

**Understanding attitudes and perceptions of nurses and medical  
doctors on providing intimate partner violence screening at  
Katutura Hospital, Namibia**

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Masters in  
Public Health at the School of Public Health, University of the Western Cape



**11 June 2017**

## DECLARATION

I hereby declare that this thesis, entitled “Understanding attitudes and perceptions of nurses and medical doctors on providing intimate partner violence screening at Katutura Hospital, Namibia” is my own work and effort, and that it has not been submitted anywhere for any degree. Where other sources of information have been used, they have been acknowledged.

A handwritten signature in black ink, appearing to be 'M. S. A. E.', written over a circular stamp or seal.

Signed:

Date: **11 June 2017**



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## ABBREVIATIONS

ANC	Antenatal care
FP	Family planning
GBV	Gender-based violence
IPV	Intimate partner violence
LAC	Legal Assistance Centre
MDGs	Millennium Development Goals
NDP4	National Development Plan 4
OPD	Outpatient Department
WHO	World Health Organisation



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## DEFINITION OF KEY TERMS

**Intimate partner violence:** The most common form of domestic violence against women, most of the perpetrators being men. IPV takes various forms such as physical, sexual and emotional violence.

**Domestic violence:** Behaviours used by one person in a relationship to control the other. These behaviours are mostly abusive.

**Gender-based violence:** Both sexual and non-sexual physical violence, emotional abuse, and forms of child sexual abuse.

**Screening:** In a hospital setting the act or work of a person who screens, for example to ascertain the signs and symptoms of a certain disease.

**Attitude:** A predisposition or tendency to respond positively or negatively towards a certain idea, object, person, or situation. Attitude influences an individual's choices of action and responses to challenges, incentives, and rewards (collectively referred to as stimuli).

**Perception:** The way in which one perceives or apprehends things by means of the senses or the mind; cognition or understanding.

**HIV/AIDS:** A sexually transmitted virus transmitted through sexual intercourse or through contact with infected body fluids such as blood or urine. HIV stands for human immunodeficiency virus, and AIDS stands for acquired immune deficiency syndrome.

**Rape:** Unlawful sexual intercourse or any other sexual penetration of the vagina, anus, or mouth of another person, with or without force, by a sex organ, other body part, or foreign object, without the consent of the victim.

**Sexually transmitted disease:** Diseases caused by sexually transmitted infections and other types of infection affecting the reproductive system.

**Cultural beliefs:** A set of shared values, goals, and practices that characterises an institution, group, or organisation.

## ABSTRACT

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This qualitative, explorative study aimed to explore the attitudes and perceptions of nurses and medical doctors at frontline services units of the Katutura Intermediate Hospital in Windhoek, Namibia, in providing intimate partner violence (IPV) screening during routine care. Frontline services were selected because that is where most of the patients come into contact with nurses and medical doctors for the first time, making this the first point of care contact at this referral hospital. The researcher conducted in-depth interviews with purposively selected sample of 18 nurses and six medical doctors employed at frontline services units of the hospital.

All the respondents concurred that IPV was prevalent in Namibia, as evidenced by the daily hospital records. Respondents admitted that the Casualty Section of the Katutura Hospital was the busiest section at the hospital, and that incident and cases of IPV were recorded there every hour, especially from Thursday through the weekend and on public holidays, as victims seek treatment for their resultant injuries. Most of the respondents expressed concern about their inability to screen for IPV during routine care due to a lack of time. Many respondents believed, however, that screening for IPV was the responsibility of social workers and not necessarily that of nurses and medical doctors. Others believed that a lack of skills among hospital staff to screen for IPV as well as staff shortages and work overload were some of the factors preventing staff from performing screening.

The study found that IPV cases were prevalent at the Katutura Intermediate Hospital, and that there was ambivalence about IPV screening and reporting among the staff who participated in the study. Some of the nurses and medical doctors who participated in the study saw IPV as a non-clinical and social issue and believed that it was the responsibility of social workers, while others felt that they might be able to do something about it but were hampered by factors such as staff shortages, a lack of privacy and work overload. The researcher recommends further research on the attitudes and perceptions of senior management and patients towards IPV screening.

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# CHAPTER 1

## INTRODUCTION

### 1.1 INTRODUCTION

Intimate partner violence (IPV), which is almost exclusively perpetrated against women, is a violation of women's rights and has serious consequences for physical, reproductive and mental health (Olalekan, Uthman, Lawoko & Moradi 2009). García-Moreno, Jansen, Ellsberg, Heise, and Watts (2005) found that there was a high prevalence of physical IPV (31%) and sexual IPV (17%) in Namibia. According to the Legal Assistance Centre, one in three women will suffer violence perpetrated by an intimate partner in her lifetime (Legal Assistance Centre (LAC) 2012a).

According to Shamu, Abrahams, Zarowsky, Shefer and Temmerman (2013), various factors have been identified that could lead to a higher risk of IPV occurring. For example, it has been found that gender attitudes influence behaviour. García-Moreno et al. (2005) found that 35% of Namibian men feel that wife beating is justifiable. Based on such perceptions, men are more likely to regard wife beating as socially acceptable. Similar findings have been documented elsewhere in sub-Saharan Africa countries such in Zimbabwe and Ethiopia (García-Moreno et al. 2005). Olalekan et al. (2009) found that owing to their socialisation more women than men see wife beating as socially acceptable. These authors (Olalekan et al. 2009) further report that couples who enjoy better education and good economic conditions, have access to the media, live in urban areas and make decisions together as couples, are less inclined to justify IPV. Similar findings were reported by Andersson, Ho-Foster, Mitchell, Scheepers and Goldstein (2007). This indicates that societies that are more economically developed tend to have fewer incidences of IPV, and that nurses and medical doctors in such societies are more likely to be able to conduct IPV screening.

### 1.2 BACKGROUND

Violence is described as the threat or exercise of physical, psychological and/or emotional harm – that is, any type of force against another person with the intent of inflicting harm or exercising power and control over them (WHO 2002). Domestic violence is a form of behaviour which involves violence or other forms of abuse by one person against another in a domestic setting,

such as marriage or cohabitation. It includes domestic abuse, spousal abuse, intimate partner violence (IPV), battering or family violence (Natan, Ari, Bader & Hallak 2011). IPV is violence by a spouse or partner in an intimate relationship against the other spouse or partner. Domestic violence can take place in both heterosexual and homosexual (same-sex) family relationships, and can involve violence against children in the family. IPV is the most common form of domestic violence against women, most of the perpetrators being men and the majority (95%) of the victims being women (LAC 2012). IPV takes various forms, such as physical, sexual and emotional violence, and mostly includes violence against women perpetrated by their husbands and/or other intimate male partners (Watts & Zimmerman 2002). IPV includes physical violence, such as slaps, punches, kicks, assault with a weapon, homicide and sexual violence (forced sexual acts and forced degrading sexual acts), which are usually followed or accompanied by emotional abuse such as preventing the victim from seeing friends, continuous belittlement or humiliation, intimidation or financial restrictions (Watts & Zimmerman 2002). In most cases the perpetrator of IPV forms part of the victim's immediate environment, such as her home, place of work, or community. This means that they are often the victim's intimate partner (e.g. boyfriend or husband), ex-boyfriend or ex-husband, a family member, a friend or an acquaintance. Among the friends and/or acquaintances of the family member, are those with a friendly relationship to the victim and who generally encounter her in a domestic setting (Flury, Nyberg & Riecher-Rössler 2010). IPV screening helps us to understand the extent of this public health problem as well as ways of addressing it.

### **1.3 RISK FACTORS FOR INTIMATE PARTNER VIOLENCE**

Various factors have been identified that could lead to a higher risk of IPV occurring both worldwide and in Namibia (Shamu et al. 2013). Such risk factors include socio-demographic factors such as being young or adolescent, single, separated or divorced during pregnancy, belonging to an ethnic minority and having a low educational status. Vulnerability in young women is frequently due to their inability to make decisions, their low economic status, and their dependency on male partners for maintenance and pregnancy care. Shamu et al. (2013) further report that pregnancy-related factors associated with IPV include unintended pregnancy, late

entry into care and inadequate antenatal care. HIV infection may be linked to IPV in general, but there is little information on the link between HIV and pregnant women.

According to Shamu et al. (2013), factors associated with IPV in Zimbabwe include women having a younger male partner, excessive alcohol consumption, partner control of women's reproductive health, and risky sexual practices. The authors report further that alcohol consumption has been known to impair young people's decision-making capacity, and that cultural and personal perceptions of reproductive health choices also contribute greatly to gender-based violence (GBV) against women, mostly because women are perceived to be inferior to men.

According to Abramsky et al. (2011), in instances where both the woman and her partner are subject to a risk factor there is a strong association with IPV. These authors (Shamu et al. 2013) further report that the identification of and response to IPV (GBV) during antenatal care in Zimbabwe is being hampered by inadequate human resources, financial and infrastructural resources as well as poor support of gender based violence training for midwives and women's reluctance to open up against abuse by their partners. Abramsky et al. (2011) further argue that for IPV prevention to be successful, "programs should increase their focus on transforming gender norms and attitudes, addressing abuse during childhood, and reducing harmful drinking".

Shamu et al. (2013) report mixed perceptions among midwives in Zimbabwe regarding addressing IPV, some describing it as a non-clinical, social and domestic problem, while others feel that they could do something about it but see it as an overwhelming task. Development initiatives to improve access to education for girls and boys may also have an important role to play in violence prevention.

In its multi-country study, the World Health Organisation (2005) reported that a history of childhood abuse, alcohol abuse and acceptance of wife beating among women in some cultures were associated with violence perpetrated by partners in intimate relationships. Abramsky et al. (2011) indicate that the 2005 multi-country study undertaken by the WHO also showed that alcohol use by either both partners or one of the partners in an intimate relationship was a risk factor leading to violence against women. A number of studies have been conducted worldwide on domestic violence and GBV with the aim of finding solutions to the problem. Previous studies

have highlighted the importance of researching IPV during pregnancy to determine the prevalence of such violence and its effect on the health of the women and babies concerned (Shamu et al. 2013).

The findings of a randomised control study on screening for IPV in the health setting (MacMillan et al. 2009) did not provide sufficient evidence to support screening for IPV; however, it did indicate that the evaluation of services for women after the identification of IPV needed to be prioritised. Studies like this are essential owing to the absence of sufficient information to support IPV screening, as well as to determine the effects of IPV screening on women and the effectiveness of the services provided to women who are victims of IPV. There is also very little information on the availability of the necessary screening and other identifying techniques that can be used to screen for IPV and to handle the challenges related to IPV screening. As stated above, one in three women will suffer violence perpetrated by an intimate partner in her lifetime (LAC 2012a).

It has been found that women of reproductive age are more vulnerable to abuse by intimate partners than women of other age groups because they are more likely to be in an intimate relationship (Shamu et al. 2013). The prevalence of IPV against pregnant women differs globally however, with rates ranging between 0.9% and 30% for physical violence. The results of these reviews may be compared to those obtained by the WHO in its multi-country study, which reported the prevalence of IPV as ranging between 1% (Japan, city) and 28% (Peru, provincial) in ten participating countries, the highest prevalence being reported in two countries, Ethiopia and Peru. Few studies have researched IPV against pregnant women, however (Shamu et al. 2013).

#### **1.4 GLOBAL PREVALENCE OF INTIMATE PARTNER VIOLENCE**

It is estimated that a third of women in Namibia experience physical and/or sexual violence at the hands of their intimate partners (LAC 2012a). The LAC (2012a) further indicates that 1 100 cases of rape are reported to the police every year, a third of these cases involving children under the age of 18. According to the LAC (2012b), Namibia has adopted a strategy of zero tolerance towards GBV, and various interventions have been introduced, such as the Combating of Rape

Act 8 of 2000, the Combating of Domestic Violence Act 4 of 2003, the National Plan of Action on GBV (2012–2016), and the National Gender Policy (2010–2020).

Violence by an intimate partner is the most common form of domestic violence in the world. Almost 95% of the victims are women, and one in three women will suffer violence at the hands of an intimate partner in her lifetime (LAC 2012a). While the prevalence of IPV differs in different parts of the world, the risk factors are similar (Abramsky et al. 2011). Abramsky et al. (2011) identify several factors that are associated with IPV: the attainment of secondary education, a high socioeconomic status and formal marriage offer protection from IPV; while alcohol abuse, cohabitation, youthfulness, attitudes supportive of wife beating, having outside sexual partners, experiencing childhood abuse, growing up with domestic violence, and experiencing or perpetrating other forms of violence in adulthood increase the risk of IPV. Worldwide, one in three women will be victims of abuse at some point in their lives, and 40–70% of female murder victims worldwide are killed by an intimate partner (LAC 2012a).

The response of the Namibian health system to IPV includes screening, counselling, treatment and referral of those affected by it (LAC 2012b). Health-care workers are involved in screening patients visiting health facilities, among them victims of IPV. Identified victims of IPV are then referred to the Women and Child Protection Unit situated on the hospital premises for further assistance. Health workers provide treatment through referrals to social workers and doctors to those who disclose physical abuse and psychological harm. After screening and treatment of physical ailments, patients are released, and there is no follow-up mechanism to determine how the IPV issue has been handled. It should be noted that health workers only act on information provided to them by patients, and that should the patient not reveal IPV, they may return home undetected (Waalén, Goodwin, Spitz, Petersen & Saltzman 2000). Waalén et al. (2000) further state that according to the participants interviewed, much more could be done through screening during routine care at frontline services units to detect incidences of IPV and provide victims with the necessary support and care at facility level. According to Ramsay, Richardson, Carter, Davidson and Feder (2002), the attitudes of women patients and health workers regarding screening for domestic violence were found to be acceptable at between 43% to 85% and two-thirds respectively.

## 1.5 PROBLEM STATEMENT

IPV screening, especially for women, may be an important step towards addressing IPV – hence the need to explore the feasibility of introducing IPV screening. However, studies on IPV screening in the health-care setting seem to indicate that no improvement occurred in the lives of those who were screened for IPV during routine care (WHO 2013). In order for health care to contribute to IPV prevention and the care of the victims, research needs to be conducted on the attitudes and perceptions of nurses and medical doctors who are likely to come into first contact with potential IPV victims. Given that the health setting is likely to be the first contact for some of the victims of IPV, either through self-referral or referral from other stakeholders, frontline services units – that is, emergency departments, antenatal care, family planning, sexually transmitted infections clinics and outpatient departments – are viewed as primary points of care for women who most frequently fall victim to IPV. Therefore providing IPV screening at these points may facilitate detection, the treatment of IPV-related ailments, the acquisition of information, and referral for further support and care. It is also at these frontline services units that health workers are able to interact more freely with patients and gain some understanding of their social circumstances. It is against this background that the attitudes and perceptions of nurses and medical doctors towards IPV screening in the health-care setting need to be gauged.

IPV greatly affects the health of the victims – in particular their reproductive health – and society at large. Women are at a high risk of contracting HIV/AIDS or STIs or developing other health problems or mental problems; suffering from stress; experiencing unplanned or unwanted pregnancies and even birth complications; undergoing abortions; and giving birth to babies with a low birth weight (WHO 2013; Abramsky et al. 2011; Olalekan et al. 2009; Shamu et al. 2013).



## 1.4 OUTLINE OF THESIS

This study is presented in five chapters. Chapter 1 introduces the study and chapter 2 discusses the literature relevant to the study and discusses the findings of the literature. Chapter 3 describes the research methodology and the design used for data collection as well as data analysis procedures, ethical considerations and rigour. Chapter 4 describes the study participants and presents the results of the study. Chapter 5 summarises the key findings from the research and suggests some recommendations based on these findings.



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## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

This chapter defines IPV and examines its prevalence and risk factors, and then describes the perceptions and attitudes of health workers regarding IPV screening and the barriers and opportunities associated with this type of screening. It presents findings from similar or related studies, defines the theoretical framework and methodological shortcomings of this study, and demonstrates the need for further research. The literature review made use of documentary evidence from similar studies of similar or related topics, which the researcher utilised to further the hypothetical deductions and recommendations of this study. The literature review afforded the researcher the opportunity to analyse available evidence, evaluate it and make recommendations.

#### **2.2 DEFINITION OF INTIMATE PARTNER VIOLENCE**

Intimate partner violence or IPV is defined as the intentional use of physical force or power, threatened or actual, against a partner, which results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation and is a form of gender-based violence (Krug, Dahlberg, Mercy, Zwi & Lozano 2002). In this study, IPV is understood to be the most common form of domestic violence against women, and is mostly perpetrated by men. IPV takes various forms, such as physical, sexual and emotional violence. In this study, the terms "abuse" and "assault" are used interchangeably in reference to violence.

#### **2.3 ATTITUDES AND PERCEPTIONS OF HEALTH WORKERS TOWARDS INTIMATE PARTNER VIOLENCE SCREENING**

According to Ramsay et al. (2009), between 35 to 99% of UK women accept screening for IPV in health settings, while health workers' willingness to perform IPV screening in the health-care setting was found to vary between 15 and 95%. This result seems to indicate that both women and health workers are accepting of screening for IPV leading to psychological and medical

interventions. This willingness on the part of health workers and acceptance of IPV screening by women is a step towards providing psychological interventions to victims as well as medical care for injuries they may have suffered.

Hegarty et al. (2015) suggest that other forms of intervention that can be used to screen for IPV are web-based systems by means of which women can respond to questions and/or identify signs of IPV which will assist the health workers conducting IPV screening in decision-making.

According to Roelens, Verstraelen, Van Egmond and Temmerman (2006), obstetrician-gynaecologists in antenatal settings in Flanders, Belgium were found to be unfamiliar with IPV and generally underestimated the extent of the problem. The study found that only a few (6.8%) of the obstetrician-gynaecologists who participated in the study had ever received or pursued any kind of education on IPV. The study reported further that most (93%) of the participants felt they did not have adequate skills to deal with IPV, although they did express their willingness to attempt to identify IPV in their patients. Although it was found that some of the gynaecologists did pose a number of routine questions on IPV during screening, they seemed to lack the necessary knowledge and skills to deal with it appropriately. The study further found that most of the participants were not supportive of the idea of universal screening for IPV but rather of identification of IPV cases as they presented themselves. It was determined that the obstetrician-gynaecologists in the study believed that screening for IPV might be an effective means to counter abusive behaviours. However, participants were unfamiliar with referral procedures and the available referral services. Other major factors identified by the study as hindering IPV screening included a perceived lack of time and a fear of offending or insulting patients.

According to Roelens et al. (2006), women who were victims of IPV did not disclose this to health-care workers unless asked. This has been found to be the case in most societies, as evidenced by another study (Rodriguez, Bauer, McLoughlin & Grumbach 1999), which found a lack of disclosure in 78% of patients.

According to a study in Kano, Nigeria, undertaken by Akpan, Lawoko and Svanstrom (2011), 74% of the participating health-care workers did not conduct IPV screening due to several

factors, such as being male, being older, and being from the Yoruba ethnic group. These findings seemed to imply that males and older health-care workers were not likely to conduct IPV screening. The Yoruba ethnic group seemed to be sensitive about IPV, hence health-care workers from this ethnic group did not actively screen for it.

According to Waalen et al. (2000), who conducted a study on IPV screening, a review of studies focusing on provider-specific barriers to screening for IPV and interventions designed to increase IPV screening in clinical settings, barriers to IPV screening were, for example, the health-care provider's lack of education regarding IPV, a lack of time, and a lack of effective interventions. The lack of time resulted from health workers struggling to cope with patient numbers. Health workers concentrated on general screening for medical care, and paid less attention to IPV screening. The health-care providers also lacked the necessary skills and knowledge regarding IPV; hence, they did not feel comfortable doing IPV screening. Additional barriers were a lack of effective interventions for IPV victims in the health-care setting, which demotivated health workers, as well as health workers' fear of offending patients. There were also patient-related factors, such as their nondisclosure. Patients' nondisclosure of IPV to health workers also may have led to missed opportunities in respect of interventions. This study also found that interventions limited to the education of health-care providers did not lead to significantly increased IPV screening and identification. The study further found that most interventions that had incorporated other strategies in addition to education, such as the provision of specific screening questions, resulted in a significant increase in the identification of IPV cases. This study therefore indicated the barriers to IPV screening in health-care settings and identified both interventions that worked and those that did not. It can thus be concluded that according to this study, the introduction of IPV screening and the conducting of such screening alone do not mean that IPV is effectively addressed, since barriers and effective intervention methods need to be identified.

In their study in California, USA, Rodriguez et al. (1999) found that despite the presence of guidelines for conducting IPV screening, most physicians did not routinely conduct such screening. Physicians mostly applied the guidelines in the case of patients who presented with injuries, but those with no injuries were not routinely exposed to IPV screening, resulting in missed opportunities. The study found further that training in IPV screening did not seem to

improve the IPV screening rate among physicians. Commonly cited barriers to the identification of IPV included patients' fear of retaliation (82%), fear of police involvement (55%), lack of patient disclosure (78%), lack of follow-up (52%) and cultural differences (56%). The study further reported some common interventions being undertaken by physicians, such as relaying safety concerns (91%), counselling (88%), referral to shelters (79%) and recording in medical charts (89%). Again, as identified by other studies, similar barriers to IPV screening in the health-care setting seem to be experienced worldwide; however the extent to which each is experienced in each setting may differ and therefore dedicated research is required to determine the extent of IPV as well as the effectiveness of interventions.

It is clear that some countries, such as the USA, have gone so far as to make IPV screening routine in health-care provision, and the introduction of certain interventions there may certainly be of use in addressing IPV (Rodriguez et al. 1999). This study also found that physicians in a public health setting (37%) were more likely to screen new patients for IPV than their counterparts in other health-care settings. This finding presents an opportunity for further study on the factors this can be attributed to. Furthermore, there is a need for additional studies to identify the best interventions for IPV screening, and to closely monitor adherence to set guidelines.

In a study undertaken in New York City, Jaffee, Epling, Grant, Ghandour and Callendar (2005) found barriers to IPV screening in health-care settings to be the number of years' experience of health workers, whether the facility was a public or a private one, and the categories of medical doctors working at the health facility. The study found that the perceived barriers were greater if the physician was in a private practice setting than the physician working as an obstetrician/gynecologist (Jaffee et al. 2015). This study could be of use in establishing differences in respect of these factors related to IPV screening among nurses and medical doctors.

In a study undertaken in south-western Ohio among primary care provider practices, Zink, Regan, Goldenhar, Pabst and Rinto (2004) found that primary-care providers identified barriers to IPV screening as being a limited understanding of the diagnosis commonly associated with IPV, older women not being willing to disclose IPV problems and seek help, as well as the lack

of services in the community to accommodate IPV victims. The study suggested involving elderly and IPV groups in addressing the issue of IPV against women among women of all ages in the community. The finding of this study followed the combined approach of intervening among health-care workers and involving other sectors, including the community in its entirety.

Similar studies, such as that undertaken by Djikanovic, Celik, Simic, Matejic and Cucic (2010) in Belgrade (Serbia), identified barriers to IPV screening among health professionals as being a lack of training and specific education on IPV, a lack of and/or a weak support network, and social insecurity. These findings are similar to those of Gutmanis, Beynon, Tutty, Wathen and MacMillan (2007) in their study "Factors influencing identification of and response to intimate partner violence: A survey of physicians and nurses", conducted in Ontario, Canada.

In their study carried out in Kano, Nigeria, John, Lawoko, Svanström and Mohammed (2010) found that social workers had a higher self-efficacy and were in a better position to access support system networks in order to refer victims than their peers in other occupational categories. The study further found that female health-care providers and doctors do not blame the victim of IPV, whereas their male counterparts and social workers tended to do so.

According to Colarossi, Breitbart and Betancourt (2010), who researched health care staff at a large urban family planning organization in the USA that has a protocol for screening for partner violence, barriers such as lack of time, training and referral resources were cited more frequently by unlicensed providers. The study found that almost all the participants agreed that IPV screening was necessary; however, licensed providers were more positive than unlicensed providers and felt ready to provide such services. Participants expressed frustration with patients' poor response to their referrals however, as well as concern that IPV screening took them away from their primary responsibility which they felt was health care.

Most of the studies on IPV screening reviewed by the researcher revealed similar barriers, attitudes and perceptions; however, more studies need to be done to identify why such attitudes

and perceptions exist among health-care providers and how they can be addressed to help combat IPV.

In a study conducted in Kuwait on barriers to domestic violence screening in primary health-care centres, Alotaby, Alkandari, Alshamali, Kamel and El-Shazly (2012) found that several medical organisations recommended screening for IPV. According to Alotaby et al. (2012), a systematic review showed that most studies on IPV screening in health-care settings found that IPV screening helped to detect more abused women than no screening would. According to these authors, prior surveys had indicated that 43–85% of female respondents found IPV screening in health-care settings acceptable, even though only a third of the physicians and half of emergency department nurses were in favour of it. This seemed to suggest that although most women found it acceptable to be screened for IPV in a health-care setting, most of the health workers – especially those in emergency departments – were not keen to conduct such screening. Alotaby et al. (2012) further found that although doctors and nurses enquiring about IPV did assist in disclosure, only a few were doing so, citing lack of time and busy schedules as well as the need to attend to emergency medical cases. Other reasons cited as barriers to IPV screening were discomfort, fear of offending patients, and a lack of knowledge about available resources.

Alotaby et al. (2012) state that women often fail to disclose their being the victim of IPV to health-care workers, despite frequent visits to health-care centres, due to feelings of shame. As a result, opportunities for intervention at health-care centres are missed, and future physical, sexual and psychological harm caused by IPV is not prevented. It is clear that the barriers found by Alotaby et al. (2012) could be addressed.

Barriers to screening for IPV vary from one region of the world to another, given that socioeconomic and cultural norms and values differ. Additional factors that could be barriers to screening, especially in developing countries, include a lack of resources, such as a shortage of staff, a lack of privacy, a shortage of screening skills, as well as acceptance of IPV against women as normal in society. A lack of policies guiding health-care workers as well as a lack of government commitment to fighting such violence across all sectors of society may also be contributing factors. Alotaby et al. (2012) believe that in order to address barriers to screening for domestic violence, infrastructure is needed and the physical environment needs to be modified to

facilitate screening for women. Physical environment modification means the creation of an environment conducive to privacy and confidentiality in order to facilitate IPV screening of women.

## **2.4 INTIMATE PARTNER VIOLENCE IN NAMIBIA**

In 2013, the MoHSS (2012a) included domestic violence in its Demographic Health Survey (DHS) for the first time. The study showed that 32% of the ever-married women 15–49 years old had experienced physical violence at least once since age 15, and that 14% had experienced it within the 12 months prior to the survey. These findings showed that the prevalence of IPV is high in Namibia, and that the move to include data on domestic violence in the Demographic Health Survey for 2013 proved to be the key in providing information on the extent of the problem. The figures provided by the survey corresponded closely to findings by Ellsberg et al. (2005), namely that there was a high prevalence of physical IPV (31%) and sexual IPV (17%) in Namibia.

It is therefore evident that IPV is high in Namibia, and as the victims of IPV seek various health-care related services, their contact with health-care workers is rendered a focal point in combating IPV.

### **2.4.1 Physical violence**

According to the DHS of 2013, overall 32% of ever-married women aged 15–49 years report having experienced physical violence at least once since age 15 years. Among the ever-married women who had experienced spousal physical violence in the previous 12 months, 36% reported experiencing physical injuries, and 6% reported experiencing violence during pregnancy. The DHS also found that 15% of Namibian women who had been victims of physical violence never sought help and never told anyone about the violence. Nine per cent (9%) of women who had experienced violence did tell someone but never sought help. It was found that help-seeking behaviours decreased with age and number of living children. It was higher in never-married women (36%), and much lower (7%) in currently married women or formerly married women



(12%). This indicated that most of the cases of domestic violence including IPV went unreported; as a result information on the extent of the problem remained incomplete.

The above findings show the prevalence of various types of IPV in Namibia that is being perpetrated by men towards women. Most of the victims visit health facilities frequently in search of medical care. This places nurses and doctors in a key position to screen for IPV. Screening would ensure that more information on the causes of and possible solutions for IPV will be obtained, which could be used in decision-making regarding IPV. Nurses and medical doctors, who come into regular contact with the victims of IPV, are therefore the right people to talk to victims about how they feel about IPV, how they experience care, and what their perceptions of routine screening for IPV are.

The study also found that 50% of women who were divorced, separated, or widowed, and 37% of women who were currently married or living with their partners, had experienced physical violence since the age of 15 years. According to the study, currently married women (21%) were less likely to have experienced physical violence in the previous 12 months than formerly married women (23%). These figures begged the question whether currently married women felt free to talk about the violence they experienced from their current partners, as it had already been shown that 15% of women experiencing violence never sought help or told anyone about their experiences.

The experience of physical violence increased with the number of living children, with 25% of childless women reporting it, compared to 37% among those with five or more children. There was a similar pattern among those who had experienced physical violence in the previous 12 months, that is, 13% of childless women experienced violence compared to 19% of women with five or more children. The most commonly reported perpetrators of physical violence among ever-married women were current husbands (50%), former husbands or partners (20%) (MoHSS 2013).

The DHS is a population-based study which measures population figures extremely accurately. However, the study was facility-based, which means that it only studied women visiting the facility. Findings would therefore differ from those in population-based studies, in that the women are more likely to have been abused and more likely to have been identified at health

facilities as they seek help or other services for injuries sustained during abuse. The DHS has been cited often, as it was the first and thus far the only study conducted in the country which covered the entire population, and was among the few that examined IPV and other types of abuse against women in Namibia. The researcher was not able to find a facility-based study on IPV screening in Namibia; hence the DHS has been cited more frequently.

Domestic violence questions were included in the DHS for the first time in 2013. How violence is defined varies across cultures and among individuals, and the culture of silence usually leads to violence not being reported. This is confirmed by the fact that 15% of women experienced violence and never sought help or told anyone about it. In the age group 15–24 years, women of 20–24 years were slightly more likely to experience physical violence (35%). Rural women (32%) were more likely to have experienced physical violence than urban women (31%), according to the 2013 DHS. Fourteen per cent (14%) of both rural and urban women had experienced physical violence within the 12 months prior to the survey.

#### **2.4.2 Sexual violence**

According to the DHS (2013), 7% of women aged 15–49 years had experienced sexual violence since the age of 15 years, and 4% had experienced sexual violence in the 12 months prior to the survey. Women aged 20–24 years were the least likely to have experienced sexual violence (5%), and those aged 30–39 were more likely to have experienced it (9%). Urban women (8%) were more likely to have experienced sexual violence than rural women (7%). The study further showed that 19% of women who were divorced, separated or widowed and 11% of women currently married or living with partners had experienced sexual violence in the previous 12 months. As with physical violence, sexual violence seemed to increase with the number of living children. Six per cent of childless women and 10% of women with five or more children reported sexual violence.

Recent experiences followed a similar pattern. Unemployed women were more likely than employed women to have experienced sexual violence since the age of 15 years and during the 12 months prior to the survey (8% and 4% respectively). The number of women having

experienced sexual violence since the age of 15 decreased with an increasing level of education, from 11% among those with no education to 8% among those with tertiary education. This pattern was also similar for those of women who had experienced sexual violence in the previous 12 months. There was, however, no clear pattern in the relationship between wealth and experience of sexual violence since the age of 15 years. The percentage of women who had experienced sexual violence in the previous 12 months was lowest among women in the highest wealth quintile. The most commonly reported perpetrator of sexual violence among ever-married women was their current husband (46%), which was an indication of a high level of spousal violence. Twenty-four per cent of women reported their former husband or partner as the perpetrator, and 12% reported strangers. Seven per cent reported sexual violence from others and 6% from their relatives. Never married women reported sexual violence from strangers (27%) and others (21%).



## **2.5 FACTORS ASSOCIATED WITH SCREENING FOR INTIMATE PARTNER VIOLENCE**

As previously indicated, IPV risk factors that have been identified include socio-demographic factors such as being young or adolescent, single, separated or divorced during pregnancy, belonging to ethnic minorities, and a low educational status (Shamu et al. 2013). Vulnerability of young women is due to their inability to make decisions; their low economic status and their dependency on their male partners for maintenance and pregnancy care. The authors further report that pregnancy-related factors associated with IPV include unintended pregnancy, late entry into care, and inadequate antenatal care. HIV infection may be linked to IPV in general, but there is little information on its link to pregnant women.

According to Shamu et al. (2013), factors associated with IPV in Zimbabwe include having a younger male partner, alcoholism, partners' control over women's reproductive health, and risky sexual practices. The authors further report that youthfulness and alcohol consumption have been known to impair people's decision-making capacity, and that cultural and personal perceptions of reproductive health choices also greatly contribute to GBV against women, mostly because they are perceived to be inferior to men in most cultures.

According to Abramsky et al. (2011), the associated factors are the strongest when both the woman and her partner are subject to a risk factor. The authors' further report that identification of and response to IPV (GBV) during antenatal care in Zimbabwe is "hampered by inadequate human resources, financial and infrastructural resources as well as poor support of gender based violence training for midwives". Abramsky et al. (2011) argue that for IPV prevention to succeed, "programs should increase focus on transforming gender norms and attitudes, addressing childhood abuse, and reducing harmful drinking". Shamu et al. (2013) report mixed perceptions among midwives in Zimbabwe regarding addressing IPV, some describing it as a non-clinical, social and domestic problem, while others feel that they could do something about it but see it as an overwhelming task. Development initiatives to improve access to education for girls and boys may also have an important role to play in violence prevention."



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## CHAPTER 3

### RESEARCH METHODOLOGY

#### 3.1 AIM

The aim of the study was to explore the attitudes and perceptions of nurses and medical doctors towards providing IPV screening during routine care at frontline services units.

#### 3.2 STUDY OBJECTIVES

The objectives of this study were the following:

- to explore the attitudes and perceptions of nurses and medical doctors towards screening women for IPV during routine care
- to explore challenges to screening women for IPV during routine care in the health system

#### 3.3 STUDY DESIGN

An explorative qualitative study was conducted which sought to gain insights into the attitudes and perceptions of nurses and medical doctors, as well as into the challenges experienced by these health workers at the frontline services units of the Katutura Intermediate Hospital with regard to providing IPV screening during routine health care. Frontline services units include firstly emergency services, specifically the casualty department, where assault and rape cases are likely to be recorded, particularly on weekends and public holidays as well as after hours.

Additional frontline services are reproductive health services, which include antenatal care, family planning and children's immunisation consulting rooms, which most women are likely to visit.

Qualitative research entails a study of contextual principles, such as the roles of participants, the physical setting, and a set of situational events that guide the interpretation of discourse (Ting-Toomey 1984). It shares the theoretical assumptions of the interpretative paradigm, based on the

notion that social reality is created and sustained through the subjective experience of people involved in communication (Morgan 1980). In their research qualitative researchers are concerned with attempting to accurately describe, decode and interpret the meanings of phenomena occurring in their normal social contexts (Fryer 1991).

### **3.4 STUDY SETTING**

Namibia is a country in Southern Africa with a population of 2.1 million people (NSA 2012). Despite being classified as a middle-income nation (NDP4 2012), the majority of the population continues to live in poverty and is faced with social challenges such as an HIV incidence of 17.8% (MoHSS 2012), the prevalence of TB and unemployment. There is huge inequality in wealth distribution, with the minority being wealthy and the majority being poor. Health care is provided through public and private health-care facilities. Most of the private health facilities are situated in urban settings and are only accessible to those who have medical aid or those who are able to pay the fees themselves. Windhoek, Namibia's capital city, is situated at the heart of the country, with an estimated population of more than 300 000 (NSA 2012). The city has one national referral hospital, one intermediate hospital, one health centre and 11 primary health-care clinics that cater for the public. There are three main private hospitals and various private consulting clinics that attend to those with private and state medical aid.

The study was conducted at the Katutura Intermediate Hospital using in-depth interviews with nurses and medical doctors working at the hospital's frontline services units, such as antenatal care, the outpatient department (OPD), the casualty or emergency unit, and the family planning and immunisation departments. Katutura hospital serves both as a district hospital for the Khomas Region and as the referral hospital for six other regions.

### **3.5 STUDY POPULATION**

The study population comprised 30 nurses and seven medical doctors working fulltime at frontline services units at the Katutura Intermediate Hospital. The study excluded student nurses, medical interns and relief staff working at these units, because they were not employed fulltime

and were therefore deemed to have too little experience in the working environment. It was also thought that they might have little interest and influence regarding the topic under discussion. The researcher conducted in-depth interviews with the participants. This method was chosen because the researcher felt that there was a need to allow participants to express themselves freely on how they viewed and perceived IPV screening in their work environment and how they viewed the incorporation of IPV screening.

**Table 3.1: Study population and sampling**

<b>Category of staff</b>	<b>Casualty</b>	<b>Paediatrics</b>	<b>Surgery</b>	<b>Gynaecology</b>	<b>Big room</b>	<b>Procedure room</b>
Medical doctors	2	1	1	1	1	1
Nurses	12	2	2	2	8	4
<b>Respondents</b>						
Medical doctors	2	1	1	1	1	-
Nurses	9	2	2	2	2	1

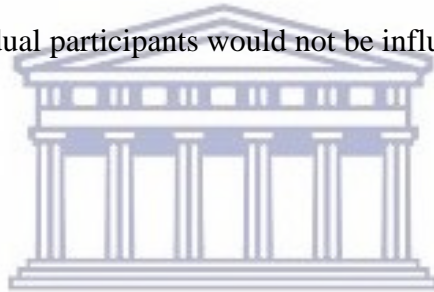
### 3.6 SAMPLING

The purposively chosen sample included nurses and medical doctors employed fulltime who had worked at the Katutura Intermediate Hospital for at least 12 months or more and were present during the period during which the research was conducted. The researcher selected 24 respondents comprising 18 nurses and six doctors out of the target population of 37, as highlighted in section 3.5 above. The exclusion of other health-care professionals was due to the fact that they did not have first contact with clients and patients who were likely to be potential IPV victims.

### 3.7 DATA COLLECTION

In-depth interviews were organised for staff in the hospital departments that had been identified, and after obtaining participants' consent, the interviews were audio-recorded. Interviews were conducted in an office at the Katutura Intermediate Hospital which was specifically reserved for that purpose during booked interview times.

In-depth interviews were used in order to collect more data on the attitudes and perceptions of nurses and medical doctors towards introducing screening during routine care of women visiting the hospital. It was believed that confidential in-depth interviews would allow nurses and medical doctors to freely express their views on the topic and recount their experiences in this regard. It was determined that data collected would be analysed and compared to that in the existing literature on IPV. To gauge different views without bias, individual interviews were chosen to ensure that the responses of individual participants would not be influenced by the presence of other participants.



### 3.8 DATA ANALYSIS

In-depth interviews with nurses and doctors were recorded using a voice recorder to accurately capture all interview proceedings. After the interviews, the recorded data was transcribed verbatim. Transcription reliability and accuracy were checked randomly by an independent transcriber. All the in-depth interviews with nurses and doctors were conducted in English; hence there was no need to translate the interviews from another language. During data analysis, data was checked for correlations and deviations to determine whether or not some interviews needed to be redone. The transcripts were entered into a qualitative data management program called Open Code in order to classify the data into codes and categories. During data analysis all data was combined, compared and discussed in relation to themes formulated (Braun & Clarke 2006).

The process involved reading through transcript texts over and over again to identify keywords, terms, or ideas used repeatedly. All other words were grouped together under one theme (Aronson 1994). Boyatzis (in Fereday & Muir-Cochrane 2008:83) explains that a theme "at minimum describes and organises the possible observations and at maximum interprets aspects of



the phenomenon". Themes were collected, thereby preventing reductionism. After each in-depth interview, the researcher studied the participant's responses in order to prepare himself for the following interview session. Reports on interviews were produced and presented in analysed format which was adequate for giving meaning to the study.

### **3.9 RIGOUR**

Rigour was ensured by applying the four criteria proposed by Guba and Lincoln (1990) – that of credibility, fittingness, auditability and conformability. To ensure credibility in this study, the respondents were carefully identified and described.

Fittingness, also called transferability, was ensured by providing a description of the study settings (Arusha and Arumeru), themes and participants so as to allow the audience to judge the applicability of the study to other settings or similar contexts for themselves (Creswell & Miller 2000). In addition, the researcher endeavoured to demonstrate that the findings were well grounded in the life experiences of the staff interviewed, and reflected both the typical and atypical elements of their work and general life experiences.

Auditability was assessed by the ease with which another researcher would be able to follow the "decision trail" used by the investigator in the study (Guba & Lincoln 1990). An "audit trail" was assured by a description of the research methodology (Creswell & Miller 2000:128). Holloway and Wheeler (1996) argue that the decision trail provides a way of establishing rigour in qualitative research and auditing an entire study. In this study, the decision trail has been provided through a clear, detailed description of the data collection and analysis process. The chosen methodology and method of data analysis have been clarified, well presented and justified by demonstrating all the actions of the research, the influences on them and the events that occurred during the course of the study (Holloway & Wheeler 1996).

Confirmability refers to neutrality in qualitative research. Confirmability is ensured when the reader is able to assess the adequacy of the research process (Holloway & Wheeler 1996). In this

study, confirmability was achieved by ensuring the auditability, credibility and fittingness of the study as described above (Sandelowski 1986).

For a qualitative study which is looking at the social problem of IPV, using a flexible study design allows the researcher to make changes where needed and to obtain in-depth information about the topic being studied. According to Robson (2011), a flexible design enables a researcher "to do it yourself" instead of relying on the use of tools and instruments. This calls for investigators to be well trained and experienced in order for them to be able to respond in the correct way to the people they are working with. It was therefore of the utmost importance that the researcher acquired qualities such as the ability to probe further in order to gain insight into the attitudes and perceptions of nurses and doctors towards introducing IPV screening at frontline services units of the Katutura Intermediate Hospital.

In addition, the researcher had to be a good listener in order to capture respondents' responses. Given the sensitivity of the topic, the researcher had to be extremely cautious with the line of questioning and maintain confidentiality. There was a need for the utmost respect for respondents. Using a flexible study design meant that there was no boundary or limit between the researcher and the subjects, as the study design was guided by the interview questions and responses. A flexible study design also allows for new theories to be captured as they arise, and for such theories to be explored further through research. This meant that during the research process, the researcher had to be flexible in accommodating new information as it was obtained from the subjects. The rich data provided by means of qualitative research has the capacity to lead to new hypotheses which may be tested and bring about new findings.

The researcher strove to achieve the objectives of the study within the identified parameters, and adhered to all ethical guidelines by ensuring the credibility of the study by means of various strategies. Applying the requirements for rigour as well as strategies such as member checking, provision of an audit trail, thick description and debriefing, also served to ensure quality throughout the study, which led to high-quality results. Criteria for participant recruitment were clearly stated and adhered to, and the rationale, settings and understanding of the context in which the research was conducted were clarified to ensure the rigour and quality of the study.

Assumptions about the research topic have been clearly cited and the study limitations identified and explained to enable readers and other researchers to read the study results easily, and understand and formulate meaning. Objectivity in this study meant that all views and perceptions of the respondents were regarded as independent, based on the belief that all respondents were entitled to their own opinions. In defence of objectivity, the researcher attempted to comply with certain standards for judging the outcomes of the study. This meant that set standards were met in respect of the criteria, method, sample and data-collection tools that were used, which acted as a baseline for judging the outcomes of the study.

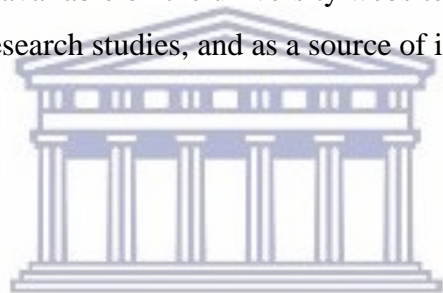
### **3.10 ETHICAL CONSIDERATIONS**

The researcher applied for ethical approval from the **Ethical Committee** of the University of the Western Cape through the High Degree Committee and the **Ethical Committee** of the Ministry of Health and Social Services in Namibia. These approvals were granted before data collection could commence as they formed the basis for permission to carry out the research. The approval by the Ethical Committee of the Ministry of Health and Social services was granted only after approval by the High Degree Committee of the University of Western Cape.

At the outset of the study, a consent form was presented and explained to each participant to give them an opportunity to choose whether or not to participate in the study. This was done after the participant information sheet had been read out and explained to them and a copy had also been offered to them.

As the study was conducted among hospital employees, the names of participants and the data obtained from interviews were kept confidential, based on the conditions stipulated in the consent form. Given the effects of IPV on members of the public and on society, respondents were offered the choice of withdrawing from the interview process at any time during the process. This was explained to them during the introduction of the research study. The researcher made it clear it was not mandatory for selected respondents to participate in the study, although participation was widely encouraged. Therefore active participation only took place once informed consent had been granted through the signing of the consent form.

Prior to the commencement of the interviews, all participants were informed that data was to be audio-recorded. It was also explained to participants that the audio-recording of the interviews would only serve the purposes of data collection, analysis and transcription. The researcher also explained that the study would be anonymous, and there would be no need to use real names during the interview. It was explained that anonymity would strengthen confidentiality. The researcher therefore requested each participant at the beginning of the interview to identify a pseudonym that they would like to be called by during the interview process that was not necessarily their own name. In addition, the researcher explained that a copy of the research would be made available to him or her upon request. A copy of the participant information sheet with all contact details was provided to each of the participants. At the end of the research, a report was produced for the purpose of grading the mini-thesis. At the insistence of the university, the report will be made available on the university website, from where it may be downloaded and used for further research studies, and as a source of information for anyone who may need it for planning purposes.



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## **CHAPTER 4**

### **RESEARCH FINDINGS**

#### **4.1 INTRODUCTION**

This chapter presents the findings of this study under themes, subthemes and codes, while answering the research questions. Study results are linked to the theoretical framework discussed in chapter 3 by means of the critical analysis approach, based on which the results are critically justified, supported and contradicted.

#### **4.2 DESCRIPTION OF STUDY PARTICIPANTS**

Of the 24 health workers recruited, 16 nurses and four doctors agreed to participate in the interviews. Of these 20 participants, 15 were female and five were male. This could be due to the fact that there were more female than male nurses at the Katutura Hospital, however the reason for this could not be determined. The researcher found that there were more female health workers at Katutura Intermediate Hospital all the days that he went to do data collection and however this was not surprising to him as he was aware of the situation before.

#### **4.3 THEMES**

The research results obtained from the interviews were grouped under the following main themes:

- views on IPV
- forms of IPV nurses and doctors encounter
- experience of conducting IPV screening daily
- screening women for IPV during routine care
- challenges preventing nurses and doctors from consistent IPV screening
- opportunities to introduce IPV screening

These main themes were further classified into subthemes and codes based on interviews with key informants and participants. These themes, subthemes and codes are illustrated in table 4.1 below and subsequently discussed individually.



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**Table 4.1: Study themes, subthemes and codes**

THEME	SUBTHEME	CODE
Views on IPV	Possible causes of IPV	<ul style="list-style-type: none"> <li>• Excessive drinking by perpetrating partners</li> <li>• Pregnancy-related arguments where perpetrating partners deny responsibility</li> <li>• Petty differences over alleged misuse of alcohol funds by IPV victims</li> <li>• Poverty induced stress and lack of self-control in IPV perpetrating partners</li> <li>• Anger problems causing systematic emotional outbursts by IPV perpetrating partners</li> <li>• IPV perpetrators' general obsession with abuse and lack of respect for victim partners</li> <li>• Victims' resistance to attempted rape and sexual harassment</li> <li>• Claims of confirmed or unconfirmed partner infidelity and diversion of funds</li> <li>• Alleged victims' disrespect of perpetrators' authority or refusal to take instructions from them</li> <li>• Accidental miscarriages and</li> </ul>

		<p>IPV perpetrators' failure of acceptance</p> <ul style="list-style-type: none"> <li>• Victims' denial of conjugal rights to IPV perpetrators</li> <li>• Arguments emanating from alleged intentional HIV/AIDS transmission</li> </ul>
Forms of IPV nurses and doctors encounter	Physical violence	<ul style="list-style-type: none"> <li>• Beating up of partners, twisting arms, pushing and slapping</li> </ul>
	Emotional violence	<ul style="list-style-type: none"> <li>• Verbal abuse such as swearing, insults, threats and shouting</li> </ul>
Experience of conducting IPV screening daily	Staffing	<ul style="list-style-type: none"> <li>• Shortage of staff</li> <li>• Lack of knowledge on screening and IPV</li> </ul>
	Time availability	<ul style="list-style-type: none"> <li>• A shortage of time due to large patient numbers</li> </ul>
Screening women for IPV during routine care	Patient-related factors	<ul style="list-style-type: none"> <li>• Patients' unwillingness to disclose</li> </ul>
	Factors related to health workers	<ul style="list-style-type: none"> <li>• Perceptions of a shortage of time and a belief that screening is the responsibility of social workers</li> </ul>
Challenges preventing nurses and doctors from consistently conducting IPV screening	Staffing	<ul style="list-style-type: none"> <li>• Work overload due to Katutura being one of Namibia's largest referral hospitals</li> <li>• Shortage of staff</li> <li>• Doctors' and nurses' lack of time</li> <li>• congestion of the casualty</li> </ul>



		section demanding urgent medical attention
	Patient factors  Infrastructural factors	<ul style="list-style-type: none"> <li>• IPV patients' unwillingness to undergo screening when required</li> <li>• A lack of privacy and confidentiality at frontline services units</li> </ul>
Staff skills and knowledge	Factors related to health workers	<ul style="list-style-type: none"> <li>• A lack of expert counselling skills amongst nurses and doctors</li> <li>•</li> </ul>
Opportunities to introduce IPV screening	Availability of resources	<ul style="list-style-type: none"> <li>• Employing social workers to screen for IPV and provide counselling</li> <li>• Building capacity through training health workers on IPV screening and counselling</li> <li>• Employing more staff at frontline services units</li> </ul>
	Awareness creation and community sensitisation	<ul style="list-style-type: none"> <li>• Conducting vigorous community awareness campaigns on IPV through various media platforms</li> <li>• Introducing programmes for IPV victims to express their experiences safely</li> </ul>

### 4.3.1 Views on intimate partner violence

All the respondents concurred that IPV was prevalent in Namibia, as evidenced by the daily hospital records. Respondents admitted that the Casualty Section of the Katutura Hospital was the busiest section in the hospital, where IPV patients were being admitted hourly, especially from Thursday through the weekend and on public holidays.

The causes of IPV as evidenced by the cases reported to trauma/emergency services were:

- excessive drinking by perpetrating partners
- pregnancy-related arguments where perpetrating partners deny responsibility
- petty differences over alleged misuse of alcohol funds by IPV victims
- poverty induced stress and lack of self-control in IPV perpetrating partners
- anger problems causing systematic emotional outbursts by IPV perpetrating partners
- IPV perpetrators' general obsession with abuse and lack of respect for victim partners
- victims' resistance to attempted rape and sexual harassment
- claims of confirmed or unconfirmed partner infidelity and diversion of funds
- alleged victims' disrespect of perpetrators' authority or refusal to take instructions from them
- accidental miscarriages and IPV perpetrators' failure of acceptance
- victims' denial of conjugal rights to IPV perpetrators
- arguments emanating from alleged intentional HIV/AIDS transmission

These causes will now be discussed individually, based on extracts from interviews with the respondents.

#### *4.3.1.1 Excessive drinking by perpetrating partners*

Katutura is the largest suburb in Windhoek and is inhabited mainly by previously disadvantaged communities. The unemployment rate and crime rate are high, and there are many shebeens selling alcohol. Due to the high unemployment rate and lack of education in the area, residents spend most of their time at the shebeens drinking alcohol, which results in conflicts and IPV. Most of the shebeens in the informal settlement of Katutura are not registered businesses therefore the municipal authority finds it difficult to control them.

One male nurse from Casualty explained: "Intimate partner violence is so prevalent at this hospital, especially considering that it is in the neighbourhood of Katutura."

A female nurse suggested that "values and norms in the society seem to be degrading"; meaning that such values and norms are being disregarded, hence the abuse of partners. Cultural norms such as that couples should not argue in public, should not drink together and should respect their elders are being disregarded as a result of alcohol abuse, resulting in some cases in people forming intimate relationships with minors, and the emergence of age-gap and mixed-culture partnerships. This in turn results in cultural conflicts in relationships and sometimes in domestic abuse.

A female nurse said the following based on a discussion she had had with one of her patients: "I think what is happening is that cases of IPV are on the increase, most probably because of abuse of alcohol and moral degradation. Perpetrators do not respect their partners as they even threaten them if they want to report to police."

This concern seems to indicate that most of the causes of IPV are known and could be identified easily during routine screening for IPV.

#### *4.3.1.2 Pregnancy-related arguments where perpetrating partners deny responsibility*

This seems to be due to alcohol abuse resulting in relationships with multiple partners and partners denying responsibility for their actions.

A young female nurse explained: "Some of the pregnant women come to the hospital informing us that the boyfriend refuses to take responsibility for the pregnancy saying it is not for him." The nurse went on to say that they referred such cases to the Women and Child Protection Unit of the Namibian Police situated within the hospital compound.

#### *4.3.1.3 Petty differences over alleged misuse of alcohol funds by IPV victims*

An experienced male doctor recounted that one of his patients had said: "He finished all the money that is why he beat me." One of the reasons given for physical violence by intimate partners is the misuse of funds, leaving the other partner with nothing to buy alcohol with, which results in verbal arguments and later in physical encounters.

#### *4.3.1.4 Poverty induced stress and lack of self-control in IPV perpetrating partners*

Due to unemployment and lack of income, partners live in stress, hence the emergence of abusive relationships. "He beat me up because I did not leave food for him and he was hungry," a victim told a male nurse.

Because there is no food in the house, the women do not cook, but when their male partner comes home drunk from the shebeens, they become abusive.

#### *4.3.1.5 Anger problems causing systematic emotional outbursts by IPV perpetrating partners; and IPV perpetrators' general obsession with abuse and lack of respect for victim partners*

Some of the partners have poor control over their emotions and cannot control their anger. This is exacerbated by cultural beliefs that women are inferior to men, and that it is proper for men to beat their female partners. Some of the male partners beat up their female partners whenever they are unhappy about a situation, resulting in physical and verbal abuse. A young female doctor

indicated that a patient had been beaten up simply for asking too many questions of her male partner after an earlier situation at the shebeen had angered him.

#### *4.3.1.6 Victims' resistance to attempted rape and sexual harassment; and claims of confirmed or unconfirmed partner infidelity and diversion of funds*

Sometimes during socialising and/or at work, women find themselves being sexually harassed by their colleagues, friends or strangers. Some of them fight back, which results in physical abuse during which the women are beaten up. Instances also occur of women denying their male partner sexual intercourse, which results in them being beaten. "I slapped him because he touched my buttocks and he reacted by hitting me with fists and kicking me," a male nurse recalled one of his patients as saying.

In trying to defend their rights and preventing further abuse, the women suffer more abuse at the hands of their intimate male partners as well as those of strangers. "I caught him red-handed with another woman, and when I asked him, he started to beat me," another young female nurse from the Big Room recalled one of her patients telling her.

Sometimes this also happens because one of the partners suspects that his or her partner is being unfaithful, and this mostly results in the abuse of the female partner.

#### *4.3.1.7 Alleged victims' disrespect of the perpetrators' authority or refusal to take instructions from them*

In many cultures a women is not supposed to talk back to her partner; whatever the man says must be obeyed. A female doctor from Casualty remembered one of her patients saying "I asked him where he was when he came home late last night, and he started beating me up saying I disrespect him".

When women question their male partners, they are beaten up. It is believed that women are not supposed to ask where their partners have been when they come home late or when they are

suspected of infidelity, as the man will beat them. Such behaviour results in one-sided relationships in which the male partner is dominant; as a result, female partners have no control and no say in what happens in their relationship.

#### *4.3.1.8 Accidental miscarriages and IPV perpetrators' failure of acceptance*

When men and women are in an intimate relationship, the male partner expects the female partner to produce offspring, so when miscarriages occur, men sometimes find it difficult to believe that they were accidental. An older nurse from Casualty remembered one of her patients telling her: "He was looking forward to having a child and has been boasting about the partner's pregnancy already to friends and colleagues, and now that there is miscarriage, he does not want to accept it." Thus when a miscarriage occurs, the male partner can find it difficult to accept, and could accuse the woman of witchcraft and intentionally terminating the pregnancy. As a result the man becomes violent and abusive towards his female partner.

#### *4.3.1.9 Victims' denial of conjugal rights to IPV perpetrators*

Almost all the respondents agreed that women were not supposed to refuse men sex. Respondents went on to highlight that when a woman shows that she does not feel like having sex on a particular day, her refusal could be interpreted as that she is cheating on her male partner.

One female nurse from the antenatal care centre recalled a woman saying: "He beat me when I refused to have sex with him but I was exhausted." It is evident that men feel that refusal implies their partners are cheating on them. However, most of the respondents felt that it was each partner's right to express their feelings regarding sex, and that it was not wrong to refuse sex if one did not feel like it. "It is my right to tell my partner that I do not feel like having sex due to several factors, such as tiredness, emotional drain, etc.," said a young married female doctor from the gynaecological section of Casualty.

#### *4.3.1.10 Arguments emanating from alleged intentional HIV/AIDS transmission*

When HIV infection is detected in one of the intimate partners, accusations about who might have infected him or her, tend to arise. This results in verbal, emotional and physical violence, mostly towards the women.

A male doctor from the paediatric section recounted one of his patients as saying: "I was tested for HIV during the routine check, and when I informed him that I am infected, he became aggressive and started verbally and physically abusing me, accusing me of infidelity and promiscuity."

This was also reported by other victims of IPV during consultations at Casualty due to injuries sustained as a result of the abuse of a male partner.

#### **4.3.2 Forms of intimate partner violence nurses and doctors encounter**

When asked about the forms of violence generally encountered in their workplace, almost half of the respondents indicated the prevalence of physical violence to be higher than that of other forms. One male nurse said: "Victims of IPV are either beaten up with clenched fists, sticks, hosepipe or bottles. They come to the hospital with swollen eyes and bruises all over their bodies. It just differs from case to case." When asked about the forms of violence she encountered in her workplace, an older, more experienced female nurse said: "Injurious beatings that cause a lot of bleeding. Sometimes you find the perpetrators still pursuing the victims at the hospital and threatening them. Some end up getting restrained by security and police at the hospital entrance. It is just a crazy situation out there at the liquor selling outlets."

One of the young male doctors said: "Grievous bodily harm that warrants arrest of the perpetrators. The victims are so injured some of them cannot even walk properly. Eyes swollen and bleeding profusely, clothes ripped apart." Other respondents concurred that physical abuse topped the list at the hospital.

Among the 20 participants who were interviewed, it emerged that ten reported physical abuse as a common form of violence, followed by sexual abuse, which was reported by six participants,

while a combination of physical and sexual violence was identified by four of the participants. A young, unmarried nurse spoke of "women being beaten by their partners or spouses they are married to," and seemed shocked that even married couples abused each other. Another nurse said: "Sometimes you just hear that 'I have been beaten', but without further clarification as to the reasons for the beating." This seemed to confirm that patients are not willing to disclose information about IPV.

Due to a lack of counselling skills and other factors, nurses and doctors do not probe for more details to identify the cause of IPV and the best possible intervention. One of the doctors said that some patients – mostly women – reported trying to fight back and ended up with more injuries: "Most of the time it is just women who come bleeding to the hospital, complaining of having been beaten by their partners. Some say they tried to defend themselves, resulting in more injuries, cuts, bruises and swollen buttocks, faces and eyes."

These findings indicate a high prevalence of physical and sexual violence among the patients seen at the frontline services units of the hospital. It also emerged that there are some victims who suffer both physical and sexual abuse simultaneously. Most prevalent, however, are physical injuries such as loss of teeth, bruised and swollen eyes, swollen faces, broken legs and/or arms, and severe bodily pain. Also prevalent are verbal insults and financial deprivation. The question still needs to be answered as to whether emotional violence is also present, but this may be difficult to identify as patients may not disclose it, and the nurses and doctors may not be sufficiently skilled and knowledgeable to detect patients who are victims of emotional abuse.

When asked about the forms of violence they encountered in the work setting, one young male doctor said: "Injuries all over the body, women crying in severe pain, lost teeth, eyes and sometimes broken hands and legs." This seemed to suggest that most of the violence experienced is physical in nature, and that women are mostly the victims. Another doctor interviewed added that sometimes clothes are ripped and torn, and victims struggle to walk. Yet another reported that some of the victims report having tried to defend themselves, which mostly resulted in more injuries. From this observation it appears that, if victims try to fight back, they end up with more injuries, which confirms the culture of male dominance prevalent in this society.



An experienced female nurse who is the head of her department said: "Victims always complain that they can see it coming, and sometimes they have to hide or run away to avoid the violence. But you know as they say love is blind, you still find people coming back together." She went on to say: "I truly feel that something has gone wrong in our society, because nowadays even young man are dating older women and vice versa." She felt that this was a new phenomenon in society. The general feeling of most of the respondents was that something had gone wrong in society, and that urgent intervention was required to prevent the situation spinning out of control.

Quizzed as to what they thought needed to be done, various interventions were cited, such as religious interventions, awareness campaigns, regulation of alcohol and drug-related products, and marriage and relationship counselling. Dependence on a partner due to poverty or based on cultural norms and claims of love led to the victims sticking to their violent partners despite the physical injuries they endured at their hands. Despite all these experiences, most of the victims still did not freely disclose their experience of IPV to health workers.

#### **4.3.3 Experience in conducting intimate partner violence screening**

There were striking similarities in respondents' experience of conducting IPV screening. They all seemed to share the opinion that there was not enough time to conduct IPV screening during their daily routines. This was attributed to high patient volumes in Casualty against the backdrop of limited medical staff to attend to all the cases at the same time. Respondents were of the opinion that perhaps screening rooms manned by social workers should be set aside at the hospital to cater for screening at all hours, as at present IPV patients were only seen by social workers once they have been attended to by nurses and/or doctors. The respondents believed that victims who did not require urgent medical attention could be attended to by social workers. Respondents also reiterated that when they were not too busy, they always tried to speak with the patients to establish the cause of the violence, and that this was how they managed to establish the reasons for IPV stated in table 4.1.

A doctor who seemed to share this sentiment explained: "I do not conduct screening, as the demands for patients' treatment supersede anything else. It is so busy at Katutura; time for

screening may not exist. After Katutura there are other hospitals to also attend to." An older male doctor from the Big Room said: "It is practically impossible given the adrenalin in the hospital."

Another reason cited by respondents for their failure to screen was the lack of privacy at Casualty, as there are not enough consulting rooms. Any screening usually has to take place in the open, leaving patients with no option but to keep quiet about their IPV experiences, as other patients are within earshot. "You have seen the number of consulting rooms available to us and the number of patients we see, so we cannot do IPV screening in the open there or behind those curtain screens," said a young male Casualty doctor. A young female doctor concurred, adding: "We have few consulting rooms, and we consult our patients on the bedside, meaning there is no privacy and patients are not free to talk about it [IPV]." It became clear during interviews that some of the staff might be willing to conduct IPV screening; however their circumstances made it extremely difficult to do so.

Others felt their lack of skills in screening and counselling for IPV also hindered them, while others believed that this was the exclusive responsibility of the social workers. "I have not been trained in counselling, and I have not really done so – I do not feel competent enough to do it," said an older female nurse at the Big Room, where patients are kept overnight for observation and medication.

Some staff felt that their lack of training in counselling was a contributing factor that prevented them from conducting IPV screening, but it could also have been used as an excuse when in fact they may not have been willing to conduct screening. One male nurse said: "Even though we try every day, sometimes the same people come back after a few days." He seemed to mean that, despite all their efforts, the violence kept happening at home, in other words nothing much changed after the victims had been seen at the hospital. The feeling was that intervention from hospital staff alone was not enough in addressing IPV, as recurrences were frequently seen at the hospital. The feeling seemed to be that there was a need for multi-sectoral interventions in respect of IPV.

Another older female nurse said: "I conduct IPV screening whenever I have the time to do so." This meant that IPV screening was seen as an additional activity that could only be conducted when there was enough time. A male nurse confirmed this: "I do not get enough time because of a busy schedule. As you may already know, the hospital is critically understaffed." A young female doctor expressed concern about the failure to screen, however also confirmed the lack of time: "It is not easy, because of the total number of patients per each ten minutes. We have to move from hospital to hospital seeing patients." Another young female doctor said: "To be honest, there is absolutely no time, as the traffic of patients is highly overwhelming. Maybe nurses do that – I don't know for sure."

A young female nurse seemed to suggest that despite the efforts of staff to screen for IPV, patients were not keen to open up. "Whenever I find time, I always try to do screening, but it is not easy, as so many of the victims are not willing to open up about their issues with their partners," she explained. It seems that patients are not keen to disclose IPV due to various factors; however, this should not prevent health workers from screening for IPV, as patients who will disclose will receive help, which may eventually lead to a more positive attitude developing in society.

Overall, all the doctors who took part in the study cited a lack of time and work overload as barriers to conducting IPV screening and hence to gaining experience in conducting IPV screening. They all seemed to suggest that this may not be their responsibility but that of the nurses and social workers, as they were always on demand to attend to critical and emergency cases. The researcher believes, however, that although it is the responsibility of social workers to counsel patients, nurses and medical doctors see patients first and do history-taking, where IPV victims could be identified and referred to social workers for further interventions.

There is, therefore, a need to create awareness about IPV among nurses and medical doctors, and to educate and sensitise them about the importance of a positive attitude towards IPV screening, if any goals are to be achieved. There is a need to make it clear to medical staff that social workers alone will not be able to succeed in addressing the problems of IPV.

#### 4.3.4 Screening women for intimate partner violence during routine care

Respondents admitted that they found treating the victims of IPV distressing, but that as trained health professional they had to maintain their composure. It also emerged that nurses tried to speak to IPV patients but that the patients were often unwilling to open up. Some respondents suggested embarrassment and fear of being judged as some of the victims' reasons for not wanting to talk about it. A large percentage of the respondents – 65% – believed that the trauma suffered and fear of the perpetrators prevented victims from opening up easily. It was felt that immediate counselling by social workers could be the solution to coaxing information from victims. Responses suggested that there was a need for the Ministry of Health to make provision for screening rooms in the Casualty Section that would be permanently manned by more experienced social workers who would be solely responsible for dealing with IPV cases around the clock.

Most of the respondents felt that screening for IPV was vital to ensuring that victims would get the necessary help, however they also felt that their workload was excessive, partly due to a shortage of staff. One of the young female nurses said: "As a woman I feel that it is very important because it will help the victims to open up. The problem is the time. Katutura Hospital is very busy and understaffed." An older female nurse seemed to support this: "It is a good thing and like I said, social workers must be engaged to work on that aspect on a fulltime basis. Sometimes screening can help victims feel free and open up to the social workers as they are not ready to discuss with the medical personnel especially nurses."

A third female nurse from Casualty seemed to feel that screening for IPV would help in creating a good relationship between nurses, doctors and patients. She said: "Screening would be helpful, as it can facilitate dialogue between the nurse or doctor and the patient." A male nurse from the paediatric section felt that if they had the opportunity to screen for IPV, they could do it, however they were very busy and understaffed. "If there was an opportunity it would be a great thing to do. But as of now, the hospital casualty section is critically understaffed." A young female nurse felt that "it is also important to talk to the perpetrators to hear their story, as this may assist in

solving IPV in their relationship". Other respondents felt it was really the job of qualified social workers to screen for IPV. All the doctors interviewed believed that screening for IPV should be undertaken by social workers, hence the ministry needed to look into the matter of employing social workers for that purpose.

#### **4.3.5 Challenges preventing nurses and doctors from consistently conducting intimate partner violence screening**

Participants were asked to explain the challenges preventing them from consistently conducting IPV screening in their work settings. Various challenges were cited, such as a lack of privacy, especially at Casualty, where screening by nurses in particular took place in the presence of other patients. Lack of time was also cited as a challenge, as most of the participants felt that the frontline services units were so busy that health-care workers had no time to screen for IPV but instead had to concentrate on the health problems presented by the patients. A shortage of staff was also repeatedly referred to, with participants indicating that it was a constant struggle to see all the patients who were admitted. Other factors cited as barriers to IPV screening were the lack of skills to conduct IPV screening, as well as a lack of counselling skills among health workers. The participants also felt that patients' unwillingness to disclose the occurrence of IPV to health workers was a challenge they faced in conducting IPV screening. Most of the participants felt that IPV screening was the responsibility of social workers and hence saw the need for more social workers to be appointed, specifically to deal with IPV issues at frontline services units.

The following challenges preventing consistent IPV screening were therefore cited:

- **work overload due to Katutura being one of Namibia's largest referral hospitals**
- **a lack of expert counselling skills amongst nurses and doctors**
- **congestion of patients demanding urgent medical attention**
- **a lack of privacy and confidentiality at frontline services units**

- **a lack of time for screening by nurses and doctors**
- **a shortage of staff**
- **IPV patients' unwillingness to undergo screening when required**

One of the doctors interviewed cited "staff shortages and lack of screening knowledge amongst the nurses" as a challenge preventing consistent screening. A lack of the necessary screening and counselling skills coupled with a shortage of staff therefore made it difficult for nurses and doctors to screen for IPV.

Another doctor felt that some cultural norms and values also contributed to the failure to conduct IPV screening, as patients did not open up about their relationship issues, including IPV. He spoke of "traditional customs and beliefs which prevent victims from opening up to share their marital problems, shortage of personnel working at the casualty section".

One of the senior nurses interviewed expressed dissatisfaction with the lack of support structures within the health-care team. She felt that the absence of support groups for counselling, health and wellness, as well as a lack of confidentiality among staff members, discouraged patients from sharing their problems in order to be assisted. She added that the lack of such support structures also meant that staff members could not confidently deal with patients' IPV problems, as their own had not been addressed: "Again I say the hospital is busy; we do not have much time between the time of attending to a new case and that of treating those already in. Sometimes also, the victims are unwilling to talk about it." This was echoed by another nurse who was interviewed.

Another concern raised was the lack of privacy, as screening and history-taking at Casualty took place in the presence of other patients. The screening rooms are also provided with two entrances, with a corridor at the back, and the movements of other staff members during the screening process create the sense of a lack of privacy.

On the subject of IPV screening, another nurse said: "It is really needed, because some are being involved in violence for lack of counselling. They need to be counselled by social workers, and I

think the Ministry must do something." The nurse felt there was a need for counselling services for the general public, as this would reduce the incidence of IPV. She seemed to be of the opinion that IPV occurred because the public did not have access to services allowing them to talk about their relationship problems and providing counselling on relationship issues as well as social challenges.

#### **4.3.6 Opportunities to introduce intimate partner violence screening**

The findings revealed that respondents seemed to concur that it would be possible to introduce IPV screening at the Katutura Hospital provided that the Ministry and hospital management devised the necessary mechanisms. Suggestions included the establishment of an IPV counselling centre at the hospital. One of the nurses interviewed felt as follows about this possible solution: "Maybe. Because it is the right thing to do, and these victims most of them are not educated. They need to be encouraged to find something to do with their time. Things like studying and applying for grants to start projects or something like that. The government must have a program where they come and talk to each victim and listen to their needs to see how they can assist."

Respondents also suggested that although nurses possessed knowledge about IPV, they needed to undergo further training in counselling IPV patients. Another respondent said: "Yes, indeed, social workers are needed at the hospital, and also the Ministry of Gender can team up with Ministry of Health to try and see how best this problem can be tackled." Yet another added: "Indeed, opportunities are there. It just requires the hospital administration to come up with workable working plans so that some nurses could concentrate on IPV screening or possibly social workers."

It was noted that some nurses openly admitted to negativity when it came to dealing with cases involving IPV; the general feeling seemed to be that victims brought the harm upon themselves. Respondents admitted the existence of this stereotyped way of thinking, especially among some nurses. It was thought that the Ministry needed to employ social workers to conduct IPV screening because of their knowledge and counselling skills. Respondents also believed that, since this would be social workers' sole responsibility, they would be able to spend sufficient

time with patients. When asked about whether she thought there was an opportunity to screen women for IPV during routine care, one of the nurses said: "Yes, maybe the Ministry of Health and Social Services needs to introduce fulltime screening through social workers stationed at the hospital. As for us nurses, we happen to be very busy." Her response seemed to suggest that it was not the responsibility of nurses to screen for IPV but rather that of social workers. The respondents appeared to feel that nurses and doctors were there to treat and not to conduct counselling.

#### **4.4 SUMMARY**

This chapter analysed and presented the findings from interviews conducted by the researcher at the Katutura Intermediate Hospital. From the selected sample of 24 respondents, only 20 nurses and doctors could actually participate in the research. There were more female nurses than male and more male doctors than female. Interviews questions were set in an orderly manner and were made short and simple. Where respondents did not understand, the researcher rephrased and repeated the questions. A number of causes for IPV were cited, which included excessive drinking by perpetrators and alleged infidelity by partners. Respondents reiterated that work pressure made it difficult for them to screen consistently for IPV victims, and that there was a need for making permanent IPV screening rooms manned by social workers available at Casualty. It was also noted that victims of IPV were reluctant to be screened due to a number of reasons, including fear of being judged by nurses and doctors and fear of exposing the perpetrators.



## CHAPTER 5

### DISCUSSION, CONCLUSION AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

The previous chapter analysed data obtained through face-to-face interviews with a selected sample of nurses and doctors at the Katutura Intermediate Hospital. The findings included those from both the literature review and the empirical investigation during which the researcher personally explored the attitudes and perceptions of nurses and medical doctors towards screening for IPV during routine care at frontline services units at the Katutura Intermediate Hospital.

#### 5.2 DISCUSSION

According to Jewkes (2013), "IPV is prevalent around the world having been ranked 5th with reference to the number of years of life lost due to disability". IPV is therefore a health priority given the impact it has on victims' health – intervention by the health sector is thus critical. A number of professional bodies have recommended the identification of victims of IPV, who are mostly women, through routine screening; however, the WHO, the Canadian Task Force and the UK's Health Technology Assessment Programme do not recommend it. Other studies (Jewkes 2013; MacMillan et al. 2009) have also not found that routine IPV screening during care leads to any improvement. Few studies have been conducted on IPV screening in health settings, and it must be noted that most of them were conducted in high-income countries. These studies argue that identifying asymptomatic women who are victims of IPV is feasible, easy and inexpensive, but that the results do not show an improvement in women's health (Jewkes 2013). These studies recommend other interventions, such as the use of leaflets, safety discussions with the women concerned, and referring women for further assistance to specialised services or counselling.

The researcher believes, however, that since Namibia has a gender policy in a place, and possesses a unit that deals with the protection of women and children, screening for IPV during routine care will help women who are victims of IPV to access this service in a confidential and professional manner. Discussing IPV with female patients presenting with complaints associated

with IPV could help health workers lend the necessary support and ensure that victims receive counselling (Jewkes 2013).

IPV may be the crucial factor in women presenting with health problem at the health facilities, therefore asking about it may be useful in obtaining information to provide the women with the necessary care, and may also lead to the women changing their lifestyle. This could be achieved through the introduction of enabling and reinforcement strategies such as screening tools, patient leaflets and formal referral systems. Feedback from nurses and medical doctors may also enhance screening for IPV (Roelens et al. 2006; Roelens, Verstraelen & Temmerman 2009). In addition, obtaining information about abusive relationships may help in providing women with information about HIV care, IPV prevention, and reproductive health decisions. Identification of IPV victims alone in a health-care setting is not ideal, but interventions such as screening women attending antenatal care and assisting them once they have been identified, may be very helpful in dealing with IPV (Jewkes 2013).

A study on physicians' perceptions by Zink et al. (2004) found that a lack of training of health providers leading to failure to identify illnesses or health problems related to IPV, and unwillingness among women to disclose information, are challenges in screening for IPV. Since little information is available about screening for IPV in developing countries and the impact this has on IPV, this study aimed to explore the perceptions and attitudes of health workers towards IPV screening, as well as their knowledge of IPV, and how this may affect their interaction with patients, especially women. It was therefore of importance to first gauge the attitudes and perceptions of nurses and doctors towards the introduction of IPV screening for women.

This study endeavoured to explore the attitudes and perceptions of nurses and medical doctors towards IPV screening of women during routine care at frontline services units at the Katutura Intermediate Hospital, and succeeded in doing so. The objectives that had been set enabled the researcher to formulate appropriate interview questions which yielded relevant answers. In addition, the sample that had been selected effectively represented other hospitals in the country and successfully provided the answers that were being sought. The following section, which is also the last, contains recommendations that could be considered by various IPV stakeholders,

including the Ministry of Health and Social Services, the Ministry of Gender, civil society organisations as well as municipal authorities.

This study was chosen to promote an understanding of the attitudes and perceptions in the health system and to determine the willingness of staff to identify women who need help in the clinics and frontline services units of hospitals, where abused women are likely to come into contact with health-care workers. It could also be used in the policymaking decisions of health systems and of the government regarding women's health and regarding efforts to address IPV. It is believed that the study will contribute to the country's attainment of its MDGs, national plans of action for the reduction of domestic violence, and the combating of rape, which mostly affects women.

### 5.3 RECOMMENDATIONS

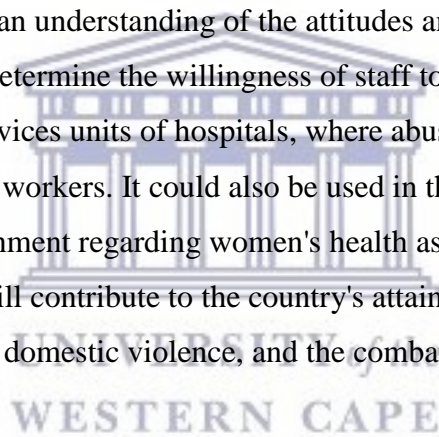
The following recommendations are based on the findings of this study:

- Medical doctors and nurses need to receive training in IPV screening. The findings revealed that nurses admitted to having knowledge of IPV but not necessarily the skills required to administer adequate screening of victims.
- The Ministry of Health and Social Services need to increase the number of nurses and doctors manning the Casualty Section of the Katutura Intermediate Hospital, especially during weekends and public holidays, as findings indicated that IPV admissions are at their highest during these periods. It was also found that, due to the shortage of staff, injured patients have to wait long hours before being attended to.
- Nurses and doctors need to remain professionally neutral while also displaying a positive attitude towards victims of IPV, and encourage such victims to undergo screening to enable the compilation of statistics that could be used in national responsive planning.
- The Ministry of Health and Social Services needs to refurbish existing structures in order to create an environment conducive to privacy and holistic care. Screening patients by their bedsides with merely a curtain for privacy is not a conducive environment for patients to disclose sensitive information.

## 5.4 CONCLUSIONS

This study endeavoured to explore the attitudes and perceptions of nurses and medical doctors towards IPV screening of women during routine care at frontline services units at the Katutura Intermediate Hospital, and succeeded in doing so. The objectives that had been set enabled the researcher to formulate appropriate interview questions which yielded relevant answers. In addition, the sample that had been selected effectively represented other hospitals in the country and successfully provided the answers that were being sought. Recommendations that could be considered by various IPV stakeholders, including the Ministry of Health and Social Services, the Ministry of Gender, civil society organisations and municipal authorities, have been presented.

This study was chosen to promote an understanding of the attitudes and perceptions in the health system with regard to IPV and to determine the willingness of staff to identify women who need help in the clinics and frontline services units of hospitals, where abused women are likely to come into contact with health-care workers. It could also be used in the policymaking decisions of health systems and of the government regarding women's health as well as efforts to address IPV. It is believed that the study will contribute to the country's attainment of its MDGs, national plans of action for the reduction of domestic violence, and the combating of rape, which mostly affects women.



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## APPENDICES

### APPENDIX 1



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#### Participant information sheet

#### Research project

**Title:** Understanding attitudes and perceptions of nurses and medical doctors intimate partner violence screening at Katutura Hospital, Namibia

#### Invitation

You are invited to participate in a research study on understanding the attitudes and perceptions of nurses and medical doctors towards introducing screening for intimate partner violence (IPV) during routine care at frontline services units at the Katutura Intermediate Hospital.

The study is being conducted by Martin Ndakalako Mukulu, a Master of Public Health student at the University of the Western Cape in the Republic of South Africa (student no 3309318),

currently employed by the Ministry of Health and Social Services (MoHSS) as a Senior Health Program Administrator (SHPA).

### **Why conduct this research?**

One of the requirements for a master's degree is to conduct a research project on a topic of interest affecting public health in our country and write a mini-thesis – hence the choice of this topic.

### **Study objective**

1. To explore the attitudes and perceptions of nurses and medical doctors towards screening women for IPV during routine care at frontline services units.
2. To identify factors that hinder/help nurses and medical doctors in screening women for IPV during routine care at frontline services units.

### **Who will take part in the study?**

The study participants will be nurses and medical doctors working at frontline services units at the Katutura Intermediate Hospital.

### **Is participation compulsory?**

Participation in the study is voluntary, and even as a participant you will have the right not to participate in every aspect of the study and/or to withdraw from the study at any stage. While we would like to welcome you as a participant, we respect your right to decline, and should you decide not to participate, this will not affect your employment by the Ministry. If you do take part in the study, you will retain this information sheet and be required to sign a consent form.

The study will not use personal information such as your real names to identify you, but a pseudonym may be used for purposes of communication, and demographic data will be obtained from you to assist in the analysis of the data. Participation in this study will only take place after the study aims have been clearly explained to you, so that you will be able to make an informed decision regarding whether to participate in the study and give your consent.

### **Identifying the researcher/interviewer**

The researcher as the interviewer will be identified by means of his student card from the School of Public Health (SOP) of the University of the Western Cape, South Africa, bearing the student number 3309318.

### **What will the study entail?**

The study will be conducted in the form of in-depth interviews with nurses and medical doctors working at frontline services units of the Katutura Intermediate Hospital, as well as key informant interviews with selected stakeholders. Such in-depth interviews are expected to last 35–45 minutes. Participants will not benefit directly from the study, but participation will be highly appreciated. The in-depth interviews will be conducted in a private room situated in the Katutura Intermediate Hospital – a quiet, safe place to ensure confidentiality and privacy. These sessions will be audio-recorded for purposes of analysis, and data will be used in writing a report, which will be marked by course convenors. The identity of those who participated in the study will be kept confidential throughout the study.

### **Possible risks and benefits of participation**

Ethical approval will be sought from the **Ethical Committee** of the University of the Western Cape through the High Degree Committee and the **Ethical Committee** of the Ministry of Health and Social Services in Namibia. The study will not be intended to cause harm to participants, but to obtain information that will assist the researcher in obtaining his degree. Should a participant become distressed during or after the research, he or she will be referred to a social worker or psychologist for emotional support. Such referral will be conducted in a professional and confidential way. The study will invite participants to give their views on IPV screening during routine care services at the Katutura Intermediate Hospital.

### **Results of the research study**

Participants will be free to download a copy of the study report if they should wish to do so. The study report will be made available on the website and may also be made available for other purposes should the need arise, such as for further research and planning.

For further information please contact:

1. Martin N Mukulu: tel. 081 270 4925; e-mail [martinmukulu2@gmail.com](mailto:martinmukulu2@gmail.com)
2. Head of Department, Prof Helen Schneider: tel. (+27) 21 959 3563; fax (+27) 21 959 2872; e-mail [hschneider@uwc.ac.za](mailto:hschneider@uwc.ac.za)
3. Dean of the Faculty of Community and Health Science, Prof Jose Frantz: e-mail [msimpson@uwc.ac.za](mailto:msimpson@uwc.ac.za)

**Thank you for taking the time to consider participating in this study. If you wish to participate in it, please sign the attached consent form and retain this information sheet.**



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## **Interview introduction**

### **Interview 1:**

Interviewer: Good afternoon, Sister!

Nurse: Good afternoon, Mr Mukulu. How are you?

Interviewer: I am well, thank you. How are you?

Nurse: I am doing well.

Interviewer: You are working today, how has your day been so far?

Nurse: Aargh, somehow a heavy one today, but managing.

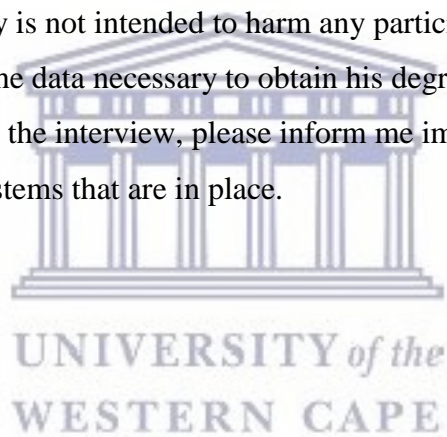
Interviewer: It is good to hear that you are managing. Ok, Sister, my name is Martin Mukulu. I am a Master of Public Health student at the University of the Western Cape, and I am currently working for the Ministry of Health and Social Services as a Senior Health Program Administrator under the Directorate: Policy Planning. I am conducting a research on the attitudes and perceptions of nurses and medical doctors towards introducing intimate partner violence screening during routine care at frontline services units of the Katutura Intermediate Hospital. I am here by inviting you to take part in this research study, which is aimed at exploring the attitudes and perceptions of nurses and medical doctors towards providing IPV screening during routine care at frontline services units. An additional objective is to identify whether there are factors which may hinder or help nurses and medical doctors in providing IPV screening during routine care at frontline services units. As I said earlier, the study will mainly focus on the nurses and medical doctors at frontline services units of the Katutura Intermediate Hospital. Frontline services units mainly form part of the Outpatient Department, the Casualty Section and the screening rooms, because these are likely to be the first points of contact with patients who are likely to be victims of IPV.

Now in terms of participation in the study, participation is voluntary, and as a participant, you will have the right not to participate in every aspect of the study and to withdraw at any stage. While I would like to welcome you as a participant in the study, I also respect your right to decline. Should you decline or withdraw from the study at any point during the interview, this



will not affect your relationship with your employer or with me. The study will not use your personal information such as your real name to identify you, but you may use a pseudonym, that is a name for purposes of communication only, and to enable the researcher to obtain any demographic data that will assist in the analysis of the study.

As explained to you earlier, interviews will be recorded, and are scheduled to take 35–45 minutes; however they may be shorter, depending on how we proceed. I will use guiding questions during the interview to guide our interview process. The information that will be obtained will be kept confidential and will be used for purposes of the study only. There are no direct benefits to participating in the study, and the study has been approved by the Ethical Committee of the University of the Western Cape through the High Degree Committee, as well as by the Ethical Committee of the Ministry of Health and Social Services under the Management Information Department. The study is not intended to harm any participant, and is intended only to enable the researcher to obtain the data necessary to obtain his degree. Should you become uncomfortable or distressed during the interview, please inform me immediately, so that I will be able to refer you to any support systems that are in place.



## APPENDIX 2



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#### CONSENT FORM

**Title of research project:** Understanding attitudes and perceptions of nurses and medical doctors on providing intimate partner violence screening at Katutura Hospital, Namibia.

The objective of the study has been described to me in a language that I understand, and I freely and voluntarily agree to participate.

My questions about the study have been answered. I understand that my identity will not be disclosed, that I may withdraw from the study without giving a reason at any time, and that this will not affect me negatively in any way.

**Participant's name.....**

**Participant's signature.....**

**Date.....**



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## **APPENDIX 3**

### **Interview schedule**

#### **Introduction**

My name is Martin Ndakalako Mukulu. I am employed as a Senior Health Programme Administrator in the subdivision Facility Planning in the Directorate Policy Planning and Human Resources Development of the Ministry of Health and Social Services at the Head Office. I am currently enrolled with the School of Public Health at the University of the Western Cape in South Africa for a Master in Public Health. My student number is 3309318. I am in my second year, and one of the module requirements is to conduct a qualitative research study on a topic of interest to public health.

The interview will be guided by the following questions:

#### **Questions for nurses and medical doctors**

1. What are your views on IPV in general?
2. Can you describe to me the forms of IPV that you encounter in your work setting?
3. Can you explain to me your experience of conducting IPV screening in your daily routine activities?
4. How do you feel about screening women for IPV during routine care?
5. Do you think there are factors that may prevent you from screening women for IPV during routine care? If there are, please explain.
6. Do you think there are opportunities to introduce IPV screening for women during routine care? If there are, please explain.

#### **Conclusion**

Allow me to take this opportunity to thank you for voluntarily agreeing to participate in this discussion, and for sharing your views on all the questions. I would like to assure you once again

that the information provided by you will be treated confidentially, and that all information revealed here will be used for study purposes only and will not be disclosed to people other than those stated in the consent form and participant information sheet. Thank you very much, and I wish you a good day.



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