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"Women enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa

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Abstract

Violence against women is pervasive in South Africa where, as in many other countries, cultural values and norms serve to condone and reinforce abusive practices against women. Primary health care nurses, who are widely distributed throughout the rural areas, may appear to be an ideal network for addressing this issue in resource-poor settings. However, based on a qualitative and quantitative study of a class of 38 PHC nurses, this paper emphasises that the nurses are women and men first—and as such, experience the same cultural values, and indeed, similar or higher levels of violence, as the clients they are expected to counsel and treat.

Current models for encouraging nurses and other health care workers to detect and address gender-based violence have evolved largely in the context of developed countries, and have focused primarily on acquiring the knowledge, skills and attitudes necessary to engage this issue in the health care setting. Yet, as this paper suggests, there is an urgent need to understand and address the lived experiences of the nurses, and the duality of their roles as professionals and as community members, before promoting the training of nurses as an effective strategy for dealing with gender-based violence.

One such training model was piloted and assessed in this study. The intervention used partnership with a domestic violence NGO to initially focus on dealing with the attitudes and experiences of the nurses as individuals, and to begin a process of self-awareness and sensitisation. Only then did the intervention turn to their roles as professional nurses.

Clearly, there is a need for further research to explore these issues in more depth and to inform the development of appropriate training strategies for health care workers, particularly in developing countries. Moreover, such research may well have implications for the design and implementation of training interventions aimed at raising awareness and capacity within other sectors such as the welfare, police and judicial systems.

Keywords: Gender-based violence; Nurses; Training; Health sector; Rural; South Africa

Introduction

The new South African government has pledged to ensure women a full and equal role in every aspect of the economy and society. Yet South African women continue to face extraordinarily high levels of violence. Physical abuse and rape are the forms of such violence which have been most clearly described in South Africa. A large community-based study of violence against women, with a random sample of 1306 woman respondents from three provinces, produced provincial estimates of the prevalence of having been subject to physical violence by a current or ex-partner of between 19% and 28% (Jewkes et al., in press). Moreover, research which has asked men about whether they have physically abused women has found corresponding

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results, and a survey of 1394 randomly selected men in Cape Town found that 41% reporting having physically abused a female partner in 10 years before the study (Abrahams, Jewkes, & Laubscher, 1999).

In regards to rape, the most recent South African Demographic and Health Survey (DHS) found a national prevalence figure for rape of 7%, with a range of 3–12% between provinces, while prevalence rates in the Three Province Survey (cited above) ranged from 4.5% to 7.2%. Moreover, this survey identified an incidence of rape for women 18–49 years of 1300 per 100,000 women. Although it is beyond the scope of this paper to discuss differences in survey methodology and their implications for interpreting results, the methodological and ethical challenges inherent in conducting such research have been raised elsewhere (World Health Organisation, 1999). It is worth noting, however, that due to such challenges, and due to the broader "normalization" of physical and sexual violence within popular understanding (Wood, Maforah, & Jewkes, 1998), it is likely that the figures described above represent an under-estimate of the true magnitude of the problem of violence against women in South Africa (Jewkes, Watts, Abrahams, Penn-Kekana, & Garcia-Moreno, 2000).

Strategies for addressing such violence face particular challenges in resource-poor rural areas where, for most women, there is little or no access to shelter, counseling services, or the judicial system (Kim, 1999). In this context, the training of primary health care (PHC) nurses may represent a critical opportunity to begin addressing gender-based violence through the health sector. There are currently about 200,000 nurses in South Africa, constituting the largest category of health personnel in both the public and private sectors. Especially in the impoverished and remote rural areas where there is an acute shortage of skilled medical personnel, the health care system continues to rely heavily on the skills of these clinically trained nurses (South African Health Review, 1996).

Internationally, in response to the overwhelming evidence documenting the prevalence of battered women seen in healthcare settings and the severe long- and short-term health consequences of abuse, nursing and other health professionals have begun to re-define domestic violence as a critical and legitimate issue for the health sector (Heise, Ellsberg, & Gottemoeller, 1999). It has been pointed out that the health care system is a logical entry point for the identification of many domestic violence survivors who, all too often, become isolated from their work or social situations. Whether they come for emergency treatment, or for the subsequent long-term effects of abuse, or even for routine care for themselves or their children, this is where nurses may be especially well-positioned to act as resources for these women (Paluzzi & Houde-Quimby, 1996; Campbell et al., 1993). Moreover, although it is known that most women will not disclose violence in their relationship without being asked (often more than once), in a survey conducted for the American Medical Association, 65% of respondents stated that they would disclose violence to their health care provider before others, including clergy, family, and friends (CDC, 1994).

Yet most health care professionals, including nurses, receive little professional training to intervene in cases of domestic violence (Hendricks-Matthews, 1991; CDC, 1989). Numerous studies in a variety of health care settings have indicated that the rates of detection and intervention in cases of domestic abuse have been appallingly low (Helton et al., 1987; Warshaw, 1989; Henderson, 1992; Motsei, 1993). Moreover, when battered women *have* been identified, they have often been treated insensitively and had their abuse minimised or ignored, with healthcare workers tending to focus on physical injuries while subtly blaming women for their abuse (Campbell et al., 1994; Warshaw, 1989). It is not surprising then, that battered women often consider healthcare professionals to be the *least* effective source of help among formal support systems (Bendtro & Bowker, 1989; Hoff, 1990).

In order to explore the context of domestic violence in rural South Africa, and to investigate the potential role of PHC nurses in addressing such violence, research was conducted among a class of 38 nurses enrolled in a 12-month residential training program based in Northern Province. This province, one of the poorest provinces in South Africa, is also one of the least urbanised, with 92% of its population living in rural areas. The Health Systems Development Unit (HSDU) a health systems research and development program within the Department of Community Health, University of the Witwatersrand, has been educating nurses to work in the rural communities of South Africa since 1982.[1] The location of this program within a rural research facility provided an ideal opportunity in which to investigate nurses' attitudes and experiences of gender-based violence and to subsequently pilot and evaluate a focused educational intervention.

The research had both qualitative and quantitative components. First, focus group research was conducted with the 38 nurses (29 women, 9 men) exploring their attitudes to and experiences of gender-based violence—both as health care workers and as members of their communities. This was followed by an educational intervention in which a 1-week intensive gender violence training module was incorporated into the nurses'

[1] Since 1998, the HSDU PHC Nurse Training Program has been operating as a partnership between the University of the Witwatersrand and the Northern Province Department of Health.

Reproductive Health curriculum. The training module was developed and implemented in partnership with a local domestic violence NGO, and addressed needs and priorities previously identified during the focus group research. The training intervention was then evaluated using a structured questionnaire.

This paper describes the nurses' attitudes and beliefs regarding gender-based violence, as well as their experiences of such abuse—both as professionals, and as members of their families and communities. It then situates these observations within emerging international efforts to raise awareness and capacity to address domestic violence within the nursing profession. Finally, in light of these findings, this paper raises key questions and concerns which need to be examined within emerging strategies which envision health care workers as one means of addressing violence against women in South Africa.

Methodology

Seven focus groups were conducted, each comprised of 5 or 6 nurses. All were black,[2] and ranged in age from 31 to 51 years of age. All had completed their basic nurse training, and had worked in their local clinics for several years, where they were responsible for the full range of primary health care services. Although the majority of the nursing class were women (reflecting the gender distribution within this profession), it was felt that mixed-gender groups could reveal additional interactions and insights which would be of interest given the subject under study. Therefore, although traditional focus group methodology usually involves same-sex groups, 3 out of the 7 focus groups were composed of both men and women, and the remainder were women only. These were chosen to correspond with prior, self-allocated student groups in order to reflect peer groups who were already familiar and comfortable with each other. Because the nurse training program is conducted in English—a language in which all the nurses are fluent—focus groups were also conducted in English using a facilitator trained in qualitative methods. All discussions were fully tape-recorded and in all instances, the facilitator summarised the tapes and made additional relevant notes immediately following the group discussion. Transcripts were compiled into one report and analysed according to content, using open coding (Strauss & Carbin, 1990) to generate units of meaning which were then labelled and categorised.

Five months after the focus groups, as part of the ongoing training program, a gender violence training module was piloted during the same nurses' Reproductive Health curriculum. This module was developed and implemented in partnership with Agisanang Domestic Abuse Prevention and Training (*ADAPT*), an NGO based in Alexandra township, Johannesburg. Responding to the needs identified in the focus groups, the training intervention initially focused on the attitudes and experiences of the nurses simply as women and men, in order to begin a process of self-awareness and sensitisation. The training then turned to the nurses' roles and responsibilities as health care professionals, exploring how they could address the issue of domestic violence in their work capacities, identifying existing barriers to action, and discussing strategies to overcome these. They also reviewed practical skills involved in detecting cases of abuse and considered how they might introduce identification and assessment protocols into their own health care settings. Finally, the nurses discussed how they could use their roles as community members and educators to raise awareness concerning domestic violence.

The *quantitative* component of the study was then introduced, in the form of a standardised questionnaire. This questionnaire was used to collect data for the following purposes:

1. to compare post- intervention attitudes and beliefs with those expressed during the focus groups;
2. to collect data on the prevalence of gender-based violence among the nurses;
3. to evaluate the intervention.

Results

Throughout the focus groups, women (in both mixed- and single-sex groups) universally defined violence against women or gender-based violence in broad terms which included physical, sexual, psychological, and economic abuse, whereas the male nurses tended to spontaneously mention only physical abuse and rape. In mixed-sex focus groups, there was an active engagement of these definitions as well as related issues, and the emerging themes are summarised below. Results from the questionnaire are presented separately, following the focus groups.

Attitudes and beliefs regarding physical abuse

Among the men, references to physical abuse were frequently described using terms such as "discipline" or "punishment". In discussing when they felt it was

[2] In this paper, the term "black" is used to refer to South Africans previously classified by the apartheid system as "African" or "black" (of solely African ancestry). The term is used here because the previous classification system remains relevant to the current social and economic circumstances of men and women in South Africa.

"justified" to beat a woman, there was a general consensus among men that "when they don't *listen*" or "when they stand for their rights, they get beaten". They also felt that a woman's perceived shortcomings in meeting household duties or child care justified such abuse. As one man stated "There is a certain you know, *laziness* that one cannot accommodate… you just disfigure her—once. Maybe when she looks ugly, then she will start doing some of this work." Similarly, women nurses indicated that a man who is known to be beating his wife is often generally regarded with approval as one who "knows how to discipline" or "he's keeping order in his home. He is a right man." In this sense, they indicated that violence against women has, to a great extent, become socially normalised: "They feel sometimes that it's the normal behaviour of men. They can't just point at him and say 'Look at that one, he beats his wife'… They take them to be normal-behaving men."

In general, while women in both mixed- and single-sex groups acknowledged the social normalisation of such violence, they argued that violence was neither an appropriate nor a justifiable response for dealing with conflict. However, many simultaneously expressed the belief that there were certain behaviours which might place women at "increased risk". A husband's use of alcohol, a wife's "disrespectful attitude", and a wife's sexual infidelity were identified as potential "triggers" for physical abuse.

In fact, the subject of sexual infidelity was repeatedly raised in every focus group. Here, both men and women stated that a husband's infidelity was socially accepted and even encouraged. In fact, because it is so widely regarded as a man's right to have extramarital affairs, it was noted that a woman's lack of co-operation in accommodating these relationships might also be an occasion for her physical abuse. Infidelity on the part of a woman, however, was universally judged to merit physical assault. As one man explained: "The wife has been fooling around with other men—I think the man has got the right… to hit, in a way, to 're-shape' the wife". Even among the women nurses, many expressed the opinion that a woman's sexual infidelity might justify a beating, and that "in the case of adultery, even your own mother won't be… against the man… you won't even have her by your side, saying 'My child, you were not supposed to be beaten.'"

Finally, among the men, battering was described as a means of expressing forgiveness for a woman's perceived transgressions: "If I do not beat you, I won't forgive you for the rest of your life. If I did it, it's another way of forgiving." In fact, a commonly expressed sentiment among the men was that, as many phrased it, "women enjoy punishment". A typical remark asserted the belief that women equate such abuse with an expression of love: "Usually, if a man hits a woman, usually there is still love inside the man… if they *sjambok* (whip) you, it means this person loves you. He still wants to keep you, because immediately after the corporal punishment, you maintain your dignity as a woman in the house." It's interesting to note that while in mixed-sex focus groups, women vigorously denied this point, when they were alone, many expressed similar views to the men: "Some women don't feel loved if they are not beaten at home. Maybe it's cultural… 'if he beats me, then it shows that he loves me.'"

Attitudes and beliefs regarding sexual abuse

There was a marked disparity between men and women with regards to definitions of sexual abuse. Women nurses universally agreed that rape within marriage was possible. Moreover, they tended to take a broader perspective of sexual abuse, which encompassed sexual harassment and "date rape" as well as a man's disregard for a woman's own sexual needs.

In regards to rape, some female nurses felt that women themselves were not to blame and that any woman could be raped. Others however, believed that women who are raped "tend to put themselves at risk", for example, through the way they dressed, through their use of alcohol or drugs, or by going about at night.

Among male participants, sexual abuse was perceived only in terms of rape perpetrated by a stranger, and therefore, the notion of marital rape was largely dismissed. In the words of one male nurse: "Today you come back, there is a bruise. He punished you for a mere—sex. Then, what more do you want? He wanted to have sex, and you're supposed to do it, that's all… .". Moreover, there was a frequently expressed belief that women often falsely accuse men of rape, either because of resentment at the termination of a relationship, or because the man had rescinded upon prior financial arrangements. In addition, the concept of "date rape" was not seen as a form of sexual abuse, even though several men described incidents of coercive sex with their women acquaintances.

Attitudes and beliefs regarding psychological abuse and economic abuse

Unlike the men, the women frequently described gender-based violence in terms of emotional or psychological abuse, referring to situations in which a man might constantly insult or undermine a woman. Others described such abuse in terms of a husband behaving with complete disregard for his wife's feelings, for example restricting her social movements while enjoying his freedom to socialise without her, or blatantly flaunting his infidelity. As one woman remarked: "Sometimes they make you to share a bedroom or a

bed with a girlfriend… they make love in your bedroom. It means you are nothing. You have no say.''

It's interesting that the concept of economic abuse was also only raised by women. They noted that while husbands generally exercised complete control over financial decisions, their wives were compelled to repeatedly ask for small amounts of cash for any household or personal expenses—regardless of their own income-earning status.

Traditional practices: lobola

There were several traditional practices and beliefs which were raised, and one which was energetically debated in every focus group was that of *lobola* or bride price, a practice in which the groom's family offers a large payment to the bride's family—traditionally, of cattle, but in modern times, of money. The men were universally in favour of lobola, however among women nurses, it was clearly regarded with great ambivalence. On the one hand, some women felt that the tradition only heightened violence against women, by promoting the concept of women as ''property'', under the control and ownership of their husbands. They felt that while the original intent of the tradition was good, its meaning had changed over time.

But other women were vehemently in support of *lobola*, claiming that it served to strengthen relationships and impart them with social legitimacy. As one woman explained: ''It shows that 'you have entered in the front door'''. Paradoxically, some felt that the concept of the woman as property might even *protect* her from abuse, giving the example of a man's parents admonishing him by saying: ''Don't beat this lady. No, you have paid *lobola* for her, so please take care of her. It's your glass—don't break it!''

A final and striking observation about *lobola* relates to the utter resignation expressed by many women, in which domestic violence was viewed as an inevitable part of a woman's lot. Here, *lobola* was seen as a form of consolation, and as one woman quietly declared: ''Even if he didn't pay the *lobola*, he is still going to beat you. It makes no difference. But it's better to be beaten when the *lobola* has been paid—unlike to be beaten for nothing… It's better because your parents have received something for the assault.''

Responding to gender-based violence: nurses' perceptions

During the focus groups, there was much animated discussion about how the nurses would respond if they discovered that their *own sister* were being abused by her husband. These comments are especially interesting because they suggest how the nurses might deal with an abused client—*without* alerting them to make favourable remarks which might be appropriate to their professional role.

Many of the men noted that they would simply *assume* guilt on the part of the woman, saying: ''My sister, she knows that she is guilty… I will blame her, because I know that women are troublesome.'' In fact, most men stated that, in accordance with tradition, they would send the woman directly back to her abusive spouse. As one man explained: ''When two people are getting married, the parents and the relatives of this lady, they usually tell her that she should *die* at her husband's place. Even he can hit you… she shouldn't come back home. She should *die* there first. So when I see my sister come with a bruise, I say 'Just go back'''.

Moreover, most men declared outright that they would not refer their sister to the police or judicial system. All agreed that such abuse was a private matter, but some suggested that referral might be appropriate *if* a woman's life were clearly at stake. But they also believed that this danger would only arise under extreme situations. As one male nurse stated, he would only make a referral to the police: ''*if* she feels that she has had enough. So we will give her the chance. Women are very tough. Even if you hit them, they can still come back and tolerate the situation. That's how they are *made*.''

In contrast to the men, some women nurses actually mentioned talking to their sister to ''hear her side of the story'', or of ''counselling'' either her or her husband. But here also, some statements reflected the underlying belief that she might have done something to deserve the beating and that she should be sent back to her husband: ''If you get that the problem lies with this wife, you give her the advice not to repeat these things… and after that she goes back… yes you send your sister back''. And in reference to the kind of counselling that would be offered, some women suggested that they would advise the woman *not* to talk to others, and that they would teach her how to avoid ''provoking'' her abuser in the future.

Finally, like their male colleagues, most women noted that they would try to resolve the issue within the family rather than refer the abused woman to the judicial system. Once again, it was the ''severity of the injury'', as many phrased it, that determined whether or not to involve those outside the family. Typical remarks included: ''If it's a chop (stab), you will… send the patient to hospital'', or ''If it's a laceration, then the police can be called.''

Personal experiences of gender-based violence

Finally, what did the focus groups reveal about the nurses' personal experiences of abuse—either as survivors or as perpetrators? Although they were not directly questioned about this during the focus groups, the

nature of the comments themselves strongly suggested that this was a common and immediate experience among the nurses.

Among the women, there was an initial tendency to discuss domestic violence as something which only happened to other—usually less educated—people. As one nurse confidently stated: "It's nowadays that we are becoming aware of our rights. That is why it's very much rare to find a professional person being abused." However, as the discussions evolved and became more animated, the comments also became increasingly personal. For example, in regards to economic abuse, the women revealed that in spite of their education and professional status, they were still obliged to hand over their salaries to their husbands at the end of each month, and felt unable to exert meaningful control over their own finances. In fact, because many had had to depend on their husbands in order to attend nursing school, they found that the men now claimed this as a justification, saying: "Because I have taken you to school, I have spent my money doing *everything* for you—now, it's your turn. And at the end of the month, you bring the whole check here."

In fact, a pattern which gradually emerged from the focus groups was that, in many ways, the women may be at *greater* risk of abuse, *due* to their professional status. Many described the situation in which a husband began to feel threatened by his professional, income-earning wife, resulting in tension and often, violence. Moreover, because it was considered "completely unacceptable" for a married woman to be seen as befriending a male colleague, they found themselves under constant scrutiny and suspicion of sexual infidelity, which could then lead to physical assaults from their husbands. As one woman described it: "In a working situation… doctors are males, drivers for the ambulance are males, people in the workshop are males… paramedics, they are all male. So if they will find you with a doctor, then you know, we are 'in love' with this one… You know, you come home with bruises everyday."

The training intervention and questionnaire

In order to fit within the existing nursing curriculum, the duration of the intervention was limited to 4 days. The initial 3 days used multiple participatory methods such as role plays and brainstorming exercises to deconstruct traditional sayings and beliefs and to examine their implications for reinforcing gender stereotypes and gender conditioning, often drawing parallels between gender-based oppression and apartheid. A film, realistically depicting the nature and consequences of domestic violence was viewed and subsequently discussed. Initially, there was a tendency to speak about gender-based violence with professional detachment, as a phenomenon which the nurses wished to be better able to address with their clients. As the days progressed, however, the experiences and insights became much more personal and emotional, and towards the end, an opportunity was created for both men and women to relate their own experiences of gender-based violence. Care was taken to create an environment of safety and confidentiality, and individual, peer, and group counselling were made available throughout the training.[3]

An anonymous and confidential questionnaire was completed by the nurses following the training intervention. Two women were absent from the program at the time, and were therefore unable to participate in the training or questionnaire. All the men were present, bringing the total number of completed questionnaires to 36 (27 women and 9 men).

Among the women, the results of the questionnaire confirmed several findings from the focus groups: 100% acknowledged marital rape to be a legitimate entity and once again, their opinions regarding *lobola* were evenly divided. However, unlike the focus groups, following the gender violence training, not one of the women nurses felt that it was ever justified to beat a woman—even in the case of sexual infidelity. In fact, from the perspective of the women, the training's greatest impact was to raise awareness about their own oppression and to personally acknowledge (often, for the first time) their own experiences of abuse. Many described this experience of "speaking out" as being simultaneously painful, empowering and healing: "It's healing, to speak out… to open my mouth and talk about the abusive situation… to talk about my past, it was healing."

Among the male nurses, many had found hearing the experiences of their female colleagues and examining their own beliefs and behaviours to be a disturbing and challenging experience, and the questionnaire reflected a number of changes in knowledge and attitudes. In regards to marital rape, the majority of men now responded that rape within marriage is indeed possible. In fact, one man admitted that seeing the film during the training had really challenged his prior beliefs. And although none of the men had spoken out against *lobola* during the focus groups, the questionnaires now revealed a division of opinion which was closer to that of the women, and some had begun to question the role of traditional practices such as *lobola* in maintaining abusive practices against women. The most striking change noted was that, in an open-ended question, not one of the men responded that it was ever justified to beat a woman. As one man commented: "There is no

[3] Peer counselling (nurse-to-nurse support) was incorporated into the training sessions themselves and individual and group counselling were available through two experienced facilitators—one from ADAPT, and one from the PHC Nurse Training Programme.

law, or license to beat a woman whatever the circumstances might be. It's a sign that love and respect did not exist.''

The questionnaire also confirmed the high levels of violence in the nurses' own lives (Fig. 1). Among the 36 female nurses, 25 had experienced at least one form of abuse by an intimate partner: more than one-third reported having been physically abused, equal numbers had been sexually abused, and most had experienced emotional or psychological abuse. Moreover, among the 8 male nurses, 6 admitted having been abusive to an intimate partner: 4 had engaged in physical abuse, 3 in sexual abuse, and 6 admitted to being emotionally or psychologically abusive.

Finally, in evaluating the gender violence training module, 100% of the nurses reported that they had found it to be a valuable educational experience and for many, it had marked a turning point in their personal and professional lives. All of the participants reported that they would wish to see such training formally and more widely incorporated into the South African nursing curriculum.

Discussion

Methodological considerations

The study participants represent a group of educated and relatively privileged professional women and men who are not randomly selected and are consequently not representative of the rural South African population. It would not be valid, therefore to generalise the findings to such a broad population. However, it is likely that the study participants do, to a large extent, reflect the prevailing attitudes and experiences of their peers—those South African nurses working in the public sector of rural South Africa.

The study utilised both focus groups and questionnaires and there are relative strengths and limitations associated with each methodology. In regards to focus groups, it is likely that group discussions which do not pin down a single person to relate his or her private life to another person (as in an individual interview) can provide insights into cultural norms and collective beliefs, even regarding such a sensitive subject as

Female Nurses: Have you ever been abused* by an intimate partner?

	N = 36
Any form of abuse reported	25
Physical abuse	10
Sexual abuse	11
Emotional abuse	24

* physical abuse: defined as having been slapped, kicked punched, burned, etc.
sexual abuse: defined as unwanted sexual contact or forced sex.
emotional abuse: defined as being verbally humiliated, forbidden to visit friends or relatives, etc.

Male Nurses: Have you ever been abusive* towards an intimate partner?

	N** = 8
Any form of abuse reported	6
Physical abuse	4
Sexual abuse	3
Emotional abuse	6

* forms of abuse defined as above.
* * 1 participant did not respond to this question; N = 8

Fig. 1. Questionnaire results: prevalence of Gender-based violence.

domestic violence (Konde-Lule, Musagara, & Musgrave, 1993). An additional advantage relates to the ethical concerns raised by conducting such research in a resource-poor rural setting where access to shelter, counselling or legal services for study participants is severely limited. The focus groups deliberately encouraged nurses to discuss this subject from their perspective as healthworkers and community observers, and a more personal exploration of the subject was deferred until the training module was implemented in partnership with a domestic violence NGO (and its associated skills and resources).

Addressing this issue from both professional and personal viewpoints enabled a frank investigation of healthworkers' attitudes and beliefs (including the less-reported perspectives of male informants) as well as the collection of prevalence data relating to their experiences of physical, sexual, and psychological abuse. Although the sample size of the questionnaire was limited, the prevalence data supports the findings from the focus groups, and reflects the need to take account of the extent of such abuse among professional healthcare workers. To our knowledge, only one other study (Moore et al., 1998) has looked at healthworkers' own personal experiences of abuse.

One of the potential limitations of focus group research is that the group dynamic may shape individual responses through interpersonal solidarity or the perceived pressure to conform to a dominant group position (Macun & Posel, 1997). Among the male nurses in particular, it was observed that men rarely contested each other's views, although they often debated those of the women. In this regards, although the prior composition of the student groups did not facilitate this, single-sex focus groups with men would have been desirable. Among women, aside from the exceptions noted earlier, significant disparities between mixed- and single-sex groups were not observed, and issues were generally freely discussed and contested with both men and women in the groups.

In general, the mixed groups created the opportunity for female and male participants to engage and debate controversial issues, and thus enabled the researchers to uncover important differences in their attitudes and beliefs. Moreover, the remarkable openness with which gender-based violence was discussed, was itself a revealing indication of the degree of its acceptability and prevalence. It is worth noting, however, that the participants in this study were drawn from a pre-existing professional and educational environment in which such interaction was possible—this would almost certainly not be the case in other community settings.

The iterative and exploratory nature of the focus group research uncovered key themes such as differential understandings of sexual violence (including marital rape) and traditional practices and beliefs such as *lobola,* which could then be further probed through the questionnaire. In many ways, the qualitative and quantitative methods complemented each other and the triangulation of methods provided confirmation of some findings while highlighting differences in others.

Current approaches to gender-based violence education within the nursing profession

A review of the literature indicates that much of the published work dealing with domestic violence initiatives within the nursing profession has emanated primarily from academic settings in the developed world, and particularly the United States. It has been suggested that health workers face considerable obstacles in attempting to address this issue with their clients, and in fact are often reluctant to directly assess for the possibility of abuse. One American study of 38 primary care physicians identified the following barriers: close identification with patients, fear of offending patients, feelings of inadequacy and frustration, lack of training, inability to "cure" the problem, and lack of time (Sugg & Inui, 1992). Similarly, authors in both developed and developing countries have identified a range of personal, professional, and structural factors which operate to inhibit routine and consistent assessment. Personal factors included a variety of myths concerning domestic violence which promote societal denial and attribution of blame, a lack of awareness of the incidence and the dynamics of abuse, as well as the belief that assessment is "too intrusive" or that the situation is too complicated or hopeless (King & Ryan, 1996; Sugg et al., 1999; Cohen et al., 1997; Watts & Ndlovu, 1997).

Yet within the health sector, and in particular, the nursing profession, there have been concerted efforts to bridge this gap, with recent progress in formally conceptualising the appropriate knowledge, skills, attitudes and practices required to deal with this issue in a sensitive and competent manner. For example, in 1994, the Special Projects Section of the American College of Nurse-Midwives designed and introduced a Domestic Violence Education Project, whose main focus is "to educate precertified and practising nurse-midwives about the issue of domestic violence, including the knowledge, skills, and attitude for proper assessment, intervention, referral, and advocacy" (Paluzzi, 1996). This focus on core competencies is similarly reflected in a Canadian interdisciplinary curriculum guide for health professionals (Hoff, 1994) in which "core violence content" refers to "the knowledge, attitudes and skills essential to any person working with survivors or assailants".

Clearly, there is a need for such educational initiatives which focus on the professional skills needed to address the issue of domestic violence in the health care setting. Yet how well do these educational guidelines translate to

other health care environments—particularly in developing countries where resources for treatment and referral may be extremely limited? What are the implications of such approaches in light of the findings identified in this study—particularly the nurses' attitudes and beliefs regarding gender-based violence, as well as their own personal experiences of such abuse?

Knowledge, skills, attitudes—and personal experience

It has been observed that "because nurses are themselves the products of our cultural tradition, they may not question the prevailing attitudes that support abuse of women", and their attitudes may therefore reflect prevailing patriarchal and victim-blaming perspectives (Sampselle, 1991). This observation is certainly evident in the present study where, as the focus groups revealed, the nurses (women, as well as men) have to a great extent internalised dominant cultural values and beliefs regarding gender and gender-based violence. From normalised concepts of physical abuse as a form of "discipline" or as an expression of love, to beliefs that women are responsible for provoking physical or sexual assaults, these attitudes and beliefs have powerful implications for how these healthcare workers might respond to incidents involving domestic violence. Furthermore, traditional aphorisms promoting a woman's "tolerance" and "perseverance" in marriage were reflected in the nurses' reluctance to refer an abused sister to the police or judicial system, and their preference to keep the issue within the family domain—until the injuries were felt to be sufficiently alarming or life-threatening.

The attitudes of health care professionals toward survivors of domestic violence have long been recognised as potentially damaging, and survivors of violence often report being twice victimised—once by their abuser, and once by the staff in the health care facility they visit (Tilden, 1989; Langford, 1996). In fact, in stark contrast to the nurse's role as patient advocate, recent discourse has started to focus attention on the potentially abusive dynamics of nurse–patient interactions (Woodrow, 1997; Hoff & Ross, 1995). In one South African study of obstetric public health services in the Western Cape, many patients reported clinical neglect, as well as verbal and physical abuse from nursing staff (Jewkes et al., 1998). Examined in this context, the potential for nurses to contribute to such damage, or in fact, to further endanger an abused client, cannot be overlooked.

Many researchers have commented upon the importance of probing and challenging one's own beliefs and attitudes regarding gender-based violence (Hoff, 1994; King & Ryan, 1996; Paluzzi & Houde-Quimby, 1996; Campbell & Campbell, 1996) and it has been suggested that a helpful educational approach might involve encouraging a nurse to imagine a scenario in which she "is the victim of abuse at the hands of an intimate partner who is deeply loved, as impossible as that may seem" (Campbell et al., 1993). Yet, as this study revealed, among the PHC nurses, a personal experience of such abuse was clearly the rule rather than the exception. In fact, as described earlier, there are certain elements to the experience of being a nurse in this context, which may actually *intensify* a woman's risk of such abuse. Yet there is little research documenting the prevalence of gender-based violence amongst nursing professionals—and the impact of such experiences on their willingness and ability to address this issue in a professional setting is simply not known.

It is possible, as one American study has suggested, that a nurse's personal or familial experience of domestic abuse will not affect her attitude toward abuse, while increasing the likelihood of attempting to identify abused women (Moore et al., 1998). However it is also possible that, within a given political, social, and economic environment, a prior or ongoing situation of abuse may make it difficult or impossible for a nurse to effectively deal with this issue within her professional capacity. For example, in the context of this study, it is difficult to imagine how a nurse who is unable to exert meaningful control over her own salary, and finds herself unable to leave an emotionally and physically abusive spouse, might counsel and advise a client in a remarkably similar position. In either case, while a few researchers have acknowledged the importance of recognising nurses' own experiences of domestic abuse, existing educational guidelines have only begun to address this critically important issue (Hoff, 1994; Hoff & Ross, 1995; Paluzzi & Houde-Quimby, 1996).

Conclusion

Recent years have witnessed an unprecedented recognition of domestic violence as a widespread and legitimate health concern. The Forty-ninth World Health Assembly Resolution declared the prevention of violence, including gender-based violence, to be a public health priority. And in envisioning "a science-based public health approach to violence prevention", WHO's Plan of Action emphasises the need "to promote, as part of the curriculum for training and the continuing professional development of health professionals at all levels, the incorporation of an understanding of violence and its health consequences, as well as the requirements for the provision of sensitive services" (World Health Organisation, 1997).

Particularly in the countries of the developed world, there have been systematic efforts to begin addressing this issue within the health sector, and several studies have confirmed that gender violence education has the

potential to raise awareness and strengthen nursing interventions for abused women (Rose & Saunders, 1986; Moore et al., 1998; Carbonell et al., 1995). Essentially all of the major American-based health care professional organisations, including the American Medical Association, the American College of Obstetricians and Gynaecologists, the American Nurses Association, and the American College of Nurse-Midwives, have responded to the need for education for their constituents in some manner (Paluzzi & Houde-Quimby, 1996). Furthermore, in the US, the Joint Commission on Accreditation of Healthcare Organisations now has an accreditation requirement which includes written protocols and documentation of staff in-service training on domestic violence (Langford, 1996).

However, such initiatives are in their infancy, and raise several important questions. As this study has shown, although nurses may represent an attractive resource for addressing the issue of gender-based violence in less-developed environments such as South Africa, little is known regarding their actual effectiveness or appropriateness in actualising this capacity. In order to act as effective advocates for abused women, and to avoid the 'double-victimisation' or even endangerment of clients, careful and informed consideration must be given to the kinds of educational interventions which will be needed. What is the nature and extent of personal, professional and collective experiences of abuse and oppression, and how might these affect nurses' willingness and ability to work with abused women? Where the prevalence of domestic violence is extremely high, as in this study, how might such educational interventions address the immediate needs of the nurses themselves, as well as identify and strengthen the kind of ongoing support systems which will be needed? And finally, how might the needs of male healthcare workers—who may themselves be perpetrators of abuse—be incorporated into such training initiatives? The inclusion of men in this study yielded important insights into the nature and prevalence of gender-based violence within the nursing context, and further research is needed to explore this dimension within other sectors dealing with survivors of abuse—particularly the more male-dominated police and judicial systems.

Healing and partnership—a model for gender violence training

There is a growing body of concrete and specific information about gender-based violence and its implications for intervention within the health care sector. Indeed, a wealth of nursing literature has been published in recent years, concerning issues of identification, assessment, and intervention with abused women. However, in light of the deeply-entrenched values and attitudes expressed by the PHC nurses in this study, as well as their own personal experiences, it is clear that any educational intervention must move beyond the intellectual or technical level to address the deeper and more personal context of the nurses' own experiences.

This study describes one approach to such an intervention, which started from the position of acknowledging and exploring the nurses' own experiences of abuse. It was only through persistent and skilled facilitation that the nurses were able to break through their professional detachment in exploring these issues, and to begin a process of self-awareness and, in many cases, personal healing. It is worth noting that the questionnaire, which was completed immediately following an intense training intervention, might tend to reflect short-term changes in attitudes, and a follow-up evaluation would be desirable. Although this has not been formally undertaken, 7 months following the training, three of the women nurses voluntarily chose to explore gender-based violence as the focus of their community-based research projects, and a clinic-based support group has evolved as a result of one of these projects.

The implications of scaling up such an approach to training are well worth consideration, particularly in light of the many competing demands for continuing education of health care workers. To what extent is it feasible to implement a 1-week training curriculum? To whom should such training be targeted? At what stage in the course of professional education, should such a curriculum be incorporated? And what should be the goals of such training? Although the answers to these questions will undoubtedly vary in different settings, recent discourse has asked whether, in the context of developing countries, the goal of "universal screening" for domestic violence is either practical or desirable (Leye, Githaiga, & Temmerman, 1999). As described earlier, because of the attitudes, beliefs and experiences highlighted in this paper, the potential for such a mandate to further traumatize or endanger women is a legitimate concern. An alternative, two-tiered education model might envision a primary objective of such training to be simply to promote the guiding principle of "first do no harm". At this level, training would focus intensively on healthcare workers' attitudes and beliefs, and attempt to raise awareness and sensitivity regarding the prevalence, nature, and consequences of such violence. Ideally, this would be formally integrated into the general medical or nursing curriculum at an early stage, with a second tier of more advanced training available to those who express both the capacity and the motivation to gain further skills (Kim, 1999). Further exploration of such alternative training approaches, and attention to the broader question of identifying strategic intervention points to address gender-based violence through the health sector are areas demanding further research in both developed and developing countries.

Finally, this paper describes an initiative which combined a concrete gender violence intervention with qualitative and quantitative research. Creating a partnership between a domestic violence NGO and an academic research unit enabled each to contribute complementing skills and resources to make this possible. In contrast to using educational materials developed in a distant and dissimilar setting, drawing on the experience and expertise of *ADAPT* ensured that the workshop reflected local understandings and beliefs regarding domestic violence. Moreover, the skilled facilitation and counselling provided by the NGO was a critical factor in providing a safe environment for personal examination, and in addressing the nurses' own experiences of abuse. This in turn enabled the sensitive and informed collection of prevalence data regarding personal experiences of gender-based violence—a task which would otherwise have raised ethical dilemmas, given the lack of counselling or referral resources available. In settings where resources to address gender-based violence are extremely scarce, and the need to couple research with action is an ethical as well as a practical imperative, this collaborative approach may well represent a model of action-oriented research which merits further exploration.

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