear to participants that they could refuse to answer questions and that they could withdraw from the study at any time. In such a case all documentation related to them would be destroyed.

3.10 CONCLUSIONS

Doing anthropological research can sometimes be complex due to the fact that the methods can be limited by the context in which the research takes place. Therefore, the researcher should be flexible in as far as data collection techniques are concerned. I became aware of my own biases and ideological standpoints, which guided the research and impacted on the information of my study. This prevented me from being a truly neutral researcher. I only became aware of this after the information was interpreted. While this can be seen as a shortcoming of the research, it is in line with qualitative research as there is an acknowledgement that research cannot be value-free and objective because people come to any situation with their own preconceived ideas.

The use of participant observation was to my advantage because I was able to observe how health caregivers interacted with patients at the health care centre. However, staying in an area for some time can result in one becoming familiar with the ways in which respondents do certain things and there is also a tendency to overlook certain issues, which one can regard, as obvious. By using qualitative methodology, I could take an inductive approach. Instead of beginning with an existing theory, I was able to begin by engaging in the natural setting, describing events as accurately as possible as they occurred (Babbie and Mouton 2001). The strength of qualitative methodology is that I was able to build rapport with the participants.

CHAPTER FOUR
DEALING WITH DOMESTIC VIOLENCE: THE INTERFACE BETWEEN THE STATE AND ABUSED WOMEN

4.1. Introduction

Since the promulgation of the Domestic Violence Act of 1998 a great deal of research has been aimed at monitoring the implementation of the Act in the criminal justice and health care systems (Bollen et al. 1999; Parenzee et al. (2001). As I indicated in the Introduction, there is an increasing tendency in state, public and media opinion to stress the necessity of dealing with domestic violence as not only a legal, but also a medical issue. Although it is imperative that health care services should respond empathetically and effectively, the tendency to medicalize violence, for example, has often been criticised (Helman 2001: 60, 114-115).

In current research on the implementation of the Domestic Violence Act of 1998, the real situation of the individuals who are supposed to make it work often remains invisible. In this chapter I specifically give attention to the response of health caregivers, the people who are the faces behind the supposedly neutral policies of implementing an Act. I also need to stress that the Act entails only one of the many changes in health care provision the staff have to deal with. They often have to struggle with the very real constraints on the services, a high workload and not the least, their own perceptions and experiences of living in potentially violent communities and dealing with the aftermath of violence. The chapter also discuss the interface of abused women with other state services.

4.2. The health caregivers and their responses

Socio-demographic characteristic of health caregivers

Most of the health caregivers interviewed for this study lived in areas such as Grassy Park, Retreat and Steenberg. They were thus familiar with the environment in which they worked, and shared many of the culturally informed notions and perceptions of the abused women. I worked with seven health caregivers who had a working experience of two to four years at the health care centre. The majority of the respondents were married. I interviewed five registered nurses, one auxiliary and one staff nurse. The highest level of education attained by most of the health caregivers was tertiary education. Their training ranged from four years for registered nurses, two years for staff nurses and a year for the auxiliary nurses. The majority of health caregivers were in the age range 32 to 44 years. All those interviewed belonged to a religious affiliation and were bilingual. The interviews were conducted in Afrikaans with two health caregivers and in English with five others. The choice of language was made depending on the medium in which the health caregivers felt more comfortable.

4.3 Working in a violent area

Like the abused women, health care respondents viewed the familiar areas within which they themselves lived and moved as relatively safe. A distinction was made from the rest of the area, which, including the vicinity of the health care facility at which they worked, was often perceived to be potentially dangerous (Gibson, 2002; see Jensen 1999). Most of the participants gave examples of the experience of violence in the wider community. Women staff learned to cope with community violence, often by behaving in what is normally considered to be masculine ways, such as adopting a toughness they felt might protect them.

They also kept alert to the constantly shifting nature of safe and dangerous spaces and to differentiate between them. Violence thus appeared to be embedded in their everyday lives. This is the case of Miss G:

"Weet jy... hierso.. jy kan nie sag wees met die mense nie. Hulle like kanse vat. Jy as se security se lewe is in gevaar. Ons kan nie loep waar ons wil nie. As ek die weekend af is dan kan ek nie in 'n Coloured club gaan dans nie want jy weet nooit waar die jongens loop nie. Die gangster kom hier by die gate da wil hulle net maak soos hulle wil. Ek laat nie my mors nie. Jy moet hulle vertel anders raak hulle jou sleg gewoond. Jy praat mooi met die mense almal is so rof en ombeskof jy kan nie anders om dieselfde te wies nie want die mense ken net rowwe taal. Hier moet jy net vloek en skel dis die taal. Nee hier moet jy nie nog mooi praat nie jy moet wies soos die mense hier. Die anner dag toe kom die gangsters hier - hulle wou op die hospital skiet. Die hospital moes gesluit gewies het vir 'n naweek want toe is die jongens morsig. Jy sien hulle wil nie die reëls aanvaar nie. Dit werk so as jy siek is, kan net een persoon saam met jou in (die hospitaal). Nee, hulle wil almal saam met hulle vriende in gaan om da binne te gaan mors... moet vir hulle search om te kyk of hulle nie messe of gunne het nie voor hulle in kan gaan. Hulle wiet dit ma jy kry nog steeds van daai mense wat hulle harde lyf hou en vir jou wil vertel. Maar ek lat nie met my mors nie. Ek vertel hulle ek is hier om my werk te doen. Dis of hulle doen wat ek hulle vra of hulle bly buite, want ek doen net my job. Nee hie moet jy harde lyf wies want anners vat die jongens kans. Dis so gevaarlik vir ons. Ons kan nie net sommer so loep in coloured areas nie want die jongens lê ons voor. Sien jy die merk een van die jongens het my met die mes gestiek. Gelukkig het ek 'n kep op gehad. Daarom sal jy sien ek dra altyd 'n kep want was dit nie vir die kep nie kon ek lielik gesteek gewees het in my kop. Daai mes het deur my kep se voorpunt gegaan. Nee dis die lewe hier". (You know...Here, you can't be soft with people- they like to take chances. Your life is in danger. We can't walk where we want to.

I don't go to coloured nightclubs when I'm off during weekends, because you never know where the gangsters move. The gangsters come to this gate they just want to do what they like. But I don't allow them to mess with me. You have to tell them otherwise they'll get used to you. You talk nice to these people but all of them are rude and harsh. So you have to do the same because that's what they are used to. I tell them I am here to do my job it's either they do what I asked them to do or they stay outside. It's dangerous we can't walk in coloured areas because the gangster are after us. Do you see this (point to the front part of the hat) the gangsters wanted to stab me but luckily for me I had a hat on. You will always see me wearing a hat because if it wasn't for the hat I could have been stabbed in my head. The knife went right through the front part of my hat...I shiver if I think of that day. No...this is life. Here you have to scold and use abusive language that's the language they know. No, I don't have to talk nice you must be like them. The gangster came here the other day and wanted to shoot on the hospital. The hospital had to be closed for the weekend because the gangsters was mixed up. You see they don't want to accept the rules. It works like that if you sick only one person can accompany you (into the hospital) if you very ill but they want to go in with their friends to mess inside the hospital... have to search them for knives and guns before they can go in and they know that but you get those who want to be tough but I don't allow them to mess with me).

In the above-mentioned narrative, certain township areas were perceived as dangerous spaces. This impacted on Ms G's leisure hours, as she had to avoid the nightclubs where she might otherwise have sought entertainment. If she had to be in a potentially dangerous area, she often mimetically performed a tough intransigence, making it clear that she was not to be messed with.

There was apparently also an ongoing effort to maintain the health care facility as a relatively safe space – therefore the concern with who was entering the premises. Potentially violent bodies, especially, needed to be regulated on the hospital premises.

This concern also served to create social distance between providers and clients and seemed to increase a sense of control and security for staff. According to Scheper-Hughes (1987), by controlling bodies in a time of crisis, societies try to reproduce and socialize the kind of bodies that they need. This burden seemed to fall in particular ways on staff like Ms G, who served as the interface between the community and the institution. It was also here that the greatest slippage occurred with staff behaving in more disorderly and mimetically violent ways in an effort not to seem vulnerable or to become victims. It can thus be argued that staff also emphasized their own aggressive behavior at times because of the potentially threatening environment and also because they had learned through experience that being "harde lyf" (tough) might protect them.

4.4 Construction of domestic violence by health care givers

It was important to understand how health care givers perceived domestic violence because it was likely to influence their responses and provision of treatment to abused women. The majority of health care workers saw domestic violence as incidents where a male partner beat his female partner. They also dealt with incidents where a man beat his female partner and the children and where male children beat their mothers. A few mentioned cases where females abused male partners. According to a nurse domestic violence usually involved:

> *"... die nabye familie. Dit is either 'n man wat 'n vrou slaan of 'n vrou wat haar man slaan". (the close family, the husband who is beating the wife or the wife who is beating the husband).*

According to another health caregiver, cases involved:

> *"Either a husband or wife who abuses one another and sometimes you think it's the husband then it is the son who was beating their mothers. It is something that happens at home in the family".*

These cases correlate with Vetten's (2000) definition of domestic violence, which refers to a condition where an individual involved in an intimate relationship is subject to abuse by the partner in that relationship. Typically, it means violence between a man and a woman involved in a romantic relationship, married or not. However, it can also refer to violence against children, elderly people and people sharing a home. However, it was evident from my research in this particular community that domestic abuse in the home did not only happen to women but also to children, especially girls. It seemed that violence was so predictable that it was almost the norm. Under such circumstances child abuse usually also becomes more prevalent. The following statements illustrate this:

> *"We get babies who have been abused by their fathers. Not long ago there was a four-month-old baby girl she was sexually molested by the father and she contracted syphilis. These kind of things is nothing new".*

Because there is an increasing call for health care institutions to deal with and even to control domestic violence, I believed that, like other forms of deviant behaviour, it would have become increasingly medicalized. Yet the opposite seemed to be the case. Incidents of domestic violence was recorded and treated as trauma and no difference was made between different kinds of injuries.

Thus, violence of whatever kind was recorded and mostly treated in relation to the injury itself, as indicated by the following:

> *"... just trauma, we don't differentiate between domestic violence and community violence. Or sometimes doctor writes dressing or suture.*

> *"It is recorded as assault and we write the name for example domestic violence uh not as domestic violence. They write there the patient was beaten by whoever husband or wife or by her son or so. That's how its been recorded".*

One important reason why domestic violence was apparently hardly ever referred to by name seemed to be the ongoing conviction, both of staff and abused women, that it was somehow very private. Staff apparently found it difficult to push abused women to talk about violence if they were disinclined to do so.

4.5 The problem of privacy and confidentiality

It soon became apparent that both staff and abused women adhered to a notion of privacy that entailed a kind of joint unspoken knowledge that was not to be discussed unless the abused woman indicated that she was willing to do so. The result was that it made it possible for staff to leave the issue of abuse unacknowledged, at least to the abused woman herself. But staff nevertheless freely talked to one another about such cases of abuse, and even did so in the presence of other patients. Although the name of the abused woman was not used, her injuries and circumstances were discussed, often as if other patients were incapable of hearing. There thus seemed to be a contradiction between this apparent lack of confidentiality and the tendency and concern of health caregivers that they should not intrude on things that are private and personal for patients.

In this way the medical notion of confidentiality could be sustained, because if the women did not want to say it was domestic violence, the health care givers could not ask. It is illustrated in the following narratives:

" It's not my right, as a health care giver to uh... intrude on your privacy doesn't matter if I'm dealing with the wound or whatever I wait for the patient to open up. Um ..... sometimes if she is willing to talk then I'll ask her if she knows that there is been help out there".

"If they don't want to talk then it stays like that because they see it as private but as I have said I'ts not everybody, because some feel that you are curious and that you want to know what is going on in their lives. You know that you have to stop or that you have to draw the line because you can see if the person talks to you, the body language, body gestures and that (nodded with head) say a lot. Sometimes they don't verbalize it but their body language say a lot. Or sometimes if I have asked a question and don't get a response than I know I have to draw the line. Many people or maybe I should say the women see domestic violence as a private issue. If you don't ask them about the incident they won't tell you anything".

It can also be argued that the fact that being in a particular space at a particular time has an effect on how women use their bodies as means of communication. According to Harvey, 1985 cited in Van Dongen (1997) command over space and time form independent but interlocking sources of social power. It could be argued that staff, who have control over the bodily space and the time of patients, can make a choice about what should be regarded as private in this setting. According to Henley (1977) the meanings ascribed to the body are determined by shared expressions of body language, which are not under the direct control of individuals.

Bodily expression is a conventionalized form of non-verbal communication, which is by far the most important component of behavior in public. It can refer to dress, bearing, movements and position, broad emotional expressions, waving and saluting. These actions allow us to gain information given off by bodies in shared vocabularies. Such bodily idioms serve to hierarchically label and grade people in interaction. In particular settings, such as the hospital, such hierarchies exert a profound

influence over the ways in which individuals, like abused women, seek to manage and present their bodies (Goffman, 1963).

According to Shilling (1993) the social meanings attached to particular bodily forms and performances tend to become internalized, and exercise a powerful influence on an individual's sense of self and feelings of inner worth. Important to social life is that there are occasions in which people are concerned to act out specific social roles like the sympathetic social worker and, in the case of the health caregivers, the role of the professional respecting the privacy of the patient. At the same time the abused women present a social 'face' that clearly indicates a tattered insistence on privacy and, with it, dignity.

4.6 Closing curtains as a performance of privacy by health care givers

Another form of privacy that was highlighted by staff was the symbolic creation of a private space by closing the curtains. Although in reality one could often hear what was being said, the closed curtains served as a representation of privacy - both in terms of time and space. According to Harvey, (1989:239) space and time are perceived and experienced differently by people, while it also expresses various practices and meanings. In this case the closed curtains both represented the hierarchical power of staff – they were the ones who could create this private space, which had particular meaning in health care philosophies and practice.

The privacy created by staff and experienced by abused women was nevertheless different. All staff understood the symbolic meaning of closed curtains. With the exception of doctors they seldom intruded on it. For the abused women the curtains were exactly that – a very thin layer between themselves and others. They might not be seen but they could be heard.

Unlike for the nurses, the space enclosed by curtains lacked 'proper' configurations for abused women. De Certeau (1988) distinguishes between place and space. The arrangement of place is located in certain accepted configurations. It is usually geometrical, geographical and panoptical, rigid and passive, such as in a scientific institution or a hospital. The health care facility itself thus had this meaning of place for staff.

Space, on the other hand, is a practised place such as streets through which people constantly move. It does not have the stability and singularity of a proper place. Space is transformed through time as agents construct and ungrid it through movement and practice, walking and talking. It is beyond the visible, constantly changing and metaphorical. Health caregivers' constructions of private space had no singular meaning and place – therefore, due the constant movement of people in and out as well as the presence of other patients, the closing of curtains was metaphorical of privacy, rather being a material reality (cf Gibson 2000). Health caregivers shifted constantly between what was regarded as confidential and private. One of the health caregivers said:

> *"We talk to them privately, we talk to them alone we close the curtains. There are only one or two people in the injection room at a time not more".*

Health care givers were supposed to treat patient's problems as confidential and also needed to 'read' the bodily cues of abused women as to whether they should regard the signs of domestic violence as a private matter in such a public space. The following extract from an interview highlights this:

> *"Many people...the women see domestic violence as a private issue. If you don't ask them about the incident they won't tell you anything. They just don't say anything or they'll say that they fell because they are scared of their husbands. There was a woman two weeks ago who came crying totally emotional. She told me that she fell over a pole but*

I could see from the bruises that she got that she didn't fall. I asked her how did she fell and if she was sure that she fell. She started to cry and told me no it was my son who assaulted me and she doesn't know what to do. But she has told the doctor that she fell over the pole because that's what the doctor wrote".

For the abused woman the private and public space thus shifted between the health caregivers and the spaces in which they found themselves. Entrenched relations of power and patriarchy probably also influenced their response.

4.7 Provision of treatment to survivors of domestic abuse

I was alerted to the lack of clear guidelines for health caregivers on how to deal with and provide treatment to abused women. Some health caregivers stressed that they waited for the woman to be open and talk about the abuse. If a woman resisted prompting in this regard, staff felt they had to respect this, because not everyone was willing to discuss their abuse. Health caregivers did not want to intrude on the privacy of the women, but tried to treat them with respect and empathy.

The general feeling was that, by forcing the woman to talk about abuse, they also forced them to go through further emotional trauma. Therefore staff deferred to the woman's indication of willingness to discuss the abuse or not, as illustrated in the following:

"Most of the time when the patient comes in at the trauma, its not always um that that the patient fe-e-el that he or she wants to talk about the situation. And I respect that because sometimes it's the first time sometimes it's a long-standing issue where you can get a bold idea. Uuhum and I feel that's not my right, as a health care provider to uh... intrude on your privacy doesn't matter if I'm dealing with the wound or whatever. I wait for the patient to open up. Um... sometimes if she is willing to talk then I'll ask her if she knows that

there is been help out there. I think everybody's approach is different and there should be a standard protocol maybe it depends on the situation".

Another health caregiver had the following to say:

"We treat them in...silence. Yes seeing that they already went through that process of domestic violence if they come in yes we want to keep that slight sense of the self, yes, of the person. We don't want them to know that what has happened the violence, which they went through mmm we don't want them to go through trauma, emotional trauma. We we handle them with the same respect and we have that empathy towards them. And we refer them yes we don't leave it there".

Health caregivers thus tried, in a roundabout way, to provide education and advice about domestic violence to women. Women often said in interviews that, after a beating that forced them to have medical treatment, they often considered laying charges against their partners.

The decision not to do so might be influenced by societal expectations related to gender and the role of a woman in relationships. Such expectations encourage women to be self-sacrificing, accommodating and to care for and protect those close to them, despite of the price they have to pay. From the interviews with the health caregivers it seemed that if and when women brought the issue of abuse into the discussion, staff tended to perpetuate stereotypical gendered expectations and notions. The following narrative supports this tendency:

"... we sometimes talk to them and give them aah tell them that they should try to to...Like a woman who came here one day with a J 88, the husband has assaulted her. I told her ag miss don't take out a J88 because its your husband, talk to him and tell him if he realize tomorrow that he have made a mistake. But next time he'll do it again. I told her shame try from your side maybe he'll realize later that he

has made a mistake and so. A person doesn't just go and lay a charge against your husband. But sometimes if it happens on a regular basis you have to warn him by calling the police or something like that."

4.8 Referrals

Although health caregivers were reticent about enquiring about abuse, they were nevertheless concerned when they saw signs of it. A way to deal with it without embarrassing the particular woman was to refer her to the social worker. Staff treated the physical manifestations of abuse, i.e. the injuries, but felt that, as a private, social issue, it lay outside their experience and expertise. To them it made sense to refer abused women to a social worker whom they believed was trained to deal with it. Yet the social workers were themselves greatly overworked and tried to prioritise what they saw as the most serious issue, namely child abuse. On the whole, social workers did not want referrals of domestic violence cases. Thus referrals seemed somewhat problematic at the health centre.

Although circulars were sent to inform staff that they should refer patients, few referrals happened by doctors. It can be argued that certain health caregivers did not regard referrals as part of their work. The fact that abused women were often loathe to discuss the cause of their injuries, made referrals difficult. Gender also played a role in this complex situation and some abused women said they would feel more comfortable to talk to another woman than to a male doctor. One nurse had the following to say in this regard:

"Doctor provides treatment and than he refers them further. Their names are written on the referral list and there are two ladies who normally come to fetch the referrals but they don't come immediately. We give the name and address of the person and we also refer them to the social worker. I don't know whether the new doctors know that they should refer the cases to the social worker.

We have um the person 's name on the notice board and we refer the patients to her. We first ask the patients' permission because its not everyone who want s to admit that they have that problem We first ask permission and the doctor also ask permission its not everybody that knows what to do. Not all the women know what to do. This woman comes on a regular basis to fetch the referrals. The doctor writes a note and put it in the envelope. But we first talk to the patient because we are in contact with them and we work with them most of the time. They don't talk easily to the doctor sometimes if it's a man than he feels more comfortable to speak to a woman. Sometimes they tell a lie to the doctor. 'No doctor I fell', and if they come to us they have a laceration or something of that nature that we have to put a dressing on. And sometimes one asks 'where did you fall?' then maybe they'll tell you 'no its not so. I didn't fall'. Understand then we will go back to the doctor and tell the doctor that he have to write a letter and should refer the patient. Like I've said with their permission because it's not all of them who want to report that they have been abused. Yes there are many of such cases that don't want to report".

When abused women were asked whether they were referred to the social worker, they had the following to say:

"ek het maar self gekom want ek het bedoel... ek gaan weer terug kom want ek het vir die social worker 'n brief gevra. Ek het na die social worker na Cafda toe gegaan. Die dokter het my net pain tablets gegie. Maar ek makeer help want ek voel ek kan nie meer nie ek nie meer aangaan nie. Ek kan nie kan nie... (huil).

(No, I came out of my own will because I mean I asked a letter from the social worker. I went to the social worker in Cafda. The doctor only gave me pain tablets but there's nothing wrong with me. I need help I feel I can't take it I can't go on anymore. I can't I can't... (cries).

In the above narrative it seems that the doctor tried to treat only the physical disease and could not address the woman's real concern and need for help. In this way the reality of the violence experienced remained unaddressed, unspoken and private - thereby perpetuating gendered and privatized spheres of suffering.

A respondent asked: *"How can he refer me to the social worker if he doesn't ask me what happened to me?*

When asked about referrals to social workers some of the health caregivers had the following to say:

" (referrals were made) Sometimes to the social worker but not always because as I've said the patient does not always say what the problem is. But if we have a standard protocol it will be easier because most of the time the women come in on a regular basis. We can tell doctor and he can refer them to the social worker".

Another respondent stated that the social worker said that *"...she is overloaded with work and that she is only dealing with child abuse".*

Despite all the state and public discussions on domestic violence as a health problem, it was in actuality still very much regarded as falling in the private and the social sphere. Unlike the protocol for rape survivors, there was no protocol on how to deal with domestic violence. Health caregivers suggested that a standard protocol would make it easier for them to identify and deal with domestic violence. One said:

"I think it would be better if we have a standard protocol. Like I have said we don't record it as domestic violence in the patient's file. You see our training doesn't involve training in this aspect that means we really lack knowledge on it. Look if the patient didn't tell you the first

time and if she comes in next time than you know that it was domestic violence and you as a health worker can be more cautious and observant the next time and that will help a lot in identifying the cases and to refer them".

Yet, as indicated above, referral was not as simple as sending a circular to staff:

"If we know that the woman have been abused than we refer but not always. The social worker don't want referrals because she say she's over loaded with work".

"Most of the time it is something to be shy of, because they don't talk about it. The doctor won't know and he won't refer her to the social worker. Because, maybe, because we don't have a standard protocol. Most of the time they (women) don't want to talk about it. Most of the time the women want help but they don't know how to ask for it."

"Most of the time one feel that that you don't want to ask the patient what has happened because it seems as if you want to be a 'busy body' but its not the reason. Most of them feel I don't want to break the silence because they see it as their family problem. We have many cases. Except for the social worker we also have a psychiatric sister that's working here. And if we know what exactly happened to the women than we ask doctor to refer them to the psychiatric sister just to talk".

It was unclear who was supposed to make the necessary referrals. If the line of authority was unclear, it became the responsibility of the doctor, the person who actually spent the shortest amount of time with the woman and who was above all intent on caring for her physical injury.

"Not everybody feel it's his or her duty to do the referrals because the doctor has to refer the patients to the social worker or to the necessary

social support structures".

Due to shortcomings in the health care system itself, health caregivers were hamstrung by a lack of training on domestic violence, as well as by a lack of policies for dealing with domestic violence. This resulted in inadequate referrals to social workers and lack of probing from health care staff as to the cause of injuries. Health caregivers were thus only treating the wounds or the injuries sustained by abused women and were definitely not medicalizing it. While health care givers had their own understandings of and responses to abuse, the women who had been injured also had their own experience of dealing with the different state responses. The first of these was the health care services.

4.2. The abused women interacting with the state

Women's experiences of the health care services

Foucault (1977), states that the social field can be seen as a myriad of unstable and heterogeneous relations of power. It is an open system, which contains possibilities of domination as well as resistance. Hospitals involve disciplinary power. Firstly, there is a differentiated hierarchy that individualizes people. For example, waiting times for patients can be perceived as a source of power and of the ways in which medicine creates its subject (Gibson 2000). Time spent waiting is a function of the hospital's disciplinary machinery. This is supported by the following views:

"You get the nurses who are good and those who are bad. Those who are good will make you sit down and ask you what happened and if you would like to talk about what happened. The others will be rude telling you that it's you again and some of them don't mind if other people hear what they say and I think that's one of the reasons why women don't go to the hospital but rather stay at home and wait for the wound to heal because some of the nurses insult you and are very insensitive. You go to the hospital early in the morning and have to wait for hours and then you still find nurses who are rude and

impatient. You also get those nurses who's rude and who are not in the mood to work and who don't show interest. The service at any hospital um... you can come in and they'll help you immediately but you also get the times where you have to wait for hours to be assisted because you have to wait for your turn. And sometimes the nurses can't see that this is an emergency. The hospital service and even the police service can be a good service but it is the type of people that you have there do you understand and that's what the problem is".

Another woman respondent had the following to say:

"*Jy gaan vroeg soentoe dan moet jy wag das niks privacy. Die nurses vra jou sommer voor die anne mese wat ga aan. Het jy weer pak gekry by jou man. Naai dis nie lekker nie. Want jy voel vernedered omdat jou gesig so lielik lyk. Party van hulle praat nes hulle wil en ek like nie daai nie. Soos die anner dag toe vra die nurste vir my baie rof... dit was die Maandag ek het mos die naweek pak gekry. Toe vra sy my hoekom kom jy nou eers maar dis die manier hoe hulle jou vra. Jy sien da's tye wat jy nie kan wegkom nie want die man is da nou moet jy eers wag dat hy werk toe en dis die riede hoekom ek eers die Maandag gegaan het". (You go there early than you have to wait there's no privacy. The nurses ask you while there is other people around what is going on. They asked you if your husband has beaten you. That's not nice. You feel humiliated because your face looks ugly. Sometimes they talk just like they want I don't like that. The other day the nurses was very harsh with me... that was the Monday because I was beaten the Saturday. She asked me why am I only coming now. You see there are times that you can't get away because your husband is there. I first I have to wait till he go to work and that's the reason that I went the Monday).*

Scheper-Hughes (1992) asserts that cultural disciplines provide codes and social scripts for the domestication of the individual body in conformity to the needs of the social and political order. Therefore, one can argue that waiting at health care facilities illustrates the subordination of the individual body to the body politic. Although the women in this study preferred to go a health centre after being abused, they were put off by having to wait, and by doing so, making the abuse known. They were also at times restrained by the presence of their abusive partners.

There were nevertheless instances where women could influence the power relations, e.g. by drawing on familiarity, friendship and collegiality when interacting with the health caregivers.

> *"Ek het mos hier gewerk by die hospital baie van die nurste ken my. Hulle is nice met my. Die ding is net jy moet soe lank wag voor tjy gehelp word."*
>
> *(I worked here and the nurses are nice to me. The thing is just that you have to wait long before you get assisted).*

Women also used other strategies to try to get help or to keep themselves safe for a while.

4.2.1. Silence as a protective mechanism against further abuse

As discussed above, women who had been hurt often kept silent when queried about their injuries. This was a means of protection from further abuse and happened most frequently when their husbands or children accompanied them. In such cases it was difficult and even dangerous to reveal the true nature of the abuse in the presence of their family members. However, women often hoped that coming to the hospital would somehow bring them to the attention of, e.g. social services, as described by the following respondent:

"Dis nie dat jy nie wil praat nie... maar hoe kan ek as my man saam met my gaan. Of my kinners is by en dan vra hy die kinners waar was ons. Hy wil wiet wat praat ek met anner mense by die kinners. As hy wiet ek het anners vertel dan ga hy my uitkak. Ma ek maker help want ek vat dit so as ek hientoe kom da ka die social worker my help".
(It's not that you don't want to talk but how can you if your husband accompanies you. Or sometimes my children come with me and than he'll ask the children with whom did I talk. If he knows that I spoke to someone he'll beat the shit out of me. But I need help that's why I came here so that the social worker can help me).

Some respondents were ambiguous about their abuse, yet hoped that health caregivers would realise what their circumstances were and while not enquiring too deeply, still read the physical signs of abuse, the black eyes or stab wounds, as the manifestations of violent masculinities on the bodies of the women. The following narrative is an indication of this:

"You go to the hospital and I mean um they can see that someone have beat you, do I have to tell them that... they can see I have a blue eye and stab wound".

In this case the assumption was that although never verbally acknowledged, the abuse was obvious and that the health caregivers should inform social services. Once more, there seemed to be an assumption that the health care services should find a way to deal with the abuse. They should read the bodies of women as abused or somehow deviant and find 'treatment' for it. Staff themselves, as mentioned earlier, resisted this push towards medicalization.

Women often found it difficult to talk about their abuse because of the immediate distance of language. It is difficult to express pain as the women experience it and relive it. Pain is resistant to representation and is inflicted to break down the self (Scarry, 1985). The silence surrounding injuries of abused women occurs in a cultural context that resists the

representation of pain.

> *"When you go to the doctor and they ask you what happened...it become so difficult to speak because of the pain you experience it's it's like a second abuse. You um... you relive it. You feel it again. You you... want to talk it but you struggle to get it out".*

There were nevertheless settings where the discussion of abuse, or of bringing maltreatment and pain to consciousness, was imperative and expected. In the police station women were expected to painstakingly describe abusive events. The women went to the police station not for healing but for some form of remedy, prevention and even retribution.

4.2.2 Use of Police Station

Abused women made use of the police station also because at the hospital there was what they perceived as a lack of privacy, the apparent unwillingness of health caregivers to step outside the boundaries of their healing tasks and the necessity to wait for long hours before being attended to. One of the women interviewed, Ms T, had the following to say:

> *"The women prefer to come to the police station. At the hospital they have to wait for hours to be assisted, there is no privacy for them. And if you are abuse you want to talk private. Here we have the trauma room where we can take the women to and we can calm them down or make them a cup of coffee. Nurses don't know how to talk to people and some for the police but I must say most of them are okay. Sometimes the police station looks like a hospital we have to clean the wounds and provide counselling to the women. The police sometimes take the women to the hospital they very helpful.*
>
> *I go to the police station because at least you can talk to someone and lay a charge so if he beats you next time the police can come and pick*

him up. I came here because I know of the trauma room and that they deal with people like me".

Women who came to the police station wanted protection rather than treatment, yet even this was not always easy. Ultimately they had to face the reality of their dependence on their abusive partners.

CHAPTER FIVE
LIVING WITH ABUSE

5.1 Introduction

Living in Retreat, Lavender Hill, Steenberg, Cafda, and Vrygrond puts people's lives at risk. Crime-related activities are high because of unemployment and poverty. Women and children are more often at risk of being victimized by their partners. Gangsterism is a common feature among youngsters living in these areas. Therefore, one can argue that violence has become embedded in the local worlds of people living in these areas. Women also have different views of what domestic violence means and that probably explains why women often tolerate violence as well as why such a large part of their lives is a story of violence. Most often men use violence against women to inscribe male dominance on the bodies of the women. Women experience sleeplessness and stress as a result of the abuse. Elder abuse and child abuse also seem to be common in these areas. In addition, many women believe that having children will provide them with the means to survive on the state grants for such children.

5.2 Socio-demographic Characteristics of the abused women

A total of 10 women were interviewed. Eight of the women were married and belonged to a religious affiliation. Of the women interviewed, four were bilingual. These interviews were mostly conducted in Afrikaans. A minority spoke only English, and their interviews were conducted in this language. The women were from areas such as Lavender Hill, Steenberg and Vrygrond. One woman had been married for four years; six had been married for six years, one for three years, one for 15 years and another for twenty years. Most of the women were unemployed and a minority were doing odd jobs to get some money.

The period of the abuse between the women and the abuser ranged from 4 to 6 years for the majority and 15 to 20 years for the minority of women. Of the women interviewed all reported physical, emotional and verbal abuse. Three of the women interviewed mentioned that their children had been abused as well.

5.3 Abused women's understanding of domestic violence

Women had different views on what domestic violence meant. Some of the respondents knew about the Domestic Violence Act.

> *"Domestic violence is wanneer jou man jou slat en somtyds kan dit die kinners wies wat saam pak kry. Dis hoekom ek police station toe kom want daai wet beskerm ons vrouens mos teen hulle". (Domestic violence is when your husband beats you and sometimes he can beat your children as well. This is why I came to the police station because the law protect us against them.)*

For some of the women beating was associated with love. This coincides with Maconachie *et al.*'s (1993) theory that women may define themselves as battered at different stages during an abusive relationship. Thus for some women, beating was a physical sign of affection, as expressed by one of the respondents:

> *"You see we as women think when a man beats you it is love because if he doesn't, it means he doesn't love you. If he don't beat you he will go to other women so that's why you have allow him to beat you".*

5.4 Living in an abusive relationship

Women and men seemed to liken an intimate relationship to a kind of ownership of the wife or lover as well as their children. This gave the husband a 'right' to 'reprimand' women.

This kind of ownership could be extreme as when a husband beat a woman and children and sexually molested the daughters. Furthermore, alcohol, mandrax and dagga abuse were in part responsible for domestic violence in most of the cases.

Women often had to face awful truths and make dreadful choices as in the case of Mrs C:

> *" I'm married for 15 years now and most of the time I had to run for my life especially at night with my children but just go back again because you feel it will get better. Because he tell you I will change but aah.....he doesn't. I went to the hospital so many times. Sometimes it's a wound in the head or a blue eye. Anyway my eldest daughter was 13 when I went to my grandmother because my grandfather was at the day hospital. I went to the day hospital to fetch my grandfather and took him home because they have raised me. Then my grandmother ask me do I know what's going on at my place. And I ask her how can I not know what's going on at my home. It was than that she told me that my eldest son told her that my husband is sleeping with my daughter. If somebody has beaten me with a stick that day.... I couldn't have I could have been dead. Oe... it was like a shock um um but still because that time people believed that you have to hide things. I was thinking of my husband's family and of my family all those things. I have confronted him and have asked him why did he do it. I will never forget, this was his exact words "This is my child". I took her, one thing the school was very supportive she was under safe line and sometimes the guidance teacher has taken both of us to safe line for counselling and um she went there for quite some time. And I have kept quiet about it but I'm regretting it today because the fact that I have never laid a charge how can I say "I have denied my child the right see you have to straighten things which was done to her". And what have we gained because he have continued with his life and what about us we were the one's*

that were suffering because that was not the last of itt ... it have carried on for some time. And aah...(lean forward) my son has caught him sleeping with my daughter, my daughter, and he was not supposed to.

Anyway I was away from home for quite sometime. This man used to humiliate me - he threw my clothes out on the street and many times I had to run for my life. He was using mandrax and dagga and my life was a living hell. My children were suffering. He stabbed my son with a screwdriver and he had to get eight stitches under his right eye. It's just terrible man uh....to be in a abusive relationship. He said he will change but it doesn't happen instead things are only getting worse.

Repeated exposure to violence caused women to develop coping mechanisms that in the long run made violence seem normal and expected as part of life (Lorion and Saltsman, 1993). Women were thus trying to reconstitute some agency as survivors and not as victim through reframing safe and unsafe situations, everyday and extraordinary violence (Jensen 2001). This is indicated in the following narrative:

"As hy my wil slat as hy gesuip is dan sê ek vir hom ek gaan die polisie bel, maar ek wietie eers waar die protection order is nie uuhuh (Laugh). Hy wiet as hy my slat gat ek die polisie bel ek vattie kak van hom nie. Ek skrik hom af met die protection order. Hy's so vrek bang um... want hy wil nie in die tronk ga sit nie. Ek wiet al. as hy gesuip is da kom moeilikeit ek ga wie gefok word". (If he wants to beat me when he's drunk I told him that I will call the police but I don't know where the protection order is uhuh. He knows if he beat me I will call the police I don't take shit from him. I scare him with the protection order. He's so scared um um because he don't want to end up in jail. I know when he is drunk it means trouble and I am going to be fucked up).

In the following narrative, coping with violence means reciprocating with violence by stabbing the perpetrator in the hand he normally uses to abuse the woman. By stabbing him in the left arm she creates a kind of safety for herself.

> *"Wiet jy wat, my man is links en as os so baklei da stiek ek hom op die linker arm want da wiet ek hy kan my nie slat nie of enige iets aan doen nie. Maar hy slat my net as hy gesuip is maar ek is bly hy werk nou weekends nou slat hy my nie. Hy's 'n vark as hy dronk is ja hy is morsig". (You know what I've done um my husband is left-handed and I have stabbed him on the left arm because I knew that he would not be able to beat or to do something to me. I got a protection order against him from the police. He only beats me when he's drunk. I'm happy that he is working on weekends now because he doesn't have time to beat me. But if he's drunk ooh he's a pig).*

Some women cope with abuse by fleeing or screaming out loud to attract attention and help. Staying alive requires a certain selfishness that pits individuals against each other and that rewards those who take advantage of those even weaker. Women often have to be tough and strong and to endure the most demeaning abuse. The narrative below is indicative of women's strength and toughness.

> *"Ek se vir die kinners julle het gewas en ge-iet. As dit begint das os weg. My ma liewe, hy't my groot ko kry. Ai Here, die hekke is toe gesluit slat hy jou ek het eendag so gese ek moes nie so gese het. Ek het gese jy's nes 'n donnerse kaffer die way wat tjy 'n mens slat lat die bloed loep net hulle baklei soe. Maar ek gaan vir jou wys. My woorde aan my man was altyd God kom stadig maar veseker. Hy kom, ek het dit altyd vir hom genoem. My kop was so teen die muur geslat dat hulle mos hierie skoene wat hulle dra met die yster in nou word jy geskop en getrap. Skoonma kom helpie. Jy lê da le en skrie help help oe!!! oe!!! jou kinners skree hulle is skoon... lyk soos wille diere die way wat die kinners in die ronde hardloop maar ons kannie by daai hek uitie want*

jy moet mos nou jou pak vat, ek is mos baas, dis my ma se plek, tjy se nie vir my ma hientoe en soentoe nie, daai is my suster en daai is my broer".

(I tell the children you have been bathed you have eaten, if he starts we are gone.

My mother is still alive he found me a grown up. Oh God...the gates are closed...he beats you. One day I said - I shouldn't have said it. You just like a bloody "kaffir" the way you beat a person it's just blood only they (kaffirs) fights like that. But I'll show you. My word was always God come slowly but surely. He's (God) coming I always told him that. My head was beaten against the wall they wear these shoes with the iron now they beat you kick and kick you. Mother in law doesn't help you. You lie down screaming help...help...Oh... Oh your children scream they look like wild animals the way the children run around but you can't get out of that gate because you have to take your beating. He's the boss- it's my mother's place and you don't tell my mother, and that's my sister and that my brother).

Women experienced shame and guilt as a sign of women's version of honor. A shameless woman has no concern for her reputation and therefore had lost her honor.

5.5 Shame and Guilt

According to Murphy (1987), guilt and shame are not as separate as they often seem to be. Shaming is an especially powerful means of social control in small scale societies, where everybody is known and behavior is highly visible, but it is less effective in complex societies like our own where we can exist in relative anonymity. But a black, bruised eye or a scar in the face cannot be hidden - it is brutally visible.

Abused women are often treated with disdain as if they were somehow responsible for their own maltreatment. Women face labelling by society if their partners abuse them. According to Stanko, (1985:31) societies have their own perception of women and their roles. In the area where I carried out my research, some people would refer to abused women as 'purple turtles' because of the bruised blue eyes that they sustained from the abuse, and in some instances relatives refuse to be associated with the abused women.

> *"My sister and her friend are teasing me they call me the purple turtle because of my blue eyes. The other time my sister told me that she is ashamed of me and don't want to walk with me".*

For the women involved it often resulted in a loss of feelings of self-worth. The damage to the women's body causes the shrinking of the self, which is further exaggerated by humiliation by others. Goffman (1963) noted that the disabled occupy the same devalued status as ex-convicts and certain ethnic and racial minorities. This is often also true of abused women, who are easily ascribed a negative identity by society. Much of a woman's social life involves a struggle against the image of how a woman should behave.

> *Interviewer: How do you feel when he calls you names?*
> *Respondent: "Ek... (huil en vou arms) jy voel worthless jy voel shit. Dit laat jou soos niks voel nie. Soos die anne dag ek was biesig om kos te maak toe hy dronk terug kom. Hy se toe hy soek sy vrete en toe gee ek mos nou sy kos. Toe se hy dis kak en toe smyt hy die kos op die vloer. Ek is moeg van hom ek voel ek kan dit nie meer vat nie. My kinners het nie eers meer respek vir hom. As hy hulle vra om iets vir hom te doen dan ignore hulle hom en weier net om dit te doen because hulle sien wat hy doen aan my. Kyk na my gesig (wys na merke in gesig) dit is hy wat al die dinge aan my doen. Ek gee nie eers meer om vir myself nie. Ek het nie 'n werk nie en is afhanklik van sy geld en ek kyk na my sister se kind vir 'n ekstra geldjie".*

(I... (crying and folding arms) you feel worthless. Like the other time I prepared food he also came back drunk. He wanted his food and when I gave him his food he said this is shit and threw it on the floor. I'm just tired of him and sometimes I feel I can't take it anymore.

My children don't have respect for him anymore. If he asks them to do something they just refuse they just ignore him because they see what he's doing to me. Look at my face (points to scars in face) it's him who is doing all these things. I don't care about myself anymore. I don't have a job I'm relying on him for money and I'm looking after my sister's child for a little money).

One of the respondents said that she has been labelled as worthless, a whore and a slut during abusive attacks or when she reprimanded her partner to leave her things. The following narrative illustrates this:

Respondent: "Ek se vir hom los my goeters af, los dit af. As jy tsjy wil iets hê gat werk vir jou. Bring vir my geld da sal ek vir jou gie. En hy vloek vir my hy sê ek 'n nai en ek is 'n poes".
(I told him he should leave my things. If he wants something he has to work and bring me money, only then I will give him of my things. He swears at me and calls me a whore and a cunt).

5.6 Violence as an expression of patriarchy

According to Stanko (1985), women's injuries reflect the effects of aggressive masculinity. In a sense the power of patriarchy is beaten into the bodies of the women and is a physical manifestation of patriarchy. It also seems that men are trying by all means to prevent women from working by injuring the women's hands.

Therefore, beating women is one way in which men try to reassert masculinity and to control women's lives by preventing them from working, as indicated in the narrative:

> *Interviewer: Would you like to tell me what caused the wound in your face?*
>
> Respondent: "Die is mos laas Sondag aand se merk toe hy my aangerand het toe ek die saak mos kom maak het. Wat hy vir my al met sy vuis in die gesig geslat het en hier teen my kop het hy my geslat die knock (point to wound in head) het hy vir my die vorige wiek gegie. Hy het die biesemstok stukken op my kop geslaan. Ek het nie eers gewiet nie toe ek ontwaak toe ek by kom toe is die hele bed se lakens vol bloed. Die is die knock wat hy my die vorige wiek gegie het (wys na wond aan linker kant van kop) en die hou is wat hy my gegie het (wys na linker merk aan linker kant van ken) Sondag oggend. En hy het my vanoggend geklap en my hande weer omgedraai hy wiet die hand is uit lit uit maar hy draai dit weer om. Ek het vir hom gese…(cry) moenie my arm om draai nie want die twie hande werk want jy is te sleg om te werk. Ek is nie lief vir die man nie. Wie kan dan lief wees vir 'n luisgat". (This is last Sunday's scar. He hit me with the broomstick. He hit me in the face and against my head – the knock (point to wound in head) this is last weeks knock. He breaks the broomstick on my head. I didn't know, when I woke up I only saw blood. The whole sheets were full of blood. This is the knock that he gave me the previous week (point to wound on left arm and chin). On Sunday morning he smack me in the face and twisted my arms. I told him…(cries) don't twist my arms because its these two hands who work because you are to lazy to work. I don't love this man. Who can love a lice ass).

Another respondent had the following to say:

> *"Jy voel soe sleg jy wil net uit want dit voel die man maak jou dood. My man het al.dag wat die Here gee gese ek sal vir jou in 'n rolstoel*

sit. Ek sal jou vermink jou hele gesig met liggaam en al. Vermink, hy gaan my vermink ek wietie. 'n Man is 'n baie jaloerse ding. Hy is 'n jaloerse mens rerig waar. Jy is oppad werk toe en kyk daai jare se vrouens het nie gewerk nie die man moes mos gesorg het vir jou en die kinners. Deesdae kan ons mos nie mee nie jy moet mos nou jou man help werk. Nou lyk dit as jy aantrek jy gat nou nie werk toe nie jy gaan nou na 'n ander man toe. Jy dink nie eers aan sulke goed nie maar dit sit hier in hulle agte koppe. Jy het 'n man da wat jy werk maar jy as vrou wiet nie dis hy wat ager die agtedeur staan nie. Kantie hy doen lankal die goed nou kom hy huis toe nou kom baklei hy net so saam met jou. Dis hoekom 'n vrou eendag vir my gese hierie manne vandag hulle is morsig". (You feel so bad you just want to get out because it feels as if the man wants to kill you. Each day that the Lord gave us my husband said that he'll put me in a wheel chair. He said he'll smash my body and face. He'll smash my body and face I don't know. Husbands are very jealous really. You are going to work; in the olden days women didn't work the men were responsible to look after the children and wife. These day women can't afford not to work you have to help your husband. When you get dress it seems as if you not going to work but you going to another man. You don't think of such things but they have it in their heads that you have a boyfriend where you work but you as a wife don't know that he is doing it. That's why one woman said the other day that these men are disrespectful).

This narrative provides an explanation of cultural ideology that promotes and perpetuates aggressive male behaviour in manhood and power relations and authority over women (Dobash and Dobash, 1997). Abuse is often used to illustrate male dominance over the weaker. This dominance can be seen in the ways in which men inscribe a form of power on the faces of women. It could be in the form of wounds, scars, or wounds on the faces and arms of the women. It is often signs of power, dominance, masculinity as well as ownership. According to Turner (1980) the body becomes the surface that represents some kind of common leading edge of society, which in turn becomes the symbolic stage upon which the misfortune of

socialization is enacted. Therefore, I would argue that women's bodies and the injuries inscribe on their bodies become symbolic of what is going on in the environment in which they live.

5.7 For many women, the story of large parts of their lives is the story of violence

Interviewer: Does he beat you in the presence of the children?
Respondent: "As hy gesuip is dan gee hy nie om nie hy vind fout met a.les wat ek doen. Hy gee nie eers om vir my pa en my sister nie wat te sê die kinners. Maar as hy nugter is en ek se vir hom ons moet dinge uitpraat dan kan hy niks sê nie Dit help nie want as hy nie gedrink is nie is hy soos iemand wat niks weet nie. Maar ek wil 'n interdict teen hom kry maar die probleem is dat ek nie geld het nie om Wynberg toe te gaan nie. My kinners raak groot en hulle het al. klaar nie respek vir hom nie. Ek voel guilty omdat ek my kinners ook deur hel moet sit. My jongste kind is sewe jaar en die oudste is dertien jaar oud. Ek weet nie of ek dit meer kan vat nie.

(When he's drunk he doesn't care because he sees mistakes in everything I do. He doesn't care about my father and sister what about my children. But when he's sober and I ask him to talk things out he can't say a thing. It doesn't help because when he is sober he is like someone who doesn't know about anything. But I want to get an interdict. But the problem is that I don't have money to go to Wynberg. My children are growing old. My youngest child is seven years old and the eldest thirteen years. I don't think I can take it anymore).

5.8 Somatic Responses to the ongoing threat of violence

One of the results of domestic violence is that women develop stress disorders such as sleeping and skin problems. In reality the effects of domestic violence can be overlooked and can remain a secret.

"Ek het stress van die abuse. Net van ek so geslat word stress ek so voorheen was ek 'n happy mens. Ek lyk ouer as wat ek moet dis die stress van die man." (I am stressed because of the abuse. It didn't happened before only now that he is beating me that I stress. I was a happy person before and look older than I should).

Another respondent:

Respondent: "I can't sleep at night because I'm not sure when when he'll beat me again... The gangsters are shooting outside sometimes at night and you hear people screaming. Lavender Hill can be messed up sometimes. The violence is in you house it's outside it's everywhere. You no longer safe in the home and outside (nod head...) I don't know. I have developed a bad rash on my arms can you see this (point to arms) this is all because of the abuse. I'm easily agitated people can't just make jokes then I become angry. There was a time that people could not touch me on the shoulder because it reminded me of the times that he took me from behind when he wanted to abuse me.
I don't take shit from anybody I had enough of him. He ruined my live and my children's lives. I'm thinking of divorce but my religious belief is against it. I promised till death do us part. This is how abuse can change your life".

What emerged from the interviews was that elderly women sometimes had to face abuse as well.

5.9 Elder abuse

Violence was not only used against women but also against elderly people. The abused women's partners also verbally and physically abused women's mothers. The following narratives illustrates that:

Respondent: I'm a pensioner and my husband died 10 years ago. At my age I have to wonder where I will get food to feed my daughter's

three children. She and her husband divorced and she dumped the children at my place. I can't just leave my grandchildren on the streets or chase them out they'll just become gangsters. But I can't cope I ...I (cry) cant't cope. I can't get money for the children because they say the mother and father is still alive. I'm suffering at my age I am suppose to relax but now I have to keep up with the worries of grandchildren. I'm not telling you a word of a lie sometimes there is nothing I mean nothing in that house. Nothing to eat we old people are suffering. You brought your children up then you have to look after your grandchildren. Life is tough because I can't apply for state grant they say both parents are alive.

These are the words of a 35-year-old respondent:

Respondent: "Hy vloek my ma uit en het vir laas gegooi toe gooi hy vir haar met 'n plank hier op haar voet en my ma is al 'n pensioner. Nou elke keer skel hy my ma van die lielikste.

Hy se my ma is sleg en my ma is 'n, is 'n "n" 'n nai en ek is net so sleg soos my ma maar al van die lielikste". (He says my mother is uh mother fuck and she is as bad as I am).

Why does he beat your mother?

Respondent: "Omdat my ma da gekom het en uh uh vir hom geskel het en vir hom gevra het hoekom hy saam met my baklei het en met die gevolg toe skel hy vir haar net so lelik uit en toe gooi hy vir haar en ek was nog da binne besig en toe ek uit kom hoor ek by my ma hy't ha gegooi. Toe gooi hy vir haar met 'n plank en my ma is vet en sy loep nie so lekker nie".

(He beats my mother because she scolded him and she asked him why is he fighting with me. He scolds her back and used dreadful language and he threw something at her. I was busy inside but when I came

outside I heard that he had thrown a plank at my mother. My mother is fat and she walks with difficulty).

What emerged from the interviews was that when women transgress the social order of how women should behave, they experienced abuse. When women challenge the traditional roles of women, which requires them to be subservient, rear children and be housewives, they are likely to experience abuse. Men have reached a stage of powerlessness and want reassert that power by beating their wives to show their maleness. The changes in relationships between men and women, which were brought about by the breakdown of traditional family structures as well as modernization, seem to be tremendously threatening to men (Vetten, 2000). The cultural construction of the male and female roles ignore the fact that we are an ever-evolving society. Some men resort to these threats to their gender identity and their power with violence (Kelly, 1998).

Women have reached a stage of taking on roles of toughness and this has become embedded in their local worlds. Women are thus prepared to endure the abuse as long as they don't allow men to silence them. The case of Mrs J illustrates this:

Respondent: "These men want us to be like their mothers to keep quiet when they beat us how can you... and that they don't like. Because they say you want to be the man in the house. Oh no, he can beat me but I won't keep quiet I'll tell him what he is like. How must I feel if he call me all these names?"

Women became reliant on the state as a means of survival. Due to their impoverished conditions, women prefer to have children in order to make a living from the state grants.

5.10 State grants as means of survival

In some of the cases I researched, children were seen as a break away from impecunious conditions. This could happen through state grants for children. Children could thus be a partial solution to their impoverished conditions and as means of survival. According to Salo (2000) the state intervenes in giving assistance to the women, but it nevertheless engages in subtle and less obvious forms of gender subordination, which makes women dependent on the state for survival. This is illustrated in the following narrative:

> *"Because I have these children I can get money from the state. Sometimes I feel to have more children because I will at least have something to live on. You become so desperate because the husband that you have can't look after his children".*

CHAPTER SIX
CONCLUSION

This chapter discusses the contribution of my study towards the understanding of health care responses at the Retreat Health Centre to cases of domestic violence and how abused women experience these responses. The results of the study indicate that dealing with domestic violence is a complex problem. The maintenance of privacy and confidentiality by health caregivers and abused women further complicate issues.

The study shows that abused women, as well as health caregivers, perceive domestic violence as a private matter. Dealing with domestic violence in the health care facilities is made more problematic by the fact that it needs to be treated, while at the same time staying confidential and being a potential intrusion on the privacy of the women who seek help. The study also shows that, to enable them to deal with constant violence, abused women develop various coping strategies. Furthermore, issues in the health care setting are complicated by the fact there are no proper referrals. This can be seen by the fact that health caregivers appear reluctant to give referrals to abused women. The issue of referrals is further complicated by the fact that health caregivers cannot refer the abused women for proper assistance if the women do not want to admit that they have been abused. Health caregivers suggest that a standard protocol would make it easier for them to identify and deal with domestic violence.

Like the abused women, the health care respondents in this study view the familiar areas within which they themselves live and move as relatively safe. However, the rest of the area, including the vicinity of the health care facility at which they work, is often perceived to be potentially dangerous (Gibson, 2002). Most of the participants gave examples of the experience of violence in the wider community. Female staff have learned to cope with community violence, often by behaving in what is normally considered to be masculine ways, by affecting a toughness they feel might protect them.

They are also alert to the constantly shifting nature of safe and dangerous spaces and differentiate between them. Violence has thus become embedded in the everyday lives of people working and living in Retreat, Vrygrond, Lavender Hill, Grassy Park and Steenberg. Not only are these areas perceived as dangerous spaces, but the violence also affects where people working in these areas spend their leisure time. There is apparently also an ongoing effort to maintain the health care facility as a relatively safe space – therefore the concern with people entering the premises. Potentially violent bodies, especially, need to be regulated on the hospital premises.

This concern also serves to create social distance between providers and clients and seems to increase a sense of control and security for staff. According to Scheper-Hughes (1992) by controlling bodies in a time of crisis, societies try to reproduce and socialize the kind of bodies that they need. This burden seems to fall in particular ways on staff that serve as the interface between the community and the institution. It is also here that the greatest slippage occurs, with staff behaving in more disorderly and mimetically violent ways in an effort not to seem vulnerable or to become victims. It can thus be argued that staff also emphasize their own aggressive behavior at times because of the potentially threatening environment and because they have learned through experience that being tough might protect them. Despite all the state and public discussions on domestic violence as a health problem, it is in reality still regarded as falling in the private and the social sphere. Unlike the protocol for dealing with rape survivors, there is no protocol on how to deal with victims of domestic violence.

Some of the respondents in this study were ambiguous about their abuse, yet hoped that health caregivers would realise what their circumstances were and, while not enquiring too deeply, still read the physical signs of abuse, the bruised blue eyes or stab wounds, as the manifestations of violent masculinities on the bodies of the women. There were nevertheless

instances where women could influence the power relations, e.g. by drawing on familiarity, friendship and collegiality when interacting with the health caregivers.

The women had different views of what domestic violence meant. Some of the respondents knew about the Domestic Violence Act. For some of the women, beating was associated with love. Maconachie *et al.* (1993) surmise that women may define themselves as battered at different stages during an abusive relationship. Thus for some women, beating is a physical sign of affection.

In some of the reported cases, children were seen as a means of a breaking away from impoverished conditions, through obtaining state grants for children. Some women perceived children as a partial solution to their impoverished conditions and as means of survival. Violence was not only used against women but also against elderly people. The abused women's partners also verbally and physically abused the mothers of these women.

As a result of the abuse, women developed somatic problems, which resulted in sleeping problems for some. Some of the women mentioned that they had developed skin problems while others mentioned that they were suffering from stress because of the abuse. In a sense the power of patriarchy was being beaten into the bodies of the women. Thus the headaches, the blue eyes, wounds and scars on the faces of the women can all be seen as physical manifestations of patriarchy as well as ownership.

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ENDNOTES

1. Coloured, African and whites are categories used during the Apartheid regime. These categories are still salient in the present context of South Africa.
2. Kaffir, derogatory term that was used during the apartheids era to refer to Africans

APPENDIX

Appendix I

HEALTH CARE RESPONSES AT RETREAT COMMUNITY HEALTH CENTRE TO CASES OF DOMESTIC VIOLENCE

In depth guide for health care givers attending to abuse women 18-45 years old.

SITE: RETREAT COMMUNITY HEALTH CENTRE

AREA: RETREAT

INTRODUCTION:

Hallo I am Jeanine Mathison, a student at the University of the Western Cape. I am doing research on how health care givers respond and provide treatment to abuse women and how the women experiences the services provided to them. You can stop me at any time if you feel you don't want to continue with the interview or if you feel that the questions are to sensitive to answer. The information that you will be given will be treated with strict confidentiality and no names will be mentioned. Will you please allow me the opportunity to interview you?

SECTION 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Sex

Male/Female

Age

Marital Status

Married

Cohabiting

Single

Separated

Other, specify

Level of education

Primary

Secondary

College

University

Other, specify

Religious affiliation

Catholic

Muslim

Other, specify

Length of training

1 year

2 years

3-4 years

Other, specify

Length of practice

1 year

2-4 years

5 years

More than 5 years

1. How do you respond and provide treatment to cases of domestic violence?

.....

2. How do the health care providers perceive domestic violence?

.....

3. Should the health care policy be revised to address the needs of abused women?

.....

APPENDIX II

HEALTH CARE RESPONSES AT RETREAT COMMUNITY HEALTH CENTRE TO CASES OF DOMESTIC VIOLENCE

In depth guide for abused women 18-45 years old who present at the Retreat Community Health Centre

SITE: RETREAT COMMUNITY HEALTH CENTRE

AREA: RETREAT

INTRODUCTION:

Hallo I am Jeanine Mathison, a student at the University of the Western Cape. I am doing research on how health care givers respond and provide treatment to abuse women and how the women experiences the services provided to them. You can stop me at any time if you feel you don't want to continue with the interview or if you feel that the questions are to sensitive to answer. The information that you will be given will be treated with strict confidentiality and no names will be mentioned. Will you please allow me the opportunity to interview you?

SECTION 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

Sex

Female

Age

Marital Status

Married

Cohabiting

Single

Separated

Other, specify

Level of education

Primary

Secondary

College

University

Housewife

Other, specify

Religious affiliation

Catholic

Muslim

Other, specify

Length of training

1 year

2 years

3-4 years

Other, specify

Length of practice

1 year

2-4 years

5 years

More than 5 years

1. How do women experience the service given by health care providers?

.....
.....
.....

2. Are there difficulties in gaining access to the necessary health care services for women who experience domestic violence?

.....
.....
.....

APPENDIX III

SITE: Retreat Community Health Centre

AREA: Retreat

DATE:

Observation and Case notes among health care providers at the Retreat Community Health Centre

1. Interaction Patterns

.....

.....

.....

2. Activities of the day

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3. Appearances among the women

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4. Amount of time waiting for assistance

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Thank you