Professional nurses' experience when caring for women who are experiencing intimate partner violence: A caring presence study

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ABSTRACT

Background: Intimate partner violence (IPV) is a world-wide problem, especially in rural areas like the Vhembe region in Limpopo province where there has been a notable increase in IPV. This problem resulted in an increase in stress-related mental illness such as depression, post-traumatic stress disorder (PTSD), suicide attempts, suicide, and drug and alcohol abuse. Many studies have been done on the causes and consequences of IPV, but few were found on the experience of professional nurses and women experiencing IPV. Professional nurses providing care to women exposed to IPV may have specific experiences in this regard, and a caring presence approach may have a positive influence on the experience of the professional nurse as well as on the well-being of the women.

Aim: The aim of this study was to explore and describe the experiences of professional nurses working in primary health clinics (PHC), community health centres (CHC), the outpatient department (OPD), and the emergency department (ED) when caring for women experiencing IPV.

The objectives were to:

- Explore and describe the experiences of professional nurses who provide nursing care to women experiencing IPV.
- Explore and describe the readiness of professional nurses to attune to and connect with women experiencing IPV.
- Explore and describe how professional nurses can be guided to provide relational care to women experiencing IPV.

Design and method: A qualitative, interpretive phenomenological study design was followed, and the population comprised professional nurses working in PHC, CHC, OPD, and ED in Limpopo, Vhembe region, Thulamela sub-district. Professional nurses were selected through purposive sampling with the assistance of a mediator and informed consent was obtained with the assistance of an independent person. The sample size was determined by data saturation, which was reached at 15 participants. The data were collected through semi-structured one-on-one interviews which were audio recorded and transcribed verbatim. The researcher and co-coder analysed the data independently by making use of an interpretive phenomenological analysis, and agreement was reached with regard to selected themes and sub-themes.

Findings: The findings describe the experiences of the participants of caring for women experiencing IPV, their readiness to attune and connect with women experiencing IPV, and their views on how they should be guided on the provision of quality care to women experiencing IPV. The findings revealed that it is the experience of participants to feel compassion for women experiencing IPV, and these findings were discussed under five main themes and sub-themes that emerged from the data analysis. The main themes entailed that participants were willing to provide quality healthcare, but work in a difficult environment, and that their view of their own level of competence, attitude, work overload, and communication skills influence how they engage with women experiencing IPV. Furthermore, the participants realised that the lifeworld of women experiencing IPV made it difficult for the women to disclose IPV, and the participants emphasised the importance of collaboration with the multidisciplinary team and other stakeholders. A last theme, caring presence, also emerged.

Conclusions: Participants felt compassion for women experiencing IPV and were willing to provide holistic care to them. However, they experienced reluctance (not full readiness) – in distinct ways that are closely related to the context of their work environment, their experience of their own competence, as well as their experience of who the women are and what their beliefs and context are – due to hindrances that limit them in connecting with and attuning to the needs of women experiencing IPV. This left them feeling frustrated, and with a deepened sense of empathy for these women, as they realised how deeply they are suffering, while at the same time they felt unable to help. They experienced the need to be guided in providing relational care to women experiencing IPV through training, as well as through collaboration between multidisciplinary team members and stakeholders.

Recommendations for nursing practice, referral policy, nursing education, and further research were formulated from the findings.

Key terms: caring, caring presence, experience, intimate partner violence, professional nurses, women.

LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
CHC	Community health centre
DOH	Department of Health
DV	Domestic violence
ED	Emergency Department
GBV	Gender-based violence
HREC	Health Research Ethics Committee
IPV	Intimate partner violence
NGO	Non-governmental organisation
OPD	Outpatient Department
PHC	Primary healthcare clinic
POWA	People against women abuse
PTSD	Post-traumatic stress disorder
SAPS	South African Police Services
WHO	World Health Organisation

DECLARATION

I, Avhatakali Mphephu, student number 23780304, hereby declare that the mini-dissertation is my own work. I further declare that the mini-dissertation has been text-edited in accordance with the requirements and has not already been submitted to any other university.

Avhatakali Mphephu

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

Intimate partner violence (IPV) is a part of gender-based violence(GBV) that occurs within intimate relationship, dating, married, living together or separated; IPV is a world-wide problem occurs in all setting, in all socio-economic, religion and cultural groups (Marques, 2018; World Health Organisation(WHO), 2012). This includes African countries like South Africa, especially in rural areas like Limpopo (Vhembe region) (Mukwevho, 2017). There is a notable increase in IPV such as sexual violence (forcing a partner to participate in sexual activities without her consent), physical violence (assaulting, slapping, burning), psychological and emotional violence (insulting, abusive words, undermining), and economical abuse (Clark *et al.,* 2017; Sundborg *et al.,* 2012:1). Intimate partner violence contributes to an increase in stress-related mental illnesses; for example, depression, post-traumatic stress disorder (PTSD), suicide attempts, suicide, and drug abuse (Clark *et al.,* 2017; Sundborg *et al.,* 2012:1). In rural areas, as much as 95% of women are exposed to IPV (Slabber & Green, 2013).

Professional nurses providing care to women exposed to IPV may have different experiences when caring for these women; a caring presence approach may have a positive influence on the experience of the professional nurse as well as on the well-being of the women. In this study, words like violence, experience, professional nurses, and caring presence are used continuously to explore the experiences of professional nurses caring for women experiencing IPV. The study took place in a rural area in Limpopo Province, Vhembe region, Thulamela sub-district. A qualitative, interpretive phenomenological design was used.

In this chapter, the background and rationale are discussed, followed by the problem statement and research question, paradigmatic perspective, research aim and objectives, study designs, research method, trustworthiness, ethical aspects, research report structure, and a summary of the chapter.

1.2 Background and rationale for the study

Intimate partner violence is an international problem and remains a challenge to human health, especially for women. Alshammari *et al.* (2018) and Slabbert & Green, (2013), mentioned IPV as a global problem especially against women of all ages and that nurses are not doing enough to identify women who are experiencing IPV. In his New Year well-wishes speech (31 December 2018) and Parliament opening speech (7 February 2019), President Cyril Ramaphosa emphasised that the community and the relevant departments should stand together to fight IPV against women. This means that professional nurses also have a huge responsibility when caring for women experiencing IPV (Parliament of the Republic of South Africa, 2019).

According to Gender Links (2013), the majority of women (±77%) in the Limpopo province experience some form of IPV in their lifetime. The Limpopo government held a symposium in 2017 on women and child abuse In the Limpopo Province, the Vhembe district reported the highest number of women experiencing IPV (Republic of South Africa, 2017). Mukwevho (2017) reported an increase in IPV in the Vhembe district, where they recorded 120 cases of domestic violence on monthly basis, irrespective of the campaigns held in the district. In two months, five women were killed by their partners (Mukwevho, 2017). Managa *et al*. (2007) also reported that only 26.9% of women who reported to be involved in IPV in the Vhembe district disclosed it to a healthcare provider, whereas 47.1% suggested that healthcare givers should ask women whether they are experiencing IPV.

The following emphasises that IPV is a significant problem and that professional nurses and the Department of Health in collaboration with other relevant departments, e.g., Welfare and Justice, need to do something to minimise this problem: “On 27 May 2016, the 69th World Health Assembly endorsed the global plan of action to strengthen the role of health systems within a national multisectoral response to address interpersonal violence, especially against women and children” (Joyner, 2016:961). Joyner (2016:961) further argued that this will promote the achievement of the Sustainable Development Goals, including gender equality and empowerment of women and girls, promoting peace, justice, and inclusive societies, and ensuring healthy lives and promoting wellbeing. Addressing sexual, domestic, and child abuse needs urgent attention (Joyner, 2016:961).

The North-West University hosted a series of seminars for staff and students during 2018, presented by Prof. J Murray, acknowledging the need for an urgent response to IPV. The

seminars were titled “Stitching a Female Corporeal Archive: Representations of Gender, Violence and Resistance” as part of the “To the Black Women We All Knew” seminars. The non-governmental organisation (NGO) called People Opposing Women Abuse (POWA) developed a number of episodes in a popular Venda television series called Muvhango, wherein a support group for the domestic violence survivors featured. Throughout South Africa, POWA has developed 16 days of Activism for No Violence Against Women and Children, which is held from 25 November to 10 December every year; 25 November is the International Day of No Violence Against Women and 10 December is International Human Rights Day. All these events are done under ambit of the Domestic Violence Act of 1998 and the Children’s Act of 2005 (Parliament of the Republic of South Africa).

Such initiatives are critically important, as the consequences of IPV include, among others, psychological effects like PTSD, major depression, anxiety disorders, complex trauma, suicidal ideation, suicide, and others (Santos *et al.*, 2018). There is a trend that physicians believe that women experiencing IPV should be treated as medical patients and they tend not to refer these patients to the relevant team members e.g., psychologists and therapists (Baraldi *et al.*, 2013:17-18). However, professional nurses are the healthcare professionals who have the first interaction with the women experiencing IPV at primary healthcare clinics (PHC), community health centres (CHC), the outpatient department (OPD), and the emergency department (ED); therefore, their own experience of providing nursing care to these women may affect the nurse-patient relationship, and adequate preparation is important to help professional nurses identify and manage women experiencing IPV (Woodti, 2001:342).

Abutaleb *et al*. (2012:83-89) stated that the management in our health systems of women being abused is poor because only 7-25% of cases are identified, and as much as 60-90% are inadequately managed. The authors further explained that nurses in the primary healthcare setting should be educated on IPV and that it should be recommended that nursing education should include education on IPV screening and management. Clark *et al.* (2017) explained that nurses have a key role in responding to women experiencing IPV and that if nurses have a positive influence on these women and their disclosure of abuse, it can bring positive results in the caring of women experiencing IPV. Clark *et al.* (2017) mentioned some of the barriers that hinder nurses from performing their role: e.g., lack of time and privacy, fear of offending the women, and lack of self-confidence. Guruge (2012) also mentioned such barriers, namely: workload, lack of knowledge and skills, fear for personal safety, language barriers, lack of communication skills, status of nurses in the health system hierarchy, and lack of support from the hospital and Department of Health.

The practice of caring presence may assist professional nurses in this regard. Caring presence is practised when nurses help patients holistically; being open to the patient and being patient oriented. It includes, among others, self-actualisation and creating a conducive environment, and is associated with listening and touch (Mohammadipour *et al*., 2017). If caring presence is taught to professional nurses as the first healthcare provider to women experiencing IPV, it can bring positive outcomes; a decrease in pressure for the women so that they can feel accepted, relieved, and able to talk about IPV issues; and a decrease in consequent stress-related mental illness (Mohammadipour *et al.,* 2017).

In this study, caring presence refers to the ability of professional nurses to relationally assess and identify women experiencing IPV, be available for the women experiencing IPV, refer them when necessary, and manage IPV survivors in a relational way (McMahon & Christopher, 2011). Caldwell *et al*. (2005), Cipriano (2007:8), and McMahon and Christopher (2011) explain caring presence as being concerned about the patient, doing what the patient cannot do for herself, creating a therapeutic environment, and providing support to the woman experiencing IPV. It can thus be argued that if professional nurses are available for women experiencing IPV, it can help them to disclose their experience and seek immediate help (Baart, 2018; Caldwell *et al*., 2005; Cipriano, 2007:8).

The focus of this study was on the experiences of professional nurses caring for women experiencing IPV, relating this to the concept of caring presence, with the purpose of equipping professional nurses in the understanding of caring presence, thereby contributing to quality patient care, positive outcomes, and disclosure by women experiencing IPV.

1.3 Problem statement

There is an increase in IPV, especially against women, contributing to stress-related mental illness like depression, PTSD, and others (Clark *et al.,* 2017). Most of these women are not attended to comprehensively in outpatient departments due to a lack of skills in healthcare providers, especially professional nurses, despite the mission of the provincial Department of Health (Limpopo) which emphasises the provision of quality, equity, and accessible patient care and is aligned with the national mission statement (Department of Health, 2017). Nurses seem either not willing, afraid to attend to, or unable to detect these problems immediately (Clark *et al*., 2017). This situation may lead to women not disclosing abuse and, therefore, an increase in complications like stress-related mental illnesses (Clark *et al*., 2017). Although nurses are

willing to provide quality care to women experiencing IPV, a study by Santos *et al.* (2018) indicate that there are challenges and barriers, such as absence of training.

Limpopo has the highest rate of IPV at 77%, followed by Gauteng with 51% and Western Cape with 36% and these rates are said to be increasing, especially in women from 25 to 55 years (Gender Links, 2012). According to Garcia-Moreno and Watts (2011), women experiencing IPV need immediate public health attention, especially in a primary healthcare setting, because early detection lessens complications of abuse. Women experiencing IPV tend not to ask for professional help and do not disclose their status of abuse unless nurses inquire about it in a non-judgemental and empathetic way (Alshammari, 2018; Fraizer & Power, 2011; Sundborg, 2012). Nurses may lack the skills and knowledge needed to provide assistance, and training on IPV issues and caring presence is important to prevent mental illness and promote wellbeing (Alshammari, 2018; Fraizer & Power, 2011; Sundborg, 2012).

Professional nurses working in frontline and primary healthcare units, such as primary healthcare clinics (PHCs) and community healthcare centres (CHCs), outpatient departments (OPDs), and the emergency department (ED) can be a core source of assistance to women experiencing IPV (Baird *et al.,* 2018). However, it seems that nurses are reluctant to ask women about IPV due to lack of preparedness, negative attitudes, and the feeling that they will not be able to help the women if she disclosed that she is experiencing IPV (Baird *et al*., 2018). The researcher's own experience confirms this trend. Working as a professional nurse at the ED of a public hospital in the Vhembe District, Limpopo Province, the researcher observed that women experiencing IPV are not given quality time by professional nurses, are being ignored and mocked, and most of the time, only physical injuries are attended to. There are cases where professional nurses walk away from a patient and leave the patient alone, unwilling to know the cause of the injury, and then attend to the next patient. The abused women will cry alone, take her file, and medicine, and leave the department without being assisted on an emotional level.

The caring presence approach advocates for a relational approach and requires that the nurse displays readiness to attune to and connect with the patient (McMahon & Christopher, 2011). Taking the latter into consideration, it makes sense that the experiences of professional nurses of providing nursing care to women who experience IPV should be explored. This will give insight into these nurses' practical wisdom and difficulties in relating to women experiencing IPV, so that recommendations can be formulated on how professional nurses working in PHCs, CHCs, OPDs, and EDs can be guided to provide more relational care to women experiencing IPV in the rural area of the Thulamela sub-district, Vhembe district, Limpopo Province.

1.4 Paradigmatic perspective

The paradigmatic perspective is the way in which a researcher looks at the phenomenon and includes philosophical assumptions (Polit & Hungler, 1997:442). The researcher's meta-theoretical, theoretical, and methodological assumptions are discussed.

1.4.1 Meta-theoretical assumptions

The researcher believes that *health* for women experiencing IPV will include being free from injuries, emotional well-being after recovery from IPV, achieving their fullest potential, being free from stress-related conditions like depression, and dealing with stressors and/or coping well with stress-related issues. Health for professional nurses working in rural areas of Limpopo Province should include their safety, a proper working environment, being well-staffed and receiving enough support from supervisors, which can help them to render quality patient care to women experiencing IPV.

The researcher agrees that *nursing* is caring for individuals of all ages, families, groups, and communities, sick or well and in all settings, including the promotion of health, the prevention of illness, and care of disabled and dying people (WHO, 2019). The researcher believes that nursing is caring holistically for women experiencing IPV, giving support, 'being there' for the women, and referring them where needed. She believes that caring presence should form an integral part of nursing so that professional nurses can be empowered to help women experiencing IPV. Training in caring presence may specifically be valuable. Caring presence may help to develop quality nursing care.

The researcher believes that *professional nurses* are the healthcare providers that care for the ill and distressed, including women experiencing IPV. Professional nurses form part of a multi-professional team and they are at the front of the healthcare team; they are the healthcare providers that women encounter first when they need help. The researcher also believes that training professional nurses on IPV issues and caring presence can make a significant difference in nursing care. The researcher will use a qualitative, interpretative phenomenological design to explore professional nurses' experiences of providing nursing care to women experiencing IPV.

The researcher believes that the *environment* may include the internal and external environment. The internal environment for professional nurses may include their beliefs, values, skills and knowledge, and their readiness to help women experiencing IPV, while the external

environment may include the facilities, ethical issues, their relationship with other multi-professional team members, and their safety when helping women experiencing IPV.

The researcher believes that in the rural areas of Limpopo Province, Vhembe region, Thulamela sub-district, the internal environment may include beliefs, skills, and knowledge; the relationship with the women experiencing IPV; and the cultural norms (in this culture, the man is always right and has authority over the woman). The external environment means organisational structures, accessibility of the health facilities, availability of material resources, and enough human resources (professional nurses).

1.4.2 Theoretical assumptions

In view of the qualitative nature of this research, the researcher followed an open-ended approach in terms of theories guiding the research. Thus, only a central theoretical argument was formulated to guide the research, and key concepts were defined from related available scientific texts. The concept 'caring presence' is seen as an integral concept in this research, guiding the formulation of the aim, objectives, research methodology, interpretation of the findings, and formulation of recommendations. The concept 'caring presence' includes attributes such as relational care, readiness of nurses, attuning, and attentiveness (Baart, 2018; Caldwell *et al*., 2005; Cipriano, 2007:8).

1.4.2.1 Central theoretical statement

Exploring and describing the experiences of professional nurses working at PHCs, CHCs, OPDs, and EDs in a district hospital in the rural area of the Thulamela sub-district, Vhembe district, Limpopo Province, of providing care to women experiencing IPV, will provide the necessary insight so that recommendations can be formulated on how professional nurses can be guided to practise caring presence and provide more relational care to women experiencing IPV.

1.4.2.2 Definition of terms

Caring presence is the practice of a nurse being present for the patient, to carry out her duty of intentionally caring; through this, patients experience quality care (Amendolair, 2007:55). Caldwell *et al*. (2005), McMahon and Christopher (2011), and Tavernier (2006:154) explain caring presence as the use of one's whole self in helping patients for healing. In this study, caring presence means readiness and full availability of nurses to the women experiencing IPV, using their abilities and skills to identify, assess, help, and manage their nursing care.

Intimate partner violence (IPV), is a part of gender-based violence (GBV) or domestic violence (DV), can be defined as behaviour that has the purpose of gaining power or control over one's spouse, partner, girlfriend or boyfriend, and this includes the following behaviours: sexual abuse, physical abuse, damage of property, emotional abuse, economic abuse, and any other controlling or abusive behaviour that poses a threat to one's safety and health (Marques, 2018; South African Police Services (SAPS), 2014; WHO, 2012). In the context of this research, the focus was on women who experience IPV. Physical abuse is the type of abuse that is most prominently reported in the context of this research, while emotional and economical abuse are rarely reported but assumed to be prevalent also.

Experience is the process of getting knowledge or skills from doing, seeing, and feeling through something that happens that affects you (Cambridge Dictionary, 2019). The phenomenologists Valle and Halling (1989:42) explain experience as a permeating reality that cannot be limited to the mental or physical sphere and includes, in this case, the professional nurse's embodied awareness of his/her world. In this study, experience will refer to the experiences of professional nurses who worked for at least two years in rural PHCs, CHCs, OPDs, and/or EDs and who are providing nursing care to women experiencing IPV.

Rural area refers to a place situated away from towns and cities and dominated by poverty and more than 80% of Limpopo province is rural, including Vhembe district (Malatji, 2020). In this study, the rural area of Thulamela sub-district, Vhembe district, Limpopo in South Africa is an area with poor facilities – including healthcare facilities and public transport – and low economic status. Many people in these areas depend on social grants, have a low educational status, and prefer cultural practices that may expose women to IPV, e.g., girls are taken from school for cultural marriages.

1.4.3 Methodological assumptions

The methodological assumptions of this research are built upon the identification of the research problem, namely that the researcher believes that nursing can make a difference, but that little research has been done on the experience of professional nurses while caring for women experiencing IPV and little is known on the theory of caring presence, especially in the rural areas of the Vhembe district, Thulamela sub-district, Limpopo Province. Qualitative interpretive phenomenological research was conducted to explore professional nurses' experience when caring for women experiencing IPV. Creswell (1998:77) states that when using the qualitative method, the researcher explores to get more in-depth information. The

research needs to yield functional findings which can be used to improve nursing practice (Botes, 1995:5). According to Grove *et al.* (2013:60), the purpose of phenomenological research is to explore phenomena as experienced by the participants rather than the researcher's reality.

To conduct this phenomenological research study, the researcher followed the phases of the research process as described by Botma *et al.* (2010:38), (1) the conceptual phase: the formulation of the problem; (2) the selection phase: the selection of an appropriate research design and the identification of the population and data collection method to be used; (3) the analysis phase: data analysis and interpretation of the data; and (4) report writing: writing the report and disseminating the findings.

1.5 Research questions

The central question of this research was: What are the experiences of professional nurses working at PHCs, CHCs, OPDs, and EDs in the rural area of the Vhembe district, Thulamela sub-district, Limpopo Province, of providing nursing care to women experiencing IPV?

Furthermore, the following sub-questions were formulated in relation to the main research question:

- How do professional nurses experience the provision of nursing care to women experiencing IPV?
- What is the readiness of professional nurses to attune to and connect with women experiencing IPV?
- How can professional nurses be guided to provide relational care to women experiencing IPV?

1.6 Research aim and objectives

The aim of this study was to explore and describe the experiences of professional nurses working at PHCs and CHCs, OPDs, and EDs in the rural area of the Vhembe district, Thulamela sub-district, Limpopo Province of providing care to women experiencing IPV.

The objectives of this research were to:

- Explore and describe the experiences of professional nurses providing nursing care to women experiencing IPV.

- Explore and describe the readiness of professional nurses to attune to and connect with women experiencing IPV.
- Explore and describe how professional nurses can be guided to provide relational care to women experiencing IPV.

1.7 Study design

A qualitative research method was used to explore and describe the experience of professional nurses when providing nursing care to women experiencing IPV (Brink *et al*., 2018:103). An interpretive phenomenological research design was followed (Smith & Osborn, 2007:54) in the sense that the findings of the research are not viewed in isolation of the Limpopo province, Vhembe district, Thulamela sub-district; where the research took place, as well as in the sense that the findings are immersed in the concept 'caring presence'. In this design, the researcher explored and gained understanding (Brink *et al*., 2018:105; Grove *et al.,* 2013:60; Moustakas, 1994:47). This means that the researcher explored in detail the personal experiences of professional nurses providing nursing care to women experiencing IPV (Brink *et al*. 2018:105; Smith & Osborn, 2007:53). The researcher was able to observe verbal and non-verbal communication of the participants during data collection (Smith & Osborn, 2007:53). The design enabled the researcher to explore the experiences of the participants and make meaning of the findings in relation to the context of the research and in relation to the concept 'caring presence'. The details of this research design are discussed in Chapter 2.

1.8 Research method

The qualitative research method is discussed in detail in Chapter 2, and the following is a summary of the research method A qualitative approach was used to answer the research question, paying attention to the study context, population and sampling, data collection tool, data collection method, and data analysis.

1.8.1 Study context

The study was conducted in a rural area of Limpopo Province, namely the Thulamela sub-district in the Vhembe district. A detailed description of this context is provided in Chapter 2. The researcher deemed this sub-district the most suitable one in which to conduct the study, as it is highly populated, with a high need for healthcare – including healthcare for needs relating to IPV – and has limited resources. Therefore, one district hospital was utilised (with one OPD and

one ED), one CHC with the highest head count of patients, and one PHC with the highest head count of patients in the Thulamela sub-district.

1.8.2 Population and sampling

1.8.2.1 Population

The studies' population was professional nurses from primary healthcare facilities (one PHC and one CHC) and a hospital OPD and ED in a rural area of Limpopo, Vhembe district, Thulamela sub-district. More detail is provided in Chapter 2.

1.8.2.2 Sampling

Sampling is the process in which the researcher chooses participants from whom he/she is going to obtain the information on the problem stated (Brink *et al.,* 2018:115). A brief outline is provided, and more detail is provided in Chapter 2.

1.8.2.2.1 Sampling technique

Purposive sampling was used to select participants.

1.8.2.2.2 Sampling size

At least 15 professional nurses working at the three selected institutions; that is, a PHC, CHC, and a hospital (OPD and ED), were purposively selected and the size of the sample was seen as adequate when data saturation was achieved (Brink *et al.,* 2018:128). Data saturation was evident when no new information emerged from the interviews and was confirmed during the data analysis process. Professional nurses from each institution were purposively selected, based on inclusion and exclusion criteria. The inclusion and exclusion criteria are listed in Chapter 2.

1.8.3 Data collection

Data collection is the process through which the researcher gathers information and answers the research question (Brink *et al*., 2018:134). This process is discussed, referring to the recruitment of participants, obtaining informed consent, and the proposed data collection technique, namely semi-structured one-on-one interviews; more details are given in Chapter 2.

1.8.4 Recruitment of participants and informed consent

A research proposal was submitted to the NuMIQ scientific committee for review. The proposal was approved, and several changes were suggested which the researcher and supervisor attended to. Ethical approval was granted by the Health Research Ethics Committee (HREC; reference number NWU-00444-19-A1), Faculty of Health Sciences Ethics, North-West University (see Annexure A). Following ethical clearance from North-West University ethical committee, the next step was to obtain permission to conduct the research from the Department of Health (DoH) Limpopo province, and district and sub-district healthcare managers of the Vhembe district, Thulamela sub-district, and the CEO of the selected hospital, as the gatekeepers of the research. Letters of request were sent to the DoH, Limpopo province, Vhembe district and sub-district; and to the selected district hospital CEO and written approval was obtained (see Annexure B).

The researcher obtained written approval from the DoH, Limpopo province; district levels and the hospital CEO and contacted the nursing managers of the PHC, CHC, and the OPD and ED to obtain their goodwill permission to collect data in their units. At each of these units, the nursing manager was requested to identify a mediator and an independent person, e.g., a social worker or an administrative officer who is not in a power relationship with the potential participants. They were requested to assist with the recruitment of participants (see Annexure C for recruitment material). Written, voluntary informed consent (see Annexure D) was obtained by the independent person. These processes are discussed in more detail in Chapter 2.

1.8.4.1 Semi-structured, one-on-one interview

Semi-structured, one-on-one interviews were conducted by the researcher to explore the in-depth individual experiences of the participants. The researcher developed an interview schedule, provided in Chapter 2 and in Annexure E, and used this set of interview questions to collect data. Initially, face-to-face interviews were planned, but due to the COVID-19 lockdown restrictions, this data collection method had to be amended to semi-structured one-on-one interviews via WhatsApp video calls. However, participants still opted for face-to-face interviews as they were reluctant to share personal information via WhatsApp video calls. Strict COVID-19 prevention cautions were taken during the interviews, as explained in Chapter 3.

More details of the process will be discussed in Chapter 2.

1.8.4.2 Field notes

Field notes are the notes that the researcher documents during the data collection in order to be able to describe what he/she experiences, hears, feels, and sees during the interview through observation of the participants (Polit & Beck, 2014:294). Field notes help the researcher to identify themes and subthemes and are done in three categories: descriptive, reflective, and demographic notes (Polit & Beck, 2014:294). In this study, field notes were written and recorded during semi-structured one-on-one interviews with professional nurses from the Thulamela sub-district, Limpopo Province (see Annexure F for an example of a set of field notes).

1.8.5 Data analysis

The recorded interviews were transcribed verbatim (see Annexure G for an example of a transcription of an interview), after which data analysis followed. The audio recordings were deleted immediately from the recording device after transcription, and the transcriptions and field notes are to be stored safely for a period of five years after completion of the research.

Data analysis is a process of reducing and organising data to produce the findings of the study that need interpretation by the researcher (Grove *et al.,* 2013). This process started during the data collection process and entailed an initial identification (becoming aware of) of significant words or phrases, followed by interpretive analysis which refers to reflecting on the deeper meaning of the participants' responses in terms of their context and the integral concept of 'caring presence' (Smith & Osborne, 2007:40). In this process, the researcher uncovered the meaning of the experiences of the participants as shared by the participants and interpreted by the researcher (Smith & Osborne, 2007:40).

The steps for data analysis are provided in Chapter 2.

An independent co-coder was identified and invited (see Annexure I) to independently analyse the data using the same data analysis steps as outlined in Chapter 2. The co-coder was experienced in analysing qualitative data. After independently analysing the data, the researcher and the co-coder had discussions to reflect on the themes and sub-themes, and to reach consensus on the findings.

1.9 Trustworthiness

The researcher ensured trustworthiness of the research by using criteria for establishing trustworthiness; that is, truth-value, applicability, consistency, and neutrality (Lincoln & Guba

1985:290). Trustworthiness in qualitative research can be achieved through credibility, transferability, dependability, and confirmability (Brink *et al*., 2018:110). The detail of these strategies is discussed in Chapter 2.

1.10 Ethical aspects

Throughout the research, the researcher had the responsibility to maximise benefit and minimise harm to the participants by, for example, ensuring participants that their participation is voluntary and that the information they share will not be used against them in any way, carefully paraphrasing the questions and providing the necessary contact details. Specific ethical aspects are discussed in the following sub-sections. Before research studies involving human beings can be undertaken, the studies should first be approved by a research ethics committee (Brink *et al*., 2018:28; De Vos, 2019:116). The proposal was submitted to and approved by the Health Research Ethics Committee (HREC) of the Faculty of Health Sciences, North-West University, Potchefstroom Campus, and permission to conduct the research study was obtained from Limpopo Province Department of Health and the management members of the healthcare institutions where the research took place (see Annexures A and B). According to Brink *et al.* (2018:29), three ethical principles which guide researchers should be considered to protect human rights:

1.10.1 Principle of respect for person

It is the responsibility of the researcher to provide the correct information to participants before signing informed consent and the professional nurses as the population can then decide whether to participate or not (Brink *et al*., 2018:29) Potential participants can only execute the right to self-determination and act autonomously if they receive all of the information regarding the proposed research (Polit & Beck, 2014:87). This principle was adhered to in this study as discussed.

1.10.2 Principle of beneficence

In this research study, benefit was interpreted in the sense that the researcher offered a greater potential benefit to the nursing profession than to individual participants. The information generated in this research will be used for future formulation of recommendations to develop proper interventions and strategies to implement and enhance the implementation of quality nursing intervention while practising caring presence among nurses. Brink *et al.* (2018:29) emphasised the protection of participants in all dimensions, e.g., physically, psychologically,

emotionally, economically, legally, and to be protected from discomfort and harm. The principle of beneficence was adhered to in this study as discussed in the sub-sections below.

1.10.3 Principle of justice

Brink *et al.* (2018:30) state that participants should be fairly selected and the elements of the principle of justice should be adhered to, namely equality and equity, which require research participants to be justly chosen based on the purpose and the expected outcome of the research described. They further mentioned respect for the participants' cultural values and their right to privacy. Research participants in this study were thus selected for reasons related to the phenomenon being investigated.

Specific ethical aspects that need further attention are discussed in the following sub-sections.

1.10.4 Risk and precautions

The researcher took responsibility for protecting the participants from possible risk by taking the relevant precautions which include signing informed consent forms, maintaining privacy, and ensuring confidentiality of the participants, and the researcher adhered to COVID-19 safety measures. A risk/benefit ratio analysis follows.

1.10.4.1 Anticipated benefits

1.10.4.1.1 Direct benefits

No direct benefits were experienced due to participating in this research.

1.10.4.1.2 Indirect benefits

The data generated in this research was used to formulate recommendations for professional nurses to provide nursing care in a relational and caring way to women experiencing IPV. The research and the recommendations can add to the body of knowledge in nursing and has the potential to improve nursing care.

The anticipated risks and precautions of this study are outlined in Table 1.1.

Table 1-1: Risks and precautions

Risks	Precautions
Physical: participants may be bored and fatigued.	The researcher made thorough arrangements with the participants regarding time and environment for the interview that were comfortable for them.
Economic: participants may be fearful that they will have to spend money in order to participate.	The researcher reassured the participants that they would not have to pay for the cellular data that was intended to be used for the interview and that anything that needed money would be paid for by the researcher. The researcher provided a small token of appreciation, namely a pen in a convenient pen holder that the participant could use while on duty or elsewhere. The tokens of appreciation were wrapped in a small plastic bag and left in the independent person's office and the participants were requested telephonically to fetch them after three days to avoid the risk of transmission of the coronavirus.
Psychological: participants may be afraid of the unknown, e.g., they may think that they will be exposing themselves to their employer, and they may experience the topic as sensitive.	The researcher reassured participants that the interview is for research purposes only and their names will not appear in or be attached to the information. In terms of the intended WhatsApp video calls, participants were ensured that the WhatsApp calls are private and cannot be accessed by anyone other than the researcher and the participant while that call is in process, as WhatsApp has enabled end-to-end encryption. This means that no one can hack into a video call and only the persons in the call have access to the call. However, participants opted for face-to-face interviews that were recorded. Recordings were saved on the password-protected laptop and deleted from the device immediately after the interviews. The researcher arranged that a psychologist was on standby provide emotional support and debriefing if needed.
Social: participants think that the information they are giving may expose them and they may lose their dignity in the community they are serving.	The researcher reassured the participants that she will keep the recording under security, and no one will be able to link the information with the participants. The transcription was anonymised immediately, before data analysis and before submitting the data to the co-coder.
Emotional: participants may be emotional when giving information, e.g., one may burst into tears thinking of his or her past or recent experience of IPV.	The researcher as a trained counsellor was able to identify emotional distress. She reassured participants that the interview is for research purposes only and their names will not appear on or be attached to the information. She arranged for a psychologist to be on standby to provide emotional support and debriefing if needed.

Risks	Precautions
Possible risk for the researcher, independent person, or mediator: becoming infected with COVID-19 due to contact with one another during gaining entry into the community and recruitment of participants.	During gaining entry to the population, the researcher, independent person, and mediator strictly adhered to health guidelines as set by the WHO and the Department of Health, and as required and practised by the hospital, community centre, and PHC clinic where the participants were recruited; that is: • Social distancing of at least 2 metres, • Regular hand washing with an 80% alcohol-based sanitiser hand rub, • Wearing of appropriate face mask, • No touching of face, • Screening of temperature and completing the screening test before entering the hospital, community health centre, and PHC clinic premises, • Limiting contact with the independent person and mediator to the minimum by communicating via telephone for final arrangements.

The benefits outweigh the risks of the research. Considering the risks outlined above, this was a medium-risk study.

1.10.5 Informed consent

All participants in this research study were briefed individually by the mediator. They received information about the research project and gave written consent for participation in the study, and permission was also obtained from the Department of Health, Limpopo Province, and the management of the clinic and hospital where the study was conducted. Written permission (informed consent) was sought from participants for the interviews (Polit & Hungler, 2004:151) (see Annexure D – Original and amended). Taking into account the COVID-19 lockdown restrictions, an amended informed consent document had to be formulated and approved – see Chapter 2 for more details.

1.10.6 Experience, skills, and competency of the researcher

The researcher and supervisor had enough knowledge and skills to execute the study, for example, how to choose the design and method of data collection, and they had knowledge on the expected outcomes, ethical issues, validity, and reliability (Fouka & Mantzorou, 2011:3). These skills and knowledge were ensured through reading of books and articles relevant to the study, attending courses and seminars on the related topics, and using their existing expertise

in qualitative research. Both the researcher and the supervisor are experienced in interviewing skills. The researcher completed a module in research methodology, and the supervisor provided continuous research supervision. Role-play training on research interviewing was conducted before the onset of data collection.

1.10.7 Data management

The researcher ensured that the data was free from errors and gaps in documentation and that it met legal and ethical requirements (Anon, 2018). Anonymised data was shared with an independent co-coder and the research supervisor only. This data, transcribed from audio-recorded format, is saved on a password-protected computer of the researcher. The documents are password protected.

1.10.8 Dissemination of research results

Information will be disseminated through the following means:

Share with participants: the information and the results of the study will be shared with the participants and the managers of the healthcare institutions in the form of PDF documents shared via WhatsApp or e-mail.

Report to DoH and managers: report and recommendations will be disseminated to the Department of Health and to the managers of the selected institutions and where possible to all healthcare managers in the Vhembe district.

Article: an article will be drafted and submitted for publication.

The mini-dissertation will be stored in the university's library (online) to be accessed by nurse educators and nursing staff as needed.

1.10.9 Conflict of interest

The researcher declares that neither she nor the research supervisor has any conflict of interest in conducting this research. The researcher did not include her own place of work, namely the Thohoyandou area, in the sample.

1.11 Research report structure

Traditional format

Chapter 1: Overview of the study

Chapter 2: Research methodology

Chapter 3: Research findings

Chapter 4: Conclusion, limitations, and recommendations

1.12 Summary

There is an increase in intimate partner violence (IPV), especially in rural areas such as the Thulamela sub-district, Vhembe district, Limpopo Province. Professional nurses working on the front line at PHCs, CHCs, and the ED and OPD of hospitals can be a core source of assistance to women experiencing IPV. However, it seems that professional nurses are reluctant to engage with these women and to provide relational nursing care, apart from providing task-related assistance such as attending to physical injuries only. The caring presence approach provides an opportunity for relational care. It makes sense to explore the experiences of professional nurses when providing nursing care to women experiencing IPV in order to prepare for a caring presence approach in this context.

The aim of this research was to explore and describe the experiences of professional nurses of providing nursing care to women experiencing IPV. The objectives included to explore and describe: the experiences of professional nurses providing nursing care to women experiencing IPV, the readiness of professional nurses to attune to and connect with women experiencing IPV, and how professional nurses can be guided to provide relational care to women experiencing IPV.

An interpretive phenomenological study was conducted through semi-structured one-on-one interviews with professional nurses working at PHCs, CHCs, EDs, and OPDs in the rural Thulamela sub-district. Purposive sampling was used, and the sample size was determined by data saturation. Interpretive phenomenological data analysis was applied. Recommendations were formulated for nursing practice, education, policy, and research.

The details of the research method for this study are discussed in the following chapter.

CHAPTER 2 RESEARCH METHODOLOGY

2.1 Introduction

Chapter 1 covers an overview of the research and methodology used in this study. This chapter discusses the rationale for selecting an interpretive phenomenological design for this study and is structured around the study context, research design and method, population and population sampling, data collection, and data analysis. Measures to provide trustworthiness are also discussed.

2.2 Context of the study

The study was conducted in a rural area of the Limpopo Province. This province consists of five districts: Capricon, Mopani, Sekhukhune, Vhembe, and Waterberg districts; with Vhembe district reporting a higher rate of IPV than the other districts (Republic of South Africa, 2017). Vhembe district is rated as quintile 2, meaning that it is one of the poorer districts, and has an estimated population of 1 451 836 (2018/19) and a population density of 54.2 per kilometre squared. It has one regional hospital, six district hospitals, eight community health centres, 115 fixed clinics, 22 mobile clinics, and one specialised psychiatric hospital, with approximately 1952 professional nurses, 854 enrolled nurses, 1478 nursing assistants, and 91 medical practitioners, among other healthcare workers (Republic of South Africa, 2018). The healthcare services in the Vhembe district have been distributed according to the following four health sub-districts: Collins Chabane, Makhado, Musina, and Thulamela.

Among the sub-districts, Thulamela is an area of 5884 kilometre squared, with a population of 618 463 (rated the 4th most populated in South Africa and the most populated area in the Vhembe district), with one specialised psychiatric hospital, one regional hospital, one district hospital, three community health centres, 39 primary healthcare clinics, and five mobile clinics, with an extremely high number of PHC visits of 1 756 887 in the year 2013 (Republic of South Africa, 2018). According to Massyn *et al*. (2015), Thulamela sub-district had a doubled increase of mental health cases between 2010 and 2013.

In the Thulamela sub-district, there are clinics that deliver services to the community members who live more than five kilometres away; some of the people have to walk or use lifts because there is no reliable public transport due to unworthy roads and there are areas the mobile clinics cannot reach because of road unworthiness. The Vhembe district has an unemployment rate of

43.8%, with youth unemployment being 50.6%, while the Thulamela sub-district had an economic growth of only 0.6% between 2001 and 2011 (Massyn *et al.*, 2015).

Based on this description and statistics, the researcher deemed this district and sub-district the most suitable one in which to conduct the study, as it is highly populated, with a high need for health care – including health care for needs relating to IPV – and has limited resources. Therefore, one district hospital was utilised (with one OPD and one ED), one CHC with the highest head count, and one PHC with the highest head count in Thulamela sub-district. Professional nurses working in this rural area of the Thulamela sub-district for more than two years were the population in the study.

2.3 Research design and method

2.3.1 Research design

The research design consists of philosophical assumptions and methods or procedures (Creswell, 2014:5). The research approach is the plan to conduct research which involves research designs, philosophy, and specific methods. A qualitative research method was used to explore and describe the experiences of professional nurses when providing nursing care to women experiencing IPV (Brink *et al*., 2018:103; De Chesnay, 2018 and Rossman & Rallis, 2012:103). The qualitative research design is a scientific research design and investigation that seeks to understand a given research problem or topic from the perspectives of the participants it involves (De Vos *et al.*, 2019:308; McCusker & Gunaydin, 2015:537-542; Polit & Beck; 2008:17). The goal of the researcher was to uncover the personal experiences of the professional nurses while providing care to women experiencing IPV (Davidsen, 2013:318-339; Parse *et al*., 1985:5).

An interpretive phenomenological research design was the most suitable for this research as the research study aimed to explore and interpret professional nurses' lived experiences when caring for women experiencing IPV within a specific context, and the researcher needed to dig deeper on the participants' experience of the phenomenon in the study in order to reach important, rich knowledge and insight (Holloway, 2005:4; Leedy & Ormrod 2010:135; Smith & Osborn, 2007:54) in the sense that the findings of the research are not viewed in isolation of the context where the research took place, as well as in the sense that the findings were immersed in the concept 'caring presence'. In this design, the researcher explored and gained understanding (Brink *et al*., 2018:105; Grove *et al*., 2013:60; Moustakas, 1994:47). This means that the researcher explored in detail the personal experiences of professional nurses when

providing nursing care to women experiencing IPV (Brink *et al*., 2018:105; Smith & Osborn, 2007:53). The researcher was able to observe verbal and non-verbal communication of the participants during data collection (Smith & Osborn, 2007:53). The design enabled the researcher to explore the experiences of the participants and make meaning of the findings in relation to the context of the research and to the concept 'caring presence'.

2.3.1.1 The use of the phenomenological method in nursing

The purpose of this method was to explore the lived experiences of professional nurses of providing care to women experiencing IPV, which was relevant to nursing as it explores the human experience related to health and expands nursing knowledge (Parse *et al.*, 1985:119). Heidegger (2008:62) emphasised interpretative phenomenology as "*access to what is to become the theme of being*". In this phenomenological design, the researcher needed to understand the meaning of nurses' experiences while caring for women experiencing IPV and provide rich data regarding the phenomenon of interest (Lanzara, 2014:45). Phenomenological design includes the "uniqueness of the person, the need for exploration of the meaning of experience", which includes the values of nursing and caring presence (Edward, 2006:237). Smith (2013) explains phenomenological studies as conscious experience with intentional forms and meanings, and it includes the philosophy of life. Researchers in nursing value phenomenology as it values the individual experience and is also concerned with the principles of holistic healing in daily life (Balls, 2009; Chesnay, 2018) and in this study, the researcher explored the individual experiences of professional nurses while providing nursing care to women experiencing IPV.

2.3.1.2 Interpretive phenomenology as a research method

Interpretive phenomenology, also called the hermeneutical phenomenological approach, aimed to seek meaning in the context of the lived experience, focuses on the need to study human consciousness by focusing on the area of the participants, and also concentrates on interpreting the meaning in the phenomenon that is hidden and not directly revealed, through investigation, analysis, and description (Holloway 2005:128 and Suryani *et al*. 2018). It also allows immediate probing during the interviews (Brink *et al*., 2018:144).

The interpretive phenomenological approach is a study that concentrates on the unveiling of hidden ideas by working towards possibilities that emerge from understanding the phenomenon. In an interpretive study, the researcher uses her own experience to interpret the experience of the participants (Balls, 2009; Davidsen, 2013:318-339; Rodriguez & Smith, 2018). Smith (2013)

explains the interpretive phenomenological approach as a study that interprets the experience of the participants by relating it to the features of the context.

In this research, this approach was applied through the population and sampling, recruitment of participants, data collection, and data analysis.

2.4 Research method

The population and sampling, recruitment of participants, data collection, and data analysis are discussed.

2.4.1 Population

According to Brink *et al*. (2018:116) and Grove *et al*. (2013:44), a population is a group of persons who meet the criteria set by researchers for a specific study and signed the consent form. The population is the total number of people from which data can be collected, which may include individuals or organisations (Parahoo, 1997:218). In this study, the study population was professional nurses from primary healthcare facilities (one PHC and one CHC) and a hospital OPD and ED in a rural area of Limpopo, Vhembe district, Thulamela sub-district. Only professional nurses working in the area for two years or more were selected because they are the frontline healthcare providers who work in the consulting rooms in the PHC, CHC, OPD, and ED, and are accountable to plan and implement comprehensive nursing care, and refer, present, and advocate for the patients to other multidisciplinary team members, including medical practitioners, as experienced by the researcher in the working environment.

2.4.2 Sampling

Sampling is the process in which the researcher chooses participants from whom he/she is going to obtain the information on the problem stated (Brink *et al*., 2018:115). This process is discussed through discussing the sampling technique, which includes inclusion criteria, exclusion criteria, and sampling size.

2.4.2.1 Sampling technique

Purposive sampling was used to select participants. According to Brink *et al*. (2018:126) as well as De Vos *et al*. (2019:392), sampling is used when the participants are representative and knowledgeable on the study topic. Firstly, as mentioned above, specific institutions were selected, based on the researcher's assumption that the selected institutions will have richer

information because of the high number of patients and high prevalence of IPV in the area (Brink *et al*., 2018:126; Grove *et al*., 2013:352; Polit & Hungler, 1997:179). It follows that professional nurses working at these institutions, with at least two years working experience in these institutions, will have experienced caring for women experiencing IPV.

Inclusion criteria

Gender: Both male and female professional nurses were included.

Geographic area: Professional nurses working in a selected PHC, CHC, OPD, or ED in the Limpopo Province, Vhembe district, Thulamela sub-district rural area.

Language: The dominating language used in the Vhembe district is Tshivenda. Participants were free to use the language of their choice including Tshivenda and English.

Rank: Only professional nurses with at least two years working experience in the Vhembe district and who are providing nursing care to women experiencing IPV were selected to participate in the study. This was to ensure that individuals who have rich, in-depth information regarding the phenomenon were selected.

Exclusion criteria

Nurses of other categories (enrolled nurses, enrolled nursing auxiliaries, and student nurses) were not selected for the study as they are mostly dealing with monitoring the stability of the patient and executing prescribed nursing tasks and not in planning and monitoring comprehensive nursing care of the patient.

Nurses working in the Thohoyandou area, Thulamela sub-district, were not selected as this is the area where the researcher works as a professional nurse.

2.4.2.2 Sampling size

According to Polit and Beck (2017), the sample size in a qualitative approach is reached when data is fully explored, and the meaning of the research topic is clear. At least 15 professional nurses working at the three selected institutions; that is, a PHC, CHC, and a hospital (OPD and ED), were purposively selected and the size of the sample was seen as adequate when data saturation was achieved (Brink *et al*., 2018:128; Parse *et al*., 1985:18). Data saturation was evident when no new information emerged from the interviews and was confirmed during the data analysis process.

2.4.3 Recruitment of participants

The proposal was submitted to the NuMIQ Scientific committee for review. The proposal was approved, and several changes were suggested, which the researcher and supervisor attended to. Ethical approval was obtained from the Health Research Ethics Committee (HREC; reference number NWU-00444-19-A1), Faculty of Health Sciences, North-West University (see Annexure A). The researcher obtained permission to conduct the research from the Department of Health (DoH) Limpopo Province, the district and sub-district healthcare managers, Vhembe district, Thulamela sub-district, and the CEO of the selected hospital as the gatekeepers of the research. Letters of request were sent to them (see Annexure B).

When the researcher obtained written approval from the district and sub-district levels and the hospital, the researcher contacted the nursing managers of the PHC, CHC, and the OPD and ED to obtain their goodwill permission to collect data in their units. At each of these units, the nursing manager was requested to identify a mediator and an independent person, e.g., a social worker or an administrative officer, who is not in a power relationship with the potential participants.

The researcher met with the nursing manager, mediator, and independent person and clarified what was expected of them and the participants. Mediators and the independent persons attended an information session held by the researcher regarding what is expected of them and to provide information as needed, and the meeting was held before the introduction of South Africa's lockdown level 5.

Before the announcement of a lockdown, the researcher met with professional nurses at their places of work as per arrangements made by the mediator and the independent person, to give more information about the study with the mediator present. During the meeting, invitations to participate in the research were given to the professional nurses (see Annexure C, recruitment material), and served as an "introductory letter", aiming to create a subjective interest in the focus of the study among participants (Rubin & Rubin, 2012:103)

Participants were thus recruited by identifying knowledgeable participants who qualify for participation (Polit & Beck, 2014:87), and the professional nurses were given adequate time to consider the invitation, i.e., one week. They were requested to inform the mediator if they were willing to participate. The mediator then provided the researcher with the names and contact details of potential participants, and the researcher made appointments with them for data

collection at a time and place convenient to them, and all these arrangements were done and appointments made before the announcement of a level 5 lockdown.

2.4.4 Informed consent

The researcher provided written informed consent documentation concerning the study to the participants in hard copies via the independent person before the announcement of the lockdown (see Annexure D – Original). This includes information on the title, purpose, research activities, selection criteria, data collection method, voluntary nature of participation, completion of the consent forms, spaces for signatures, and the researcher's contact details to the participants. The researcher was unable to commence with data collection due to the announcement of lockdown level 5 and had to wait until lockdown level 2 and level 1. An amendment request was submitted to HREC, which was approved (see Annexure A), and COVID-19 regulations were added to the informed consent documentation (see Annexure D – Amended). Hard copies of this new informed consent documentation were wrapped in a plastic bag and left in the independent person's office for three days, and the independent person was asked to open the cupboard as the researcher had put the informed consent documentation in the cupboard, observing all prescribed safety measures, e.g., social distancing, wearing masks, and sanitising hands. Screening was done on the premises before anyone was allowed to enter the premises. After three days, the independent person opened the cupboard and invited the participants individually to fetch the informed consent documentation while they were on duty. The same safety measures were followed, and the cupboard was sanitised after the documents had been removed.

The potential participants read and signed the new informed consent documentation, co-signed by a witness, and the documents were taken back to the independent person's cupboard to be collected by the researcher during data collection, following the same safety measures as when they collected the documents; that is: social distancing, wearing masks, and sanitising hands. Screening was done on the premises before anyone was allowed to enter the premises.

2.5 Data collection

Data collection is a process in which the researcher gathers information and answers the research question (Brink *et al*., 2018:134). This process is discussed under the method of data collection, which includes semi-structured one-on-one interviews, the interview schedule, the data collection process, and field notes.

2.5.1 Method of data collection

The method of data collection is described in the following section.

2.5.1.1 Semi-structured one-on-one interviews

Semi-structured one-on-one interviews were conducted by the researcher to explore the in-depth individual experiences of the participants. This decision regarding data collection was made based on the following planning:

What data would be collected: the researcher explored the research question and therefore no need for quantity, but quality information was needed.

How data would be collected: semi-structured one-on-one interviews of approximately 30-60 minutes were conducted.

Who would collect the data: the researcher as a trained data collector collected the data. Training on semi-structured one-on-one research interviewing was provided by the research supervisor.

Where data would be collected: participants were given an opportunity to choose an environment suitable for the interview, around the Thulamela sub-district, and all the participants chose their areas of work.

When data would be collected: the data was collected during September/October 2020 (Brink *et al*., 2018:135).

2.5.1.2 Interview schedule

The researcher developed an interview schedule and used the set of interview questions to collect data. She was probing the participants' responses by posing additional questions as appropriate (Babbie & Mouton, 2016:289; Brink *et al*., 2018:144).

To develop the interview schedule, the researcher considered the following aspects:

- Communicate appropriately
- Use simple language
- Be specific

- Craft questions carefully
- Keep questions neutral
- Be non-judgemental
- Begin with less threatening questions

Based on these principles, the research aim and objectives, the research context as well as the concept of caring presence, the following questions formed the interview schedule (also see Annexure E):

- What is it like to provide nursing care to women experiencing domestic violence?
- What makes it easy for you to attune to and connect with women experiencing IPV?
- What makes it difficult for you to attune to and connect with women experiencing IPV?
- How would you like to be guided to provide care through relationship to women experiencing IPV?

The interview questions were translated into Tshivenda (see Annexure E) for the convenience of the participants. The translated questions were checked with a professional nurse fluent in both English and Tshivenda to ensure correct translation of the questions.

The first interview was seen as a trial run interview. The recording of the interview was submitted to the research supervisor for quality control. The supervisor provided feedback, after which the researcher continued with data collection.

2.5.1.3 Data collection process

Data was supposed to be collected via one-on-one WhatsApp video calls due to the lockdown, but the participants were reluctant to share their information via WhatsApp video calls and they still preferred one-on-one, face-to-face interviews; they were informed about the risks of this choice. Therefore, one-on-one, (N=15, n=15) face-to-face interviews were conducted following safety measures for COVID-19: screening was done on the premises before anyone was allowed to enter the premises; social distancing of at least 2 metres; wearing of appropriate face masks; regular hand washing with an 80% alcohol-based sanitiser hand rub; no touching of face; no hand-shaking; no hugging; the researcher had to sanitise the chair, table, and lock

handles after each participant left the room; and the researcher arranged tokens of a pen and small bottle of sanitiser in a box a week before data collection – each participant took one token to avoid sharing during the interview.

One-on-one interviews were audio recorded, and field notes were taken directly during the interviews. The interviews were conducted in a safe and comfortable setting, i.e., a private room (De Vos *et al*., 2019:351). Informed consent was confirmed with the participant and the interview was commenced when the participant had verbally repeated that he/she voluntarily consented to participate. The participants were assured that the information they shared would be kept confidential and that their names or any other identifying information, such as the names of the facilities where they were employed, were not shared with anyone. Confidentiality was furthermore ensured by asking the co-coder and independent person to sign confidentiality agreements (see Annexure H for an example). After data collection, the recordings and notes were protected through safe storage, such as storing it on the researcher's password-protected computer in the researcher's office, and the recordings were removed from the researcher's cell phone.

2.5.1.4 Field notes

According to Polit and Beck (2014:294), field notes are taken during data collection to describe what the researchers hear, see, feel, and experience. Field notes help the researcher to identify themes and subthemes and are done in three categories: descriptive, reflective, and demographic notes (Polit & Beck, 2014:294). In this study, field notes were written and recorded during interviews with professional nurses from Thulamela sub-district, Limpopo Province (see Annexure F for examples of the field notes).

2.6 Data analysis

Data analysis is a process of reducing and organising data collected to produce the findings of the study that need interpretation by the researcher (Grove *et al*., 2013). The process started during the data collection process and entailed an initial identification of significant words or phrases, followed by interpretive analysis which refers to reflecting on the deeper meaning of the participants' responses in terms of their context and the integral concept of caring presence (Smith & Osborne, 2007:40). The recorded interviews were transcribed verbatim, after which data analysis followed. The recordings were deleted immediately after transcription, and the transcriptions and field notes will be stored safely for a period of five years after completion of the research. In this process, the researcher uncovered the meaning of the experiences of the

participants as shared by the participants and interpreted by the researcher (Smith & Osborne, 2007:40).

The following steps, as outlined by Smith and Osborne (2007:66-75) in their discussion on interpretive phenomenological analysis, were followed in this process:

- Read through the transcribed interviews and get a sense of the whole.
- The researcher selects one transcript, reads and rereads through it, becoming familiar with the content and reflecting on 1) what the participant shared, 2) the context, and 3) what this means in terms of the experience of the participant and in terms of caring presence. Each reread may bring new insights.
- Use the left-hand margin to note interesting and significant phrases.
- Return to the beginning of the transcript and use the right-hand margin to note emerging theme titles. The notes in the left-hand margin are translated into concise phrases to capture the essence of the phrases. Slightly more scientific terms may be used, but the link between these theme titles and the participant's response and the researcher's notes must be apparent. Continue through the whole transcript.
- List the emergent themes on a separate paper, and search for connections between the themes. Cluster similar themes together to form a list of themes.
- Check the list of themes by reading the transcript again to make sure that the themes are a true reflection of the data and finalise the list of themes.
- Repeat the process for the remaining transcripts, being open for similar and/or new themes to emerge.
- Be aware of the point during data analysis when no new themes emerge, in order to confirm data saturation.
- Compare the resulting lists of themes, cluster similar themes together, and finalise the themes emerging from the data.

An independent co-coder was identified and invited (see Annexure I) to independently analyse the data using the same data analysis steps as outlined above. The co-coder was experienced in analysing qualitative data. After independently analysing the data, the researcher and the co-coder had discussions to reflect on the themes and sub-themes and to reach consensus on the findings.

2.7 Trustworthiness

The researcher ensured trustworthiness of the research by using criteria for establishing trustworthiness; that is, truth value, applicability, consistency, and neutrality (Lincoln & Guba 1985:290). Trustworthiness in qualitative research can be achieved through credibility, transferability, dependability, and confirmability (Brink *et al*., 2018:110).

To ensure truth value and credibility, the researcher used the strategies of prolonged engagement and peer examination. She ensured prolonged engagement by spending prolonged time with the participants, engaging with the research participants to build rapport and facilitate in-depth discussions with them. Regarding peer examination, the researcher is supervised by a supervisor experienced in qualitative research, she had submitted the research proposal to the NuMIQ scientific committee for peer review, and she will submit the completed study for peer examination.

The criteria of applicability, through ensuring transferability, were met by applying the strategies of providing a thick, dense description of the research in the form of a mini-dissertation, and through using purposive sampling to ensure that participants who were representative of the phenomenon under study were selected.

Consistency and dependability were also achieved through a dense description, through taking rich and thorough field notes, and through involving an independent co-coder during data analysis. These strategies also contribute to ensuring neutrality and conformability.

2.7.1 Credibility

Credibility refers to the confidence in the truth of the data and the interpretations (Polit & Beck, 2012:585) and it includes activities that increase the probability that credible findings would be produced (Brink *et al*., 2018:158). Brink *et al*. (2018:158) added that credibility also includes the following techniques: prolonged engagement and peer debriefing as discussed above.

2.7.2 Dependability

The researcher described the whole research process, including the exact methods used during data collection and data analysis. Dependability was ensured by keeping a detailed account of the research process in order for the process to be traceable, thus allowing another researcher to follow the research process used by the researcher (Brink *et al*., 2018:159).

2.7.3 Confirmability

The researcher involved a co-coder who is experienced in qualitative research by giving the co-coder the raw data and audio recordings for an independent analysis. The researcher also comprehensively described the research process (Brink *et al*., 2018:159).

2.7.4 Transferability

Brink e*t al*. (2018:159) explain transferability as the ability of the researcher to apply the research findings, and this also consists of a thick description, purposive sampling, and data saturation.

2.8 Summary

This chapter discussed the research design, research method, data collection methods, population, sampling, data analysis, and trustworthiness. The study aimed to explore professional nurses' lived experiences when providing care to women experiencing IPV and the recommendation on the caring presence approach, in the context of a rural public hospital, health centre and clinic in Limpopo Province, Vhembe district. Chapter 3 presents a discussion of the research findings and the literature integration.

CHAPTER 3 RESEARCH FINDINGS

3.1 Introduction

Chapter 2 discussed the research methodology, including study context, research design, research method, data collection, and measures to obtain informed consent and to ensure trustworthiness. This chapter explains the findings of the research, integrated with literature.

3.2 Realisation of data collection

In this study, semi-structured one-on-one interviews were conducted with the population being professional nurses from Limpopo Province, Vhembe district, Thulamela sub-district, in one PHC, one CHC, and one hospital (ED and OPD). All these institutions are from the rural areas of Vhembe district, Thulamela subdistrict.

Permission from all three institutions was received before the level 5 lockdown; participants were purposively selected, and the informed consent obtained with the help of the mediator and independent person; a trial run interview with one voluntarily participant from each institution was conducted as preparation before lockdown. The data from these interviews was not included in the main study.

The main interviews were intended to be conducted via WhatsApp video calls for safety against COVID-19, but all the participants were not comfortable with video recording and they still opted for face-to-face interviews(N=15; n=15), with all the safety measures of COVID-19 followed by both the researcher and the participants, and the researcher had to wait until lockdown level 2 and level 1 before commencing with data collection. During the interviews, safety measures were upheld: screening was done on the premises before anyone was allowed to enter the premises; social distancing of at least 2 metres was maintained; wearing of appropriate face masks; regular hand washing with an 80% alcohol-based sanitiser hand rub; no touching of face; no hand-shaking; no hugging; the researcher had to sanitise the chair, table, and lock handles after each participant left the room. Each participant was greeted verbally, verbal consent was requested by the researcher, and the researcher re-informed the participant about the topic of the study, ethical considerations, confidentiality, and anonymity of the data.

A total of 15 professional nurses were interviewed; four participants from the PHC, four from the CHC, and seven from the hospital, where four were from the ED and three from the OPD. All the participants decided to respond in English, and where one was unable to express him-

/herself in English, they were free to switch to their languages and the researcher translated to English as needed.

The table below (Table 3.1) represent the demographic data of the 15 participants from the rural area of Limpopo Province, Vhembe district, Thulamela sub-district.

Table 3-1: Demographic data of the participants

Participant no.	Gender	Age and race	Qualifications	Work experience	Nursing unit
1	Female	30, black	Nursing diploma, Trauma trained	7 years	ED
2	Female	33, black	Nursing diploma, trauma specialised	6 years	ED
3	Female	27, black	Nursing degree	5 years	ED
4	Female	55, black	Nursing diploma, PHC specialised	26 years	PHC
5	Female	24, black	Nursing diploma	2 years	PHC
6	Female	40, black	Nursing diploma, PHC specialised	5 years	PHC
7	Male	45, black	Nursing degree	5 years	CHC
8	Female	26, black	Nursing degree	3 years	CHC
9	Female	48, black	Nursing degree, trauma specialised	+10 years	ED
10	Female	35, black	Nursing degree, midwifery and PHC specialised	8 years	CHC
11	Female	42, black	Nursing degree	7 years	OPD
12	Female	49, black	Nursing diploma, PHC specialised	20 years	PHC
13	Female	47, black	Nursing degree	15 years	OPD
14	Female	32, black	Nursing diploma	+10 years	CHC
15	Female	48, black	Nursing diploma	+10 years	OPD

The interviews were recorded and transcribed verbatim for the purpose of data analysis (Brink *et al*., 2018:160). At the beginning of each interview, the researcher requested verbal consent to record the interview and reassured participants that their names and personal information would not be needed. During the interview, the researcher was taking field notes from her observation, what she saw, and from non-verbal behaviours of the participant (De Vos *et al*., 2011:372).

Semi-structured interviews were conducted where the researcher realised that the topic of the study is sensitive and sometimes the participants became emotional. In some instances where the participants started to refer to themselves as a victim of domestic violence, the interview had to be stopped. Four participants were referred for further counselling: two from the hospital to

the psychologist, one from the PHC to the social worker, and one from the CHC to the social worker. The researcher used her psychiatric nursing skills in responding to participants who were emotional. In cases where the participant decided to continue with the interview, another date and time was arranged for the interview. Four semi-structured interview questions, in line with the research problem and approved by the supervisor, were asked by the researcher, and the researcher probed for clarity, further explanation, and more information. The one-on-one semi-structured interviews were conducted over a period of one and a half months.

3.3 Realisation of data analysis

After audio-recorded data had been transcribed verbatim, the researcher and the co-coder analysed the data independently, following the steps of data analysis discussed in Chapter 2. The researcher then met with the co-coder, they discussed and compared the results and consensus was reached, and main themes and sub-themes were developed (Creswell, 2013:184). The names of the participants, PHC, CHC, and the hospital were removed on the transcripts for the confidentiality of information and privacy of the participants.

From the audio-recordings and transcribed data, the researcher read the transcripts to get a sense of the whole. One transcript was selected and re-read to become familiar with the content, reflecting on what the participant shared, the context, and the meaning in relation to caring presence. The researcher wrote interesting notes and phrases in the left margins, re-read the transcript, and wrote the themes in the right margin. The researcher listed the themes on a separate paper, clustered similar themes together, checked the list of themes, and ensured that the themes are a true reflection of the data; this was repeated for the remaining transcripts, considering new themes to emerge, then comparing the lists of the themes, clustering similar themes together and finalising the themes emerging from the data.

From the analysis, five main themes and related sub-themes emerged from the responses of the participants to the questions in the interview schedule.

3.4 Findings

The findings describe the experiences of the participants of providing nursing care to women experiencing IPV. Specifically, the findings represent how they experience providing nursing care to women experiencing IPV, their experience of and readiness to attune to and connect with women experiencing IPV, and their views on how nurses can be guided to provide relational care to women experiencing IPV.

In the discussion of the findings, the themes and sub-themes are discussed, supported by direct quotations from the participants. Regarding the quotations, the transcription number indicates the sequence of the transcriptions, and the capital letter P indicates 'Participant', for example P8.

The following table (Table 3.2) indicates the five themes and related sub-themes that emerged from the analysis of the data.

Table 3-2: Themes and sub-themes

Themes	Sub-themes
1. Participants are willing to provide quality healthcare, but work in a difficult environment	Infrastructure Shortage of nursing staff
2. Participants experienced that their view of their own level of competence, their attitude, work overload, and communication skills influence how they engage with women experiencing IPV	Lack of relevant skills Attitude Work overload Communication skills
3. Participants realised that the lifeworld of women experiencing IPV made it difficult for them to disclose IPV	Culture Fear of in-laws Poverty and insecurity
4. Collaboration with the multidisciplinary team and other stakeholders	Multidisciplinary team Other stakeholders
5. Caring presence	Willingness to attune to and connect with women experiencing IPV. Spending quality time with women experiencing IPV Willingness to be personally present. Willingness to provide holistic care

The findings of the research revealed that professional nurses are willing to provide holistic care to women experiencing IPV but that there are hindrances to providing quality care. These experiences emerged from the data as themes and sub-themes.

3.4.1 Theme 1: Participants are willing to provide quality patient care but work in a difficult work environment

Participants revealed that they are willing to provide quality patient care, but the healthcare system is failing them. Participants indicated that they are working in a difficult environment that needs consideration and should be attended to as soon as possible for them to be able to

deliver quality patient care to all, including women experiencing IPV. Some of the difficulties they experience are as follows:

3.4.1.1 Infrastructure

Participants revealed that the infrastructure of their workplaces is not conducive to taking full assessments, especially for sensitive issues like domestic violence. There are no separate rooms to consider women experiencing IPV. Such assessments take some time to probe until they find out exactly what the patient is suffering from. For example, in areas like the ED, they revealed that the bays are separated only by curtains and there is no privacy. These circumstances make it difficult for the participants to connect with women experiencing IPV through comprehensive assessment and in-depth discussion as they are aware that there is no privacy and confidentiality for them in these healthcare environments.

"The other issue is the space you find out that the cubic I am using while speaking to this patient the next patient could hear, so it makes it difficult for me to connect with this other patient, because they will be having fears of being judged, what if I say this, they will say I am being abused" (P8).

"Some is the space we have like here in casualty the space is too small in such a way that we don't have space where I can stay with my client or patient being two, so you'll find out that my client needs help and I want to help her but other nurses are there with their patients you can find out that the person is now afraid to say everything she wants to say to you" (P1).

"There is not enough space here in casualty, so we try by all means to put the woman in small theatre where we give the patient privacy and then we start to talk to the patient I mean try arguing there is a try" (P2).

"I have seen that there is a shortage of space of which it leads to no privacy, I want to say there is no privacy when we are dealing with this type of a people. So, when there is no privacy, one cannot even feel free to explain about what had happened to you today. So, our challenge is the setup. That is, there is no specific space allocated for interviewing a woman involved in abuse" (P10).

3.4.1.2 Shortage of nursing staff

Participants revealed shortage of staff as something that hinders them to care for women experiencing IPV. Participants from the clinic, community health centre, and hospital revealed

that they are understaffed and that there are no trained nurses who can properly assess women experiencing IPV, which lengthens the waiting period for the women experiencing IPV.

"Because we have shortage of staff you will find out that other patients are waiting for you outside so for that reason you cannot spend a lot of time with one patient so that I can get details about what happed to them" (P1).

"Shortage of staff will make me work in a way that I have to manage time which means that I won't be giving too much attention to the patient because I will be saying by the way I have to finish this and go and attend another patient which means that the shortage of staff is related to the time being provided to the patient" (P3).

"*The issue of time and shortages because in our hospital we have the issue of shortage of doctors, we spend less time with them, trying to push the queue outside, you find out that when you about to move to the next patient, this one start to open up, and you tell them you had your chance but you didn't want to talk and is not because we don't care but is because of the shortage of staff" (P8).*

"Another thing is we have got a shortage of staff members while dealing with emergencies, resuscitating that side. And we are where we are running short of staff members of which one can go and attend to that patient. And so, it takes time for us to go and attend to that patient" (P9).

3.4.1.3 Literature integration

The findings on the infrastructure and shortage of nursing staff above are supported by literature. The WHO (2017:37) explains that there should be enough healthcare providers covering all the shifts, and a trained staff member should be available during all the shifts to provide care for women experiencing IPV. Alshammari *et al*. (2018:237-253), Coetzee *et al.* (2013:163), Guruge (2012), and Mukwevho (2019) list a shortage of nurses in both PHC and hospital as one of the barriers to care of the women experiencing IPV. Colombini *et al*. (2017); Purwaningtyas *et a*l. (2019); Rees et.al 2014 and Vranda *et al*. (2018) explain that the infrastructure in hospitals and PHC settings is of poor quality with no privacy and leads the women to feel uncomfortable to disclose their status of IPV.

3.4.2 Theme 2: Participants experienced that their view of their own level of competence, their attitude, work overload, and communication skills influence how they engage with women experiencing IPV

Participants experienced that there are aspects that may hinder them or help them to fully engage with women experiencing IPV. This finding is described in the following four sub-themes.

3.4.2.1 Lack of relevant skills

Participants revealed that they are trying to use the skills they have but they feel that they are not equipped and not competent enough when it comes to the assessment and management of women experiencing IPV. Participants also revealed that the lack of relevant skills causes them to feel incompetent and reluctant and/or afraid to approach the women when they suspect IPV. Because they are unsure how to manage them, they indicated that they need training and workshops to be equipped with relevant knowledge and skills. Some of them who experienced IPV themselves give advice based on their own experience, but they still feel that they need formal training on how to support women experiencing IPV.

"As nurses I think it is important for us if we can be helped more especially on the skills about domestic violence, yes that could help us to manage easily. Continue of training, having workshops and in-service training" (P3).

"We just using our own experience to say this have worked for me some years back let me try to apply it now, if we get workshops on assisting troubled women in relationships or at home, she might be abused or going through domestic violence, we can assist them properly it can also become quick for them to get assistance, I need a formal and proper skills to assist" (P7).

"I think the other thing is lack of assessing skills if I can put it in that way, we nurse we short proper skills to probe or assessing the patient. We need more experience and knowledge in order to be able to assess the women correctly, even a fear, like what if this woman tells me she is being abused, what am I going to do? Will I also fail this woman too? Will I be able to help this woman, the thought of failure also comes in, what if she opens up to me and I am unable to help her further" (P8).

"We are not better trained to do specifically to women who have been injured or have been and abused. And therefore, we need those skills, in-services training, I will be happy if they can take

us to the workshops so that we have those skills, if they can train us on how to deal with the domestic violence patients" (P9).

"We need that revival of skills, we need the ongoing teaching yes we did that on our course, but we need more skills, if you have knowledge and skills you gain confidence on confronting certain issues like domestic violence and all and you will provide information with knowledge otherwise you will lead woman" (P10).

3.4.2.2 Attitude

Participants revealed that in spite of their feelings of incompetence, they are trying to display positive attitudes towards women experiencing IPV in order to win their trust and enable them to disclose their status of experiencing IPV. Participants added that they are trying to avoid being judgemental when helping women experiencing IPV. They also indicated the consequences of displaying a negative attitude as a healthcare provider caring for women experiencing IPV: that women will not be open if the nurse displays a negative attitude – they only speak freely when they are warmly welcomed with a positive, friendly smile.

"Having a positive attitude towards the patient because may find that the patient may just come and stand because she is frustrated the way you tell you have to say how are you sister? She will be free to answer you greeting with a smile is the best thing that will attract that person positive attitude to be open and to connect with those women" (P3).

"If I'm somehow negative it can also take time for her to open up for me to get the information that I want and intend, I will fail to assist in a proper way, that it also depends on the attitude towards the patient, they also read the face, they saw whether the person is reachable or the person is somehow if I can put it in that easy, so after they get that information is then that they can open up and tell why are they here or what's the problem at home" (P7).

"*I make sure I put my all when attending to this women because I know is not safe out there not only in the community even in the comfort of our own home, because they are being violated everyday so I make sure that when woman comes in being beaten up I make sure I connect with them all the way, I don't judge them, I always try to be neutral and when they are crying I try to comfort them" (P8).*

"*If you are friendly, you talk nicely to the person and the person can be open to you and give you more, more information whereby you can refer the patient and get help" (P9).*

3.4.2.3 Work overload

In all the institutions where data was collected, participants revealed that work overload affected their interest and willingness to provide quality patient care to women experiencing IPV. They needed quality time to probe until they got to the real problem of these women, and they indicated that they take time to disclose. Participants emphasised that work overload causes them to consequently miss the real problem of the women experiencing IPV.

"You may find that maybe due to the workload that we usually have in here you may find that the nurse maybe let's say in the morning you are right but, in the afternoon, you find that maybe you have worked a lot and when somebody comes in and she is doing what she is doing the way she is doing when you talk to her" (P5).

"We spend less time with them, trying to push the queue outside, you find out that when you about to move to the next patient, this one start to open up, and you tell them you had your chance, but you didn't want to talk and is not because we don't care but is because of the shortage of staff" (P8).

"There are so many patients we see in a day; you end up not probing enough because you can see the queue is long and there are lots of patient to attend to, so you end up not seeing those signs of abuse because they do not say that they are being abuse you just pick it up when you are probing that this woman is being abuse" (P10).

3.4.2.4 Communication skills

Participants revealed that they are trying to implement the communication skills that they acquire through experience, but they are still not comfortable with the way they communicate with women experiencing IPV, especially when the women are not opening up and they have to probe; that is where they feel they still have the need to be trained on the proper way to communicate with women experiencing IPV.

"I think as a professional nurse I supposed to the in-service training so that we can have a knowledge on how to can communicate with the women experiencing domestic violence and then just absolutely miserable but need to be the ongoing process so that we can be able to determine when the women are being abused or not that can be limiting situation" (P11).

"If you are having this good communication skills in assessing skills, you can go deep into everything and you may find that, you know, this person is having this type of problem. It's not that deep inside is just that her problem is not solved" (P15).

3.4.2.5 Literature integration

Literature confirms the findings that the participants' level of competence, attitude, workload, and communication skills influence how they engage with women experiencing IPV. Alshammari *et al.* (2018: 237-253), Colombini *et al.* (2017), Guruge (2012), Sundborg *et al.* (2012), and the WHO (2017:37) confirm these finding by emphasising the importance of training on the issue of women abuse to nurses. "Nurses need comprehensive skills so that health for women does not suffer" (WHO, 2017:37). Sundborg *et al.* (2012) and the WHO (2017:37) explained that women did not open up about their status of IPV if staff members did not enquire, and for nurses to enquire they need skills and knowledge. Sundborg *et al.* (2012) and the WHO (2017:37) added that training programmes should be continuous to equip professional nurses with knowledge. Sundborg *et al.* (2012), Rees *et al*. (2014), and the WHO (2017:37) confirm the finding about the negative attitude of the healthcare providers having negative impacts on the care of women experiencing IPV by explaining that the attitude of the healthcare providers has an influence on how a woman will be assessed and managed. Colombini *et al.* (2017) and Guruge (2012) confirm that a lack of effective communication skills is also a barrier for women to disclose their status of abuse whereas good communication welcomes the women and promote the disclosure of their status. Guruge (2012); Mukwevho (2019) and Visentin *et al.* (2015), confirm the findings on work overload of nurses by indicating workload as one of the leading causes of nurses' bad attitude leading to poor patient care.

3.4.3 Theme 3: Participants realised that the lifeworld of women experiencing IPV made it difficult for them to disclose IPV

Participants experienced that women experiencing IPV find it difficult to disclose this to healthcare providers due to difficult aspects in their lifeworld. These aspects are discussed in the following sub-themes that emerged from the data.

3.4.3.1 Culture

Participants experienced that, according to their culture, women are considered as the property of their husband and their in-laws. It is as if women cannot think, cannot plan – a man and his sisters (considered as aunts or *"vho makhadzi"),* are the ones that have authority and can take

decisions in the family. Participants shared that the manner in which males are socialised contributes to the belief that he owns everything, including his wife, and that he is always right. On the other hand, a woman is socialised to be submissive and not to tell other people what is going on within the family. Participants also revealed that it is culturally accepted when a man assaults his wife, but it is taboo for a woman to beat her husband; she may even lose her marriage. They also indicated that when a woman is getting married, a bridal shower is conducted wherein the woman is given rules and norms such as: in this house there is no one who came back after marriage (*mbuyavhuhadzi);* the grave of the wife is at her marriage place; when things go wrong in your family you have to calm them *(vhuhadzi ndi nama ya thole, ya fhufhuma ndi a fhunzhela)*. All these rules normalise abuse in the family and women do not report it.

"In our culture they see nothing wrong with a man beating up his wife, they say if he is beating you up is because you are not being submissive and he is disciplining you is not any form of domestic violence, they do not believe in such thing. And I think that was what happened to this case, they saw nothing wrong with that, as long as he is providing you with food and shelter or even if he can take you as his second wife" (P8).

"*Another thing which I have experienced is that our culture also plays a big role in abusing women because in our culture, you are being afraid to say that you have been beaten by your husband, you feel ashamed" (P9).*

"*When woman do not want to speak, they will tell you I fell, I hit the door unless you probe, because of the culture woman are told to submit, woman are told not to say their things of their marriages, when a Venda woman is getting married, they do bridal showers for them so at the bridal showers they tell them they do not need to expose thing that are happening in their marriage, they tell them the husband is the head of the house and they keep that, and they do not want to break their cultural norms" (P10).*

"*According to our culture, we are not supposed to voice out when the husband is beating you. According to our culture, is normal when the man is beating you and that it makes the woman not to verbalize. They are not free to verbalize because they think maybe it is normal, they are not disclosing" (P13).*

3.4.3.2 Fear of in-laws

Participants revealed that women are afraid of their in-laws (the mothers-in-law and the sisters-in-law); they tend to tell lies because they are afraid that if their husband is arrested then his relatives will turn their back against them.

"Women are told not to say their things of their marriages, they are afraid to lose their husband, they are afraid to be single it makes it difficult to attune to these women experiencing domestic violence, also our social economic status the poverty, these women think that if I open up and the man is arrested who will support us" (P10).

"It makes it difficult how can you help if they do not want to open cases, they keep quiet, they don't talk to their family members they are afraid that their husband's family will judge them.

Researcher: Okay you mean the in-laws?

The in-laws yes, then they will be just saying I will be quiet, it has to be my secret but anywhere at the end it will end up hurting the woman herself because she will lose life and at the end children will remain suffering" (P3).

"*Some of the people can be open and tell you what happened, and you will also find out that some of the people cannot explain what happened when you tell them that is abuse they will never tell you anything because they are afraid of the abusers" (P1).*

"Another thing is fear of the family members this woman will be afraid of how the family will looks at her" (P6).

3.4.3.3 Poverty and insecurity

Participants mentioned that a large number of women from their areas is poorly or not educated; they are unemployed, are referred to as housewives, and are considered as housekeepers who should work or serve their in-laws and husband in order to be provided with food, shelter, and clothing. They added that the women in the rural areas are not considered, have nothing to say when it comes to decision making, and have to endure hardship. The women will endure all forms of abuse because the husband is the one providing for her and her children's basic needs. Participants experienced compassion towards these women and felt driven to empower them.

"Like I said before those women don't speak up and the main reason for them not to speak up its that most of them are not working, they depend on their husband" (P6).

"S*o, being a woman living in South Africa with all this fears of what is happening that's what makes me to want to be close to those victims, let's say is those that are married, and she said I am tolerating such behaviour because I am married and I do not want to go out of the marriage, what will my kids eat? I try by all means to empower those women that it is still possible for you to prosper, you can still raise your kids on your own if that what you have to do for this violence to stop, they rely on those people abusing them for money, most of those women are unemployed, they depend on those man because they are breadwinners, because they know if they open up they will lose what they benefit from those man and that's the thing that's makes it difficult.* Y*ou ask why he beat you up, they say I was asking for money, so he said you a troublesome every time I get home you ask for money so yes it also contribute" (P8).*

"Another thing is like and that if she's unemployed. She also she wants to be felt free to say anything because she knows those witnesses would not like to say she must open a case and then she knows that that man is the one she dependent on and now is gone, now the problem will be a big problem with the kids with no one to support" (P12).

3.4.3.4 Literature integration

These findings resemble existing literature on related topics. Authors emphasise that it is an unfortunate phenomenon in African cultures that power is given to the man culturally due to the money that he pays when marrying his wife; to an extent that he feels he literally owns the woman (Ngoc Do *et al.,* 2013; Sprague, 2016:572). Nasrullah *et al.* (2015) and Vranda *et al*. (2018) furthermore indicated that African women reported that they are being abused and insulted in front of their in-laws by their husbands while their in-laws reported their mistakes to their husbands. Allen (2017), Field *et al.* (2018), Gibbs *et al*. (2017:1), and Sprague (2016:571) also confirm that women in rural areas are insecure economically, educationally, and in food supply, and thus are more vulnerable to IPV than other women – and the act of abuse by her husband is socially acceptable and normalised.

3.4.4 Theme 4: Collaboration with the multidisciplinary team and other stakeholders

Participants indicated that collaboration with other people with an interest or concern in the provision of quality patient care in different institutions can give support to nurses who are on the front line of the healthcare system, especially those who are working at public institutions like OPDs, EDs, PHCs, and CHCs. Two subthemes emerged.

3.4.4.1 Collaboration with the multidisciplinary team

Participants from the hospital indicated that they are able to refer and present their patients, women experiencing IPV, to other team members like doctors, social workers, and psychologists, but they still feel that it is not enough. Sometimes they have to stay with a referred woman for hours before being attended to by the team members concerned. Participants from PHCs and CHCs specifically indicated that they have difficulties in referring the women for further assistance, as their patients depend on the perpetrators financially and they would not provide the finances for them to travel long distances to the hospital where the relevant multidisciplinary team members are situated. Participants thus identified the need for closer collaboration between multidisciplinary team members and a more accessible referral system for women experiencing IPV.

"Most of them are having social issues and here at the clinic we have a social worker but the problem they are working during office hours Monday to Friday holidays weekend they are not there and those people will come on holidays weekend and when you say come back on Monday maybe two days after she won't come back and I can feel that this person needs to be attended right now that's the other problem that we have and that person may make another decision and decides not to come back because it took time and that person had a problem that needs to be attended to same time that's the problem" (P6).

"We must try to invest in multidisciplinary teams and should be involved so that we know how to handle the domestic violence patients better refer what needs to be done" (P10).

"I can figure out or this is not a medical condition it needs further multidisciplinary team members to attend to it mother and father need to be involved" (P11).

3.4.4.2 Collaboration between different stakeholders

Participants revealed that there is a need for interaction among different stakeholders that should provide comprehensive care to women experiencing IPV as this will lead to quality, holistic care for women experiencing IPV. The following stakeholders were mentioned by the participants.

Department of Police: Participants indicated that they need to work hand in hand with the police when caring for women experiencing IPV, for the safety of the victim and theirs. They added that if they know how, where, and what to report, with the direct numbers of the police station concerned, they will be able to help women experiencing domestic violence.

“If health centres knows if there is someone experiencing domestic violence, they know exactly who to call so that we can fast-track this process of getting these women to go to trauma centre and wait for 24 hours to wait for somebody who is coming from Thohoyandou, so if we get that department links it can be so fast, health care centres and hospital know where to refer and who to talk to if something is not happening” (P7).

“S*omething like involving the police, we should involve the police in” (P12).*

Department of Justice: Participants believe that if the Department of Justice works hand in hand with the Department of Health, the law and justice will be served, and the perpetrators should learn from others and stop their acts of abuse.

“I think of if it happens that there is a proper linkage between different departments like health departments, we are talking about Justice also other law enforcement agencies like police because once there is a domestic violence there is an injury” (P7).

“*If there is a social problem, domestic violence, and maybe social workers, we send to a psychologist where they can talk to that patient and then maybe to the department, like a Department of Justice, a place where everybody can get help” (P9).*

Department of Social Development: Participants suggested that working with the social workers available, especially at the clinics and community health centres, may help the women immediately when reporting the act of abuse; the social worker will do home visit and may identify some of the causes of abuse and help the women. Two participants from different institutions indicated that the main cause of domestic violence in their areas is the child grant; where the father will assault the mother when she denies him the money.

“I think we still need more social workers because if those social workers can go to the community we know that there’s some social workers in the community who do attend trainings where they talk about domestic violence when they can go to the mass gathering of the community and speak about domestic violence not only social workers even we as healthcare workers and talk about domestic violence I think that can be helpful because you may find out that they’re those elderly people in the community” (P3).

“I can see easily that this one was abused; the social development should come in” (P10).

Department of Education: Participants revealed that the Department of Education can also play an important role by including the IPV and domestic violence issues in their curriculum as

early as in primary levels to help both males (perpetrators) and females (victims) to know how to handle each other, what abuse is and when one is being abused, and by including it in tertiary education, including nursing schools where nurses can be guided on the assessment and management of women experiencing IPV.

"At the schools' level I think if we can have curriculum of domestic violence starting from primary level, secondary level even in tertiary I think that thing can be helpful because as a child will growing up knowing that these things of domestic violence it's not good I think that is the best way that we can be able to overcome this issue of domestic violence" (P3).

"The issue of this domestic violence should be educated from the level of primary up until to the university, it should be at all the curriculum, cause this issue can happen to anyone of any age, it doesn't happens to adults only, even our 5 years girls are being abused even our 3 years girls are also being abused, they need to be educated that if you see a man do such and such a thing it means that they are abusing, so if the community have such a knowledge when they come to us it became easier, they can also trust us" (P8).

"And even at schools from primary level, secondary to tertiary they need to be educated, if they can include a curriculum, so that they must know, and we can prevent" (P9).

Department of Broadcasting: Participants suggested working hand in hand with the media around the particular community. Giving health talks and running awareness campaigns through the available medias may help the community at large, as in most rural areas they listen to the radio more than watching TV and have internet issues.

"I think it can help because when explaining it in the radio there are many women who are being abused by their husband and they're afraid to talk maybe they can feel free to come" (P5).

"I think there is a need to be a collaboration between the Department of Health, Department of Justice, Department of Social Development and Department of Education because all these things work hand in hand, because there is student who is being abused and the teacher should be able to communicate with someone in the Department of Health or in the Department of Justice that I have a learner who is going through such thing, so that they can get early health and for social worker going out the community must be able to communicate with the Department of Justice to say, I have observe this and this how do we go about it, even the police if there is a case reported to them they should also communicate with Department of Social Development together with Department of Health. This is not an issue of one department

we work hand in hand, because to the hospital, to the community, the Department of Justice" (P8).

3.4.4.3 Literature integration

The findings in this theme are supported by various literature sources. Guruge (2012:6) supports these findings by stating that there is a lack of proper communication amongst nurses and other multidisciplinary team and this deprives women experiencing domestic violence of quality health care. Uchadi (2001:9) also stated this and emphasised the importance of collaboration of different stakeholders in the healthcare system in that it can improve health care to women experiencing IPV. Both Guruge (2012:3) and Uchadi (2001:5) advocate for strengthening the importance of the interaction of different departments for the protection of women experiencing IPV. They mentioned that lawyers may help the women with safe shelter and provide women with protection orders from their husband. Hart and Klein (2013:93) also supported the findings by explaining the importance of educating people about IPV issues in the media and social media to help women experiencing IPV with early identification of violence. Guruge (2012) strengthens the findings by explaining the process of referral, where the physicians treat physical injuries and refer the patient to his or her teacher or to the headman and to report the case to the police officers and also to the forensic medical examination team, whose findings are referred to the trauma centre.

3.4.5 Theme 5: Caring presence

The data from the transcripts and field notes helped the researcher to detect the act of caring presence in the participants while caring for women experiencing IPV, and four sub-themes emerged, as discussed below.

3.4.5.1 Willingness to attune to and connect with women experiencing IPV

Many participants showed the willingness to attune to and connect with women experiencing IPV, though they indicated tissues such as workload, poor infrastructure, and lack of skills that hinder them in providing this care. Their willingness to attune to the needs of the women and to connect with the women resulted in the women opening up to them and disclosing that they are experiencing IPV. The researcher observed this willingness through what the participants said and through their non-verbal communication, and most of them are ready to be further equipped through workshops and in-service training.

“I need to be given the permission to attend all the sessions that she is doing with the social worker and the psychologist” (P5).

“*Not like we are not willing in our setting in our clinic you will find that some other days you will find that we are short staff you find that others are on lunch and you have remained alone you find that you still have a queue, and she feels that she is taking a long time if she came between 12h00 to 14h00” (P6).*

“It touches because we are losing women. We are losing women every day. Domestic violence is always increasing, increasing because we are poorly intervening” (P14).

“*But I managed to convince the lady to speak up because I could see she also had some bruises and you could see she did not sustain them from just falling, until she speaks and say her husband is the one who violated her” (P8).*

“It is painful to me but I have to be strong for the woman to see that she is getting full assistance from the person who is really willing to assist her but deep down its painful, but I do all my best for her to be comfortable and feel free” (P2).

3.4.5.2 Spending quality time with women experiencing IPV

Participants revealed that they understand that women experiencing IPV need enough time to speak out; participants are willing and trying to spend their time with the women experiencing IPV in order to probe when taking the history of these women. They revealed that it is not easy to find out the real problem from the women experiencing IPV; it needs time to probe and to comfort her.

“I am talking about when she comes in my consulting room then I have to give her time maybe sometimes you’ll find that the nurse is in hurry she wants to finish the work so you must not show her that you are in hurry you must make it a point that you are there for that woman” (P6).

“*I just opened up and make time to be with them and try to listen what really happening in their life, if I am not busy, if we have enough staff in the ward, I make sure I put my all when attending to these women. The issue of time and shortages because in our hospital we have the issue of shortage of doctors, we spend less time with them, trying to push the queue outside, you find out that when you about to move to the next patient, this one start to open up, and you tell them you had your chance but you didn't want to talk and is not because we don't care but is because of the shortage of staff” (P8).*

"*As a staff, I think we need more workshops and also in-service training about this domestic violence so that you can be able to detect and then to manage" (P12).*

3.4.5.3 Willingness to be personally present

Participants indicated that they are willing to be personally present for the women experiencing IPV, but they also indicated that the issues of shortage of staff and work overload prevent them from being personally present to women experiencing IPV, as discussed under themes 1, 2, 3, and 4. The researcher managed to identify the urge to be personally present for the women experiencing IPV during the interviews through non-verbal communication.

"Then the other thing is that I just want to be free to them and then as a nurse I don't want people to see me just as a nurse they have to see me as a caring person as sister and as a mother that's the thing that makes it easy for me to connect with those people the way I socialize with them I want them to be free I don't want them to see my profession and makes it difficult for them to connect with me and to be open to me when I communicate with them I make sure that, no this is my sister this is my mother I communicate in a way that the person will free and say I've got a sister I've got a mother who is taking care of me" (P3).

"If I am not busy, if we have enough staff in the ward, I make sure I put my all when attending to this woman when woman comes in being beaten up, I make sure I connect with them all the way, I don't judge them, I always try to be neutral and when they are crying I try to comfort them" (P8).

"By being flexible smiling with them and showing that you are there for them you need to assist them that is when you and you have time to listen for what they want to say so that and don't judge and don't judge them being friendly with them and creating a what a separate space when talking with them where there are no interference I think they become more open and can able to explain everything what is happening" (P11).

"*Those patient needs us to be there for them, but we don't be there for them because of the workload, because of such a shortage of staff" (P14).*

3.4.5.4 Willingness to provide holistic care

Participants show that they are willing to provide holistic care to women experiencing IPV although some of the issues discussed above challenge them. They suggested interaction with

other multidisciplinary teams and other departments to provide holistic care and indicated the need for proper training for them to provide holistic care.

"I just opened up and make time to be with them and try to listen, give them that smile to feel appreciated and it means I have to hold their hand during the assessment I think as nurses we need more of in-service training or workshop on how to assess these women, we should have more health awareness campaign about such issues like to go to churches, to chief kraals when they are having their gathering, like to the community (*P8).*

3.4.5.5 Literature integration

The findings from this theme are supported by literature. Sundborg (2012:15-18) mentioned the improving preparedness of professional nurses as an important element that will help professional nurses to provide quality patient care to women experiencing IPV. She added that proper training and support will also strengthen the willingness of professional nurses in the provision of quality care. In his lecture, Baart (2018) placed an emphasis on spending time with a patient in need; that it helps patients to be free, comfortable, and open up. Gaining trust from the patient requires quality time and a good nurse-patient relationship (Caldwell *et al*., 2005). Professional nurses who display the feelings of personal presence gain trust from their patients (Du Plessis, 2016:1). Caldwell *et al*. (2005), Cipriano (2007:8), and McMahon and Christopher (2011) mentioned that professional nurses should be present for patients in order to carry out their caring duties. Mohammadipour *et al*. (2017:19) indicated in her study the importance of helping the patient holistically and being open and patient-orientated in providing care to the women experiencing IPV.

3.5 Summary

In this chapter, research findings on the experiences of professional nurses when caring for women experiencing intimate partner violence were discussed, compared, and integrated with the existing literature. The findings were also supported by quotations from the transcripts of semi-structured, one-on-one interviews, and themes and sub-themes were identified and discussed. The next chapter will provide the conclusion, limitations, and recommendations of the research study.

CHAPTER 4 CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

4.1 Introduction

The previous chapter discussed the research findings integrated with literature. The research findings were supported by quotations from the transcripts of the one-on-one semi-structured interviews, and themes and sub-themes were identified and discussed. This is the final chapter which includes the conclusions, limitations, and recommendations.

4.2 Conclusions

The researcher set out to answer the following research questions:

What is the experience of professional nurses working at PHCs and CHCs, OPDs, and EDs in the rural area of the Thulamela sub-district, Vhembe district, Limpopo Province of providing nursing care to women experiencing IPV; and:

- How do professional nurses experience providing nursing care to women experiencing IPV?
- What is the readiness of professional nurses to attune to and connect with women experiencing IPV?
- How can professional nurses be guided to provide relational care to women experiencing IPV?

In line with these research questions, the aim and objectives of the research were:

Aim: To explore and describe the experiences of professional nurses working at PHCs, CHCs, OPDs, and EDs in a rural area of the Thulamela sub-district, Vhembe district, Limpopo Province of providing care to women experiencing IPV.

Objectives:

- To explore and describe the experiences of professional nurses providing nursing care to women experiencing IPV.
- To explore and describe the readiness of professional nurses to attune to and connect with women experiencing IPV.

- To explore and describe how professional nurses can be guided to provide relational care to women experiencing IPV.

The findings of the research answer the research questions, and the research aim and objectives were thus reached. It was furthermore evident from the findings that the context played a major role in the experience of the participants, and the concept caring presence is interwoven in the discussion of the findings and the literature integration – confirming that an interpretive approach in the research process was warranted and followed.

As an overall conclusion, the findings revealed that it is the experience of participants to feel compassion for women experiencing IPV and they are willing to provide holistic care to them. However, they experience reluctance (not full readiness) – in distinct ways that are closely related to the context of their work environment, their experience of their own competence, as well as their experience of who the women are and what their beliefs and context are – due to hindrances that limit them in connecting with and attuning to the needs of women experiencing IPV. This leaves them feeling frustrated and with a deepened sense of empathy for these women, as they realise how deeply they are suffering, while at the same time feeling unable to help. They also experience a need to be guided in providing relational care to women experiencing IPV through training, as well as through collaboration between multidisciplinary team members and stakeholders.

Regarding the specific hindrances the participants experienced, it was clear that one of the hindrances is the work environment. The practicality of not having a private space where women can ventilate their feelings and disclose their experience of IPV in privacy and confidentiality prevented the participants to fully engage with these women. In an attempt to protect the women from disclosing in a non-private space where other patients can overhear and possibly judge them, participants did not encourage women to disclose their experience. In doing so, participants realise that they are part of a system where women experiencing IPV are not supported in the way they should be supported. These circumstances coupled with staff shortages where there is limited time to give full attention to women experiencing IPV lead to frustration and a feeling of impotence to help in the participants.

Another hindrance was that the participants realised that they did not experience themselves as competent to assist women experiencing IPV, making them reluctant to reach out and help as they feared failure, leaving the women possibly feeling even more hopeless and without help. Although they tried to maintain a positive attitude towards the women, trying their best not to

judge them, they realised that they need training in communication skills and more time to spend with the women in order for the women to trust them enough to disclose that they are experiencing IPV.

A further disheartening hindrance is that the women that are seen by the participants live in a context that is conducive for IPV to thrive, and where it is exceedingly difficult to report and stand up against IPV. These women are bound by their culture to be submissive, and the behaviour of perpetrators is protected by their extended family. The women are financially dependent on their husbands and realise that they risk being ostracised if they should report the IPV. Being part of this context – where some of the participants also experienced IPV themselves – the participants have a deep understanding of the women's experience. It is this understanding that at times keeps them from breaking the silence about IPV – as a way of protecting these women and themselves.

The cycle of IPV can be broken if there is stronger collaboration between multidisciplinary members and relevant stakeholders. If this team is more accessible to the women, and if a more solid and accessible referral system exists, women experiencing IPV can be served in a more effective manner.

Interwoven in the experiences of the participants providing nursing care to women experiencing IPV were the nuances of caring presence. Even if it was not always possible for the participants to provide practical assistance, their *willingness* to connect with and attune to the needs of the women, to be personally present with and spend time with them, and to provide holistic care brought relief and hope to both the participants and the women.

4.3 Limitations

Despite the rich information given by the participants, the fact that the participants agreed to use English in the interview leads to some information possibly not being revealed because of limited English language ability. Furthermore, the findings are limited to one district in Limpopo, to EDs, OPDs, CHCs, and PHCs, and to professional nurses. The research findings can thus not be generalised to all nurses in SA. Also, the findings are limited to the viewpoint of professional nurses, and the experience of patients and other stakeholders will provide even more insights.

The study was conducted in one district hospital, one PHC, and one CHC in Vhembe district; as such, the results cannot be generalised to other hospitals in Limpopo Province.

4.4 Recommendations

Based on the research findings and conclusions, the following recommendations were formulated: recommendations for nursing practice, referral policy, nursing education, and further research.

4.4.1.1 Recommendations for nursing practice

Attention should be given to the infrastructure of hospitals, clinics, and community health centres to ensure that there are private and safe spaces for women to disclose IPV.

Debriefing sessions for nurses should be provided, exploring their readiness to connect with and attune to the needs of women experiencing IPV and to provide relational care.

Training in caring presence: there should be ongoing training in caring presence to nurses of all categories to ensure quality patient care to women experiencing IPV.

Training in assisting women experiencing IPV: nurses should receive continuous education and training on assisting women experiencing IPV, and this should include provision of counselling and support to women experiencing IPV.

Collaboration between multi-professional team and stakeholders: women experiencing IPV may experience needs in different dimensions, which may include physically, emotionally, spiritually, and sometimes basic needs like shelter, food, and clothing; these may need the multi-professional team to work together, including other stakeholders in assisting the women experiencing IPV, e.g., through monthly meetings.

4.4.1.2 Recommendation for policy

Policy regarding a referral system: the healthcare system should provide both the hospitals and PHCs with a policy for referral to other institutions or to other multi-professional team members.

Guidelines or procedure on the assessment and management of women experiencing IPV: policy makers should ensure that comprehensive policies are in place for responding to IPV in health services and for preventing IPV at a community level. Healthcare providers should be supported in providing appropriate care, taking cognisance of common barriers.

4.4.1.3 Recommendations for nursing education

One of the objectives of the Nursing Act (33 of 2005) is to prepare student nurses to function independently and competently in rendering comprehensive nursing care and to assume responsibility and accountability for such practice; therefore, nursing education should include the recommendations of this research in the nursing curriculum offered at nursing colleges and universities.

Training should be provided in relational care, self-awareness and self-care, a balanced view on knowledge (following the correct procedure), and relying on own inner wisdom, so that 'not knowing' does not become a hindrance in providing relational care / being there with/for the patient, training in supportive interviewing, and inquiry as a way of providing support.

The nursing curriculum should be revised and the issues of IPV, DV, GBV, or any abuse should be included to equip nurses to provide quality patient care to women experiencing IPV; these should include all nursing categories.

There should be continuous education, as indicated by the participants, through workshops and in-service training concerning the issues of IPV for early identification, assessment, and management of women experiencing IPV.

Caring presence issues should also be incorporated in the nursing curriculum to emphasise the importance of caring presence in nursing.

4.4.1.4 Recommendations for further research

Further research is needed to explore the experiences of women experiencing IPV in terms of their need for relational care by nurses.

The research was conducted with professional nurses only; therefore, there is a need to explore the views of other nursing categories, multidisciplinary team members, and stakeholders on providing holistic/relational care to women experiencing IPV.

Further research is needed to explore the views of the husband and extended family on beliefs/culture in relation to IPV.

In this research, only one district hospital in Vhembe district, Limpopo Province was utilised with one PHC and one CHC, and it is recommended that the research be conducted in different

institutions to obtain more quality information and to improve quality care to women experiencing IPV.

4.5 Summary

In Chapter 1 of the study, an overview of the study was provided by outlining the introduction, background of the study, the research problem formulated, research question, and purpose of the study. The chapter also included the problem statement discussed on the professional nurses' experiences when caring for women experiencing IPV: professional nurses revealed the willingness to provide quality care to women experiencing IPV, though they are facing a lot of challenges that limit them in providing the care they are willing to provide to these women; they are also ready to be guided through workshops and in-service-training to provide quality care.

Chapter 2 included a discussion on the paradigmatic perspective, including meta-theoretical assumptions, theoretical assumptions, central theoretical assumptions, and methodological assumptions. The research question, aim, and objectives were also discussed in this chapter. The research design and research method were presented. Research methodology, including population, sampling, sample size, data collection, and data analysis were also discussed. Ethical aspects, trustworthiness, and measures to ensure rigour were discussed.

Chapter 3 discussed the research findings and literature integration, supported by quotations from one-on-one semi-structured interviews by the participants, and a discussion followed on the emerged themes and sub-themes. Chapter 4, the final chapter, discussed the conclusion, limitations, and recommendations.

The study on professional nurses' experiences when caring for women experiencing IPV was not a simple study to carry out, but a learning opportunity even to the researcher. Professional nurses from all different institutions where data was collected revealed the willingness to provide quality care to women experiencing IPV, although they indicated that there are obstacles that hinder them to provide quality care, as discussed in the recommendations. The topic is sensitive to nurses as most of them are females, in such a way that sometimes the researcher had to discontinue the interview and provide counselling to the participant and sometimes even refer to a psychologist for further management. The researcher learnt from the participants that IPV is real and skills and knowledge, space for privacy, enough nursing staff, and integration of different stakeholders remain important; caring presence issues are also important and need to be emphasised to all healthcare providers.

Nurses have an important role to play in their work in hospital and community settings, to assist women (and their children).

REFERENCES

Abutaleb, I.N., Dashti, T.A., Alasfour, S.A., Elshazyl, M. & Kamel, M.J. 2012. Knowledge and perception of domestic violence among primary care physicians and nurses: a comparative study. *Alexandria journal of medicine, 48(1):83-89*.

Allen, T.E. 2017. Intimate partner violence among female students at a rural university in Limpopo Province, South Africa: A mixed methods study with intervention implications. Department of Global Health Duke Kunshan and Duke University.

Alshammari, K.F., McGarry, J., & Higginbottom, G.M.A. 2018. Nurses' education and understanding related to domestic violence and abuse against women: an integrative review of the literature. *Nursing open*, 5(3):237-253.

Amendolair, D. 2007. Caring behaviours and job satisfaction: a study of registered nurses in medical surgical units in North and South California acute care hospitals. Minneapolis: Capella University. (Thesis – PhD).

Anon. 2018. Research data management, data management plan. University of Cambridge.

Baart, A.J. 2018. Public lecture on caring presence, October. Potchefstroom: North-West University.

Babbie, E. & Mouton, J. 2016. The practice of social research. Boston, MA: Cengage Learning.

Baird, K.M., Saito, A.S., Eustace, J. & Creedy, D.K. 2018. Effectiveness of training to promote routine enquiry for domestic violence by midwives and nurses: a pre-post evaluation study. *Women and birth*, 31(4):285-291.

Balls, P. 2009. Phenomenology in nursing research: methodology, interviewing and transcribing. Nursing Times, 105:31. https://www.nursingtimes.net/clinical-archive/leadership/phenomenology-in-nursing-research-methodology-interviewing-and-transcribing-13-08-2009

Baraldi, A.C.P., De Almeida, A.M., Perdonáa, G., Vieira, E.M. & Dos Santos, M.A. 2013. Perceptions and attitudes of physicians and nurses about violence against women. *Nursing research and practice*, 2013:785025.

Botes, A.C. 1995. The operationalisation of the research model in nursing. (Unpublished).

Botma, Y., Greeff, M., Mulaudzi, M. & Wright, S. 2010. Research in health science. Cape Town: Heinemann.

Brink, H., Van der Walt, C. & Van Rensburg, G. 2018. Fundamentals of research methodology for health care professionals. 4th ed. Cape Town: Juta and Company.

Caldwell, B., Doyle, M.B. & Morris, M.S. 2005. Presencing: channelling therapeutic effectiveness with the mentally ill in a state psychiatric hospital. *Issues in mental health nursing,* 26:853-871.

Cambridge dictionary. 2019. Cambridge University Press. https://dictionary.cambridge.org/ Date of access: 10 May 2019.

Cipriano, P. 2007. Celebrating the art and science of nursing. *American nurse today*, 2(5):8.

Clark, M.T., Bradbury-Jones, C. & Taylor, J. 2017. Strengthening the nursing role in reducing the impact of intimate partner violence on children and families [PowerPoint presentation]. https://www.qni.org.uk/wp-content/uploads/2017/01/2_Maria_Clark_final.pdf Date of access: 10 May 2019.

Colombini, M., Dockerty, C. & Mayhew. S.H. 2017. Barriers and facilitators to integrating health service responses to intimate partner violence in low- and middle-income countries: a comparative health systems and service analysis. *Studies in family planning,* 48(2):179–200.

Colombini, M., Mayhew, S.H. & Watts, C. 2017. Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities. https://www.who.int/bulletin/volumes/86/8/07-045906/en/

Coetzee, S.K., Klopper, H.C., Ellis, S.M. & Aiken, L.H. 2013. A tale of two system-nurses practice environment, wellbeing, perceived quality of care and patient safety in private and public hospitals in South Africa: a questionnaire survey. *International journal of nursing studies*, 50:162-173.

Creswell, J.W. 1998. Research design: qualitative and quantitative approach. London: SAGE.

Creswell, J.W. 2014. Research design: qualitative, quantitative, and mixed methods approaches. 4th ed. Thousand Oaks, CA: SAGE.

Davidsen, A.S. 2013. Qualitative research in psychology: phenomenological approaches in psychology and health sciences. 318-339. Published online:15March 2013. @https//www.ncbi.nim.nih.gov

De Chesnay, M. 2018. Nursing research using phenomenology: Qualitative designs and methods in nursing. New York, Springer. https://minoritynurse.com

De Vos, A.S. 2001. Research at grassroots: a premier for the caring professionals. Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouche, C.B. & Delport, C.S.L. 2019. Research at grassroots: for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik.

Du Plessis, E. 2016. Presence: a step closer to spiritual care in nursing. Holistic nursing practice, 47-50

Edward, K. 2006. A theoretical discussion about the clinical value of phenomenology for nurses. Holistic nursing practice, 20(5):235-238.

Field, S., Onah, M., van Heyningen, T. et al. 2018. Domestic and intimate partner violence among pregnant women in a low resource setting in South Africa: a facility-based, mixed methods study. *BMC women's health,* 18:119. https://doi.org/10.1186/s12905-018-0612-2

Fouka, G. & Mantzorou, M. 2011. What are the major ethical issues in conducting research? *Health science journal*, 5(1):3-14.

Fraizer, A. & Power, C. 2011. Domestic violence: what can nurses do? https//www.crisis prevention.com/Blog/September-2011/Domestic-Violence-What-Can-Nurses-Do

Garcia-Moreno, C. & Watts, C. 2011. Violence against women: an urgent public health priority. Bulletin of the World Health Organisation. https://www.who.int/bulletin/volumes/89/1/10-085217/en/

Gender Links. 2013. GBV indicators study. Limpopo Province, South Africa. http://genderlinks.org.za/programme-web-menu/publications/gbv-indicators-study-limpopo-province-south-africa-2013-11-22/

Gibbs, A., Duvvury, N. & Scriver, S. 2017. What works evidence review: the relationship between poverty and intimate partner violence. Poverty+IPV+Evidence+Brief_new+copy.pdf

Grove, S., Burns, V. & Gray, J. 2013. The practice of nursing research. 9th ed. Elsevier. Health Sciences Division.

Guruge, S. 2012. Nurses' role in caring for women experiencing intimate partner violence in the Sri Lankan context. *International scholarly research notices*: online. http://dx.doi.org/10.5402/2012/486273

Hart, J. B., & Klein, R.A. 2013. Practical implications of current intimate partner violence research for victim advocates and service providers. US Department of Justice. https://www.ncjrs.gov/pdffiles1/nij/grants/244348.pdf

Indian Scribes. 2018. Preparing questions for a qualitative research interview. https://www.indianscribes.com/preparing-qualitative-research-questions-for-an-interview/ Date of access: 10 May 2019.

Joyner, K. 2016. How can we manage intimate partner violence better? *South African medical journal*, 106(10):961. DOI:10.7196/SAMJ. 2016.v106i10.11460

Lanzara, S. 2014. A phenomenological study exploring Baccalaureate nursing students' experiences in simulation. (Doctoral thesis). Pennsylvania: Indiana University of Pennsylvania.

Leedy, P.D. & Ormrod, J.E. 2010. Practical research: planning and design. 9th ed. Boston: Pearson Education.

Limpopo Provincial Government. Department of Health. 2017. Mission and vision. http://www.doh.limpopo.gov.za/mission-and-vision Date of access: 10 May 2019.

Lincoln, Y.S. & Guba, E.G. 1985. Naturalistic inquiry. London: SAGE.

Malatji, M.T. 2020. Rural development outcomes and policies in South Africa's Limpopo province. Unisa ETD.

Managa, L., Pengpid, S., Peltzer, K. 2007. Intimate partner violence and HIV risk among women in primary health care delivery services in Vhembe district, South Africa. *Gender and behaviour,* 5(2):1302-1317.

Marques, L. 2018. Intimate partner violence, what is it and what does it look like? Anxiety and depression association of America.

Massyn, N., English, R., Mc Cracker, P., Ndlovu, N., Gerritsen, A., Bradshaw, D., Groenewald, P. 2015. Disease profile for Vhembe Health District Limpopo. Health System Trust. https://www.hst.org.za/publications/HST%20Publications/Disease%20profile%20for%20Vhembe_2015.pdf

McCusker, K. & Gunaydin, S. 2015. Research using qualitative, quantitative or mixed methods and choice based on the research. *Perfusion journals*, 30(7):537–542.

McMahon, M.A. & Christopher, K.A. 2011. Toward a mid-range theory of nursing presence. *Nursing forum,* 46(2):71-82.

Mohammadipour, F., Atashzadeh-Shoorideh, F., Parvizy, S. & Hosseini, M. 2017. Concept development of "Nursing Presence": application of Schwarts-Barcott and Kim's hybrid model. *Asian Nursing Research*, 11(1):19-29.

Moustakas, C. 1994. Phenomenological research methods. London, England: SAGE.

Mukwevho, N. 2017. Domestic violence, rape & ritual killings plague in Vhembe. *The South African Health News Service*. https://www.health-e.org.za

Mukwevho, N. 2019. Service delivery remains poor at Limpopo hospital. *The South African Health News Service,* 19 Sep. https://health-e.org.za/2019/09/19/service-delivery-remains-poor-at-limpopo-hospital/

Nasrullah, M., Zakar, R., Zakar, M.Z. et al. 2015. Circumstances leading to intimate partner violence against women married as children: a qualitative study in Urban Slums of Lahore, Pakistan. *BMC int health hum rights,* 15:23. https://doi.org/10.1186/s12914-015-0060-0

Ngoc Do, K., Weiss, B. & Pollack, A. 2013. Cultural beliefs, intimate partner violence and mental health functioning among Vietnamese Women. HHS Public Access. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3866026/#

Parahoo, K. 1997. Nursing research: principles, process and issues. New York: Palgrave.

Parse, R.R. 2011. The art of human becoming in practice. Discovery international publications. Discoveryinternationalonline.com/wp11/2011-HBT-IN-ractice.pdf

Polit D.E. & Beck C.T. 2017. Nursing research. Generating and assessing evidence for nursing practice. 10th Edition. Wolters Kluwer Health, Lippincott & Wilkins

Polit D.E. & Beck C.T. 2012. Nursing research. Generating and assessing evidence for nursing practice. 9th Edition. Wolters Kluwer Health, Lippincott & Wilkins.

Polit D.E. & Beck C.T. 2008. Nursing research. Generating and assessing evidence for nursing practice. 8th Edition. Wolters Kluwer Health, Lippincott & Wilkins.

Polit, D.F. & Beck, C.T. 2014. Essentials of nursing research: appraising evidence for nursing practice. 9th ed. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Hungler, B.P. 2004. Nursing research principle and methods. Philadelphia: Lippincott Williams & Wilkins.

Polit, D.F. & Hungler, B.P. 1997. Essentials of nursing research: methods, appraisal and utilization. 3rd ed. Philadelphia: Lippincott.

Purwaningtyas, N.H., Wiwaha, G., Setiawati, E.P. et al. 2019. The role of primary healthcare physicians in violence against women intervention program in Indonesia. *BMC fam pract,* 20:168. https://doi.org/10.1186/s12875-019-1054-0

Rees, K., ZweigenthaI, V., Joyner, K. 2014. Health sector responses to intimate partner violence: a literature review. *Afr. j. prim. health care fam. med.* (Online), 6(1). http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2071-29362014000100049

Republic of South Africa. 2019. State of the Nation Address.

Republic of South Africa. 2018. Limpopo provincial government Vhembe district health plan: 2018/19-2020/21.

Republic of South Africa. 2018. Symposium on violence against women children. https://www.gov.za/nationalgendersummit

Rodriguez, A. & Smith, J. 2018. Phenomenology as a healthcare research method. Volume 21. Evidence-based nursing. @https://ebn.bmj.com

Rossman, G.B. & Rallis, S.F. 2012. Learning in the field: an introduction to qualitative research. 3rd ed. Los Angeles: SAGE.

Rubin, H.J. & Rubin, I. 2012. Qualitative interviewing: the art of hearing data. 3rd ed. Thousand Oaks, CA: SAGE.

Santos, W.J., Oliveira, P.P., Viegas, S.M.F., Ramos, T.M., Policarpo, A.G., Silveira, E.A.A. 2018. Domestic violence against women perpetrated by intimate partner: Professionals' social representations in primary health care. *Rev Fund Care Online*. 10(3):770-777. DOI: http://.dx.doi.org/10.9789/2175-5361.

South African Police Service. 2014. Domestic violence. https://www.saps.gov.za/resource_centre/women_children/domestic_violence.php Date of access: 10 May 2019.

Slabbert, I. & Green, S. 2013. Types of domestic violence experienced by women in abusive relationships. *Social work*, 49(2):234-247. doi:10.15270/49-2-67.

Smith, J.A. & Osborn, M. 2007. Interpretative phenomenological analysis. Psychology and Health 22, 517-534. @ http://med-fom-familymed-research.sites.olt.ubc.ca/files/2012/03/IPA_Smith_Osborne21632.pdf.

Sundborg, E.M., Saleh-Sattin, N., Wandell, P. & Tornkvist, L. 2012. Nurses' preparedness to care for women exposed to intimate partner violence: a quantitative study in primary health care. *BMC*, 11(1). https://bmcnurs.biomedcentral.com/articles/10.1186/1472-6955-11-1.

Suryani, R.L., Allenidekania, A. & Rachmawati, I.N. 2018. Phenomenology study on nurses' experiences in understanding the comfort of children at the end-of-life. *Indian journal of palliative care.* Volume 24 (2): 162-166.PMID. https://www.ncbi.nlm.nih.gov.

Uchadi, C.D., Putnam, C.A., Mastrofski, J., Solomon, S. & Dawson, D. 2001. Evaluation a multi-disciplinary response to domestic violence: Property of National Criminal Justice Reference Service. Published by Department of Justice. The DVERT program in Colorado Springs.

Valle, R.S. & Halling, S.N. 1998. Existential-phenomenological perspectives in psychology: exploring health of human experience. New York, Springer.

Visentin, F., Vieira, L.B., Trevisan, I., Lorenzini, E. & Silva, E.F. 2015. Women's primary care nursing in situations of gender violence. *Invest educ enferm,* 33(3):556-564.

Vranda, N., Kumar, N.C., Muralidhar, D., Janardhana, N. & Sivakumar, P.T. 2018. Barriers to disclosure of intimate partner violence among female patients availing services at tertiary care

psychiatric hospitals: A qualitative study. Volume 9(3): 326-330. @ https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6050765/.

World Health Organisation. 2019. Nursing. https://www.who.int/topics/nursing/en/.

Woodti, M.A. 2001. Nurses attitudes towards survivors and perpetrators of domestic violence. *Journal of holistic nursing*, 19(4):340-59. https://www.ncbi.nlm.nih.gov/pubmed/11847842.

ANNEXURE A: ETHICS APPROVAL (ORIGINAL AND AMENDED)

Original approval:

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 086 016 9698
Web: http://www.nwu.ac.za/

North-West University Health Research Ethics Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECApply@nwu.ac.za (for human studies)

24 January 2020

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 24/01/2020, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general and specific conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Professional nurses' experience when caring for women experiencing intimate partner violence: a caring presence study
Principal Investigator/Study Supervisor/Researcher: Prof E du Plessis
Student: A Mphephu-23780304

Ethics number: N W U - 0 0 4 4 4 - 1 9 - A 1

Institution Study Number Year Status

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study
Commencement date: 24/01/2020 **Risk:** Medium
Expiry date: 28/02/2021

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly monitoring report and the concomitant issuing of a letter of continuation. Monitoring reports are due at the end of August and February annually until completion.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:*
  - *Six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for active monitoring.*
- *The date of approval indicates the first date that the study may be started.*

- *In the interest of ethical responsibility, the NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the study are revealed or suspected;*
    - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
    - *submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206*

Special in process conditions of the research for approval (if applicable):

a. Please provide the NWU-HREC with the goodwill permission letters from the district (Vhembe district) and sub-district (Thulamela) healthcare managers, granting access to the participants as indicated.
b. Please provide the NWU-HREC with the goodwill permission letters from the CEO of the selected hospital.
c. Please provide the NWU-HREC with the goodwill permission letters from the nursing managers of the primary healthcare clinic, community health centre (CHC) and the out-patient department (OPD) and the emergency department (ED).

As the study progresses the aforementioned conditions should be submitted to Ethics-HRECProcess@nwu.ac.za with a cover letter with a specific subject title indicating "Outstanding documents for approval: NWU-XXXXX-XX-XX." The letter should include the title of the approved study, the names of the researchers involved, that the documents are being submitted as part of the conditions of the approval set by the NWU-HREC, the nature of the document i.e. which condition is being fulfilled and any further explanation to clarify the submission.

The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating the nature of the submission e.g. "Outstanding documents for approval: NWU-XXXXX-XX-XX". The e-mail should indicate the nature of the document being sent. This submission will be handled via the expedited process.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

Chairperson NWU-HREC

Current details:(23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.4 Templates\9.1.5.4.2_NWU-HREC_EAL.docm
20 August 2019

File Reference: 9.1.5.4.2

Amendment request approved:

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222
Web: http://www.nwu.ac.za

Health Sciences Ethics Office for Research, Training and Support

North-West University Health Research Ethics Committee (NWU-HREC)
Tel: 018-285 2092
Email: Wayne.Towers@nwu.ac.za

Prof E du Plessis
Nursing sciences
NuMIQ

7 August 2020

Dear Prof du Plessis

APPROVAL OF YOUR AMENDMENT REQUEST BY THE NORTH-WEST UNIVERSITY HEALTH RESEARCH ETHICS COMMITTEE (NWU-HREC) OF THE FACULTY OF HEALTH SCIENCES

Ethics number: NWU-00444-19-A1

Kindly use the ethics reference number provided above in all future correspondence or documents submitted to the administrative assistant of the North-West University Health Research Ethics Committee (NWU-HREC) secretariat.

Study title: Professional nurses' experience when caring for women experiencing intimate partner violence: a caring presence study

Study leader/Researcher: Prof E du Plessis

Student: A Mphephu-23780304

You are kindly informed that your amendment request (changing data collection strategy to an online format in response to the COVID-19 pandemic) to the aforementioned project has been approved. Any future amendments to the proposal or other associated documentation must be submitted to the NWU-HREC, Faculty of Health Sciences, North-West University, prior to implementing these changes. These requests should be electronically submitted to Ethics-HRECApply@nwu.ac.za, for review BEFORE approval can be provided, with a cover letter with a specific subject title indicating, "Amendment request: NWU-XXXXX-XX-XX". The letter should include the title of the approved study, the names of the researchers involved, the nature of the amendment/s being made (indicating what changes have been made as well as where they have been made), which documents have been attached and any further explanation to clarify the amendment request being submitted. The amendments made should be indicated in yellow highlight in the amended documents. The *e-mail*, to which you attach the documents that you send, should have a *specific subject line* indicating that it is an amendment request e.g. "Amendment request: NWU-XXXXX-XX-XX". This e-mail should indicate the nature of the amendment. This submission will be handled via the expedited process.

Please note: Due to the nature of the amendment i.e. (semi-structured individual interviews via WhatsApp video call with professional nurses in the rural Thulamela sub-district), this study will be able to proceed during the current alert level, following receipt of this approval letter. No additional COVID-19 restrictions have been placed on the study except that the researcher must ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

We wish you the best as you conduct your research. If you have any questions or need further assistance, please contact the Faculty of Health Sciences Ethics Office for Research, Training and Support at Ethics-HRECApply@nwu.ac.za.

Yours sincerely

Digitally signed by Prof Petra Bester
Date: 2020.08.13 12:34:29 +02'00'

Chairperson: NWU-HREC

ANNEXURE B: PERMISSION FROM THE DEPARTMENT OF HEALTH LIMPOPO, DISTRICT MANAGEMENT AND HOSPITAL MANAGEMENT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref	:	LP-201910 - 023
Enquires	:	Ms PF Mahlokwane
Tel	:	015-293 6028
Email	:	Kurhula.Hlomane@dhsd.limpopo.gov.za

Mphephu A

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Professional nurses experience when caring for women experiencing intimate partner violence.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
    b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
    c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    e. The approval is only valid for a 1-year period.
    f. If the proposal has been amended, a new approval should be sought from the Department of Health
    g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated

Head of Department **Date** 25/11/19

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OFHEALTH
VHEMBE DISTRICT

Ref: S5/6
Enq: Muvari MME
Date: 21-02-2020

Dear Sir/Madam.....MPHEPHU A.....

Permission to conduct a research on the
" PROFESSIONAL NURSES EXPERIENCE WHEN CARING FOR Women **"**

1. The above matter refers.

2. Your letter received on the 21-02-2020 requesting for permission to conduct a research is hereby acknowledged.

3. The District has no objection to your request.

4. Permission is therefore granted for the study to be conducted within Vhembe District. You are expected to submit the results to the District.

5. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavors.

..... 21/2/2020
CHIEF DIRECTOR: DISTRICT HEALTH DATE

Private Bag X5009 THOHOYANDOU 0950
OLD parliamentary Building Tel (015) 962 1000 (Health) (015) 962 4958 (Social Dev) Fax (015) 962 2274/4623
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1754, (015) 962 1001/2/3/4/5/6 Fax (015) 962 2373, (015) 962 227

The heartland of Southern Africa – development is about people!

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
[redacted] HOSPITAL

Ref: 4/2/2
[redacted]
11/03/2020

LIMPOPO PROVINCE
DEPARTMENT OF HEALTH
2020 -03- 13
[redacted]

TO: Ms Mphephu A
PO BOX 2459
Thohoyandou
0950

RE: PERMISSION TO CONDUCT RESEARCH STUDY ON "PROFESSIONAL NURSES' EXPERIENCE WHEN CARING FOR WOMEN EXPERIENCING INTIMATE PARTNER VIOLENCE "

1. The above matter refers.
2. Permission to conduct the above mentioned study is hereby granted.
    - Kindly be informed that In the course of your study there should be no action that disrupts the services.
    - You are to give report to quality assurance manager of Donald Fraser Hospital after completion of research study at Donald Fraser Hospital.
    - After completion of the study, a copy should be submitted to our institution to serve as a resource.
    - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    - You are therefore requested to contact nursing administration office number 7, OPD basement for logistic arrangements.

3. Please bring along the following documents:

- Permission letter granted from department of health.
- Permission letter granted from educational institution.
- This letter.

Hoping you will find this in order

SIGNED [redacted] Date 13/03/2020

CHIEF EXECUTIVE OFFICER

Private bag [redacted]
Tel: [redacted]

ANNEXURE C: RECRUITMENT MATERIAL

To: Professional nurses

Limpopo province, Vhembe district,

Thulamela sub-district (outside Thohoyandou)

Emergency Department, OPD, clinic and community health centre

My name is Avhatakali Mphephu and I am a master's student from the School of Nursing Science, North-West University. I am writing to invite you to participate in my research study about 'Professional nurses' experience when caring for women experiencing intimate partner violence (IPV): a caring presence study.

You're eligible to be in this study because you are a professional nurse and you are on the frontline of healthcare providers and you are the first one's women encounter when they need help and quality patient care.

If you decide to participate in this study, you will need to sign an informed consent, be available on the agreed date, and an individual interview at your place of work or agreed place, in a private room where open-ended, with follow-up questions will be asked. I would like to audio record the conversations and then we'll use the information to make recommendations to guide professional nurses to provide nursing care to women experiencing IPV.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me through the independent persons (Names to be inserted).

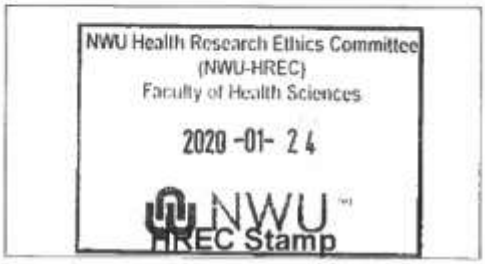
Thank you very much.

Sincerely,

(The independent person:)	Avhatakali Mphephu
Tel/ cell no…….	0765940710
Email address…….	avatakalimp@gmail.com

ANNEXURE D: INFORMED CONSENT (ORIGINAL AND AMENDED)

Original:



Informed consent documentation for professional nurses in Thulamela sub-district, Vhembe district of Limpopo

TITLE OF THE RESEARCH: Professional nurses' experience when providing nursing care to women experiencing intimate partner violence: a caring presence study

ETHICS REFERENCE NUMBERS: NWU-00444-19-S1

PRINCIPAL INVESTIGATOR: Prof Emmerentia du Plessis

POST GRADUDTE STUDENT: Avhatakali Mphephu

ADDRESS: Limpopo, Vhembe, Lwamondo Area, Tshishushuru Village

CONTACT NUMBER: Cell 0765940710/ 0646802341

You are being invited to take part in a **research study** that forms part of a masters' degree in Psychiatric nursing.

Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary,** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00444-19-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health

Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1. What is this research study all about?

- *This study will be conducted at Limpopo, Vhembe region, Thulamela sub-district in December 2019 – January 2020 and will involve the researcher and supervisor trained in qualitative research. Professional nurses will be included in this study.*
- *We plan to explore your experience when providing nursing care to patients who have experienced intimate partner violence.*
- *The aim of this research is to explore and describe the experience of professional nurses working at primary healthcare clinics and community healthcare centres, outpatient department and emergency department in the rural area of the Limpopo Province, Vhembe district, Thulamela sub-district, when providing care to women experiencing intimate partner violence in order to make recommendations for nursing practice, education and research.*

2. Why have you been invited to participate?

- *You have been invited to be part of this research because you are a professional nurse working in a primary healthcare clinic, community health centre, outpatient department or emergency department in the Limpopo province, Vhembe district, Thulamela sub-district rural area. Both male and female professional nurses, providing nursing care to patients who experience intimate partner violence are included. You will be free to use Tshivenda or English, or both.*
- *You will not be able to take part in this research if you have less than two years' experience working in a rural area of the Limpopo province, if you are an enrolled nurse, enrolled nursing auxiliary or a student nurse, and if you currently work in the Thohoyandou area.*

3. What will be expected of you?

- *You will be expected to:*
- Participate actively in an individual interview with the researcher, which will take about 45 minutes to an hour of your time. If you provide permission, I would appreciate it to audio-record the interview and the question are as follows:
  - What is it like to provide care healthcare to women experiencing domestic violence?
  - What makes it easy for you to attune to and connect with women experiencing domestic violence?
  - What makes it difficult for you to attune to and connect with women experiencing domestic violence?
  - How would you like to be guided to provide care through relationship to women experiencing domestic violence?

4. **Will you gain anything from taking part in this research?**

- *You will not directly gain from this study. The findings will be used to write recommendations for professional nurses to provide nursing care in a relational and caring way to patients who experience intimate partner violence.*

5. **Are there risks involved in you taking part in this research and what will be done to prevent them?**

- *The risks to you in this study are that you may have fear of the unknown about the confidentiality of what you share during the interview, you may be bored and get fatigue during interview, you may fear that you will have to spend money for participation in the study; no identifying information will be shared with anyone outside of this research project, active participation is required and the researcher will travel to the venue selected or pay for the participants' transport if they will have to travel to the venue, the researcher will also provide refreshments and tokens to the participants.*
- *There are more gains in this study than there are risks.*

6. **How will we protect your confidentiality and who will see your findings?**

- *Anonymity will be protected by the researcher. Your privacy will be respected by the researcher. Your results will be kept confidential by the researcher. Only the researcher, the research supervisor and a co-coder will be able to look at what you shared during the interview (data). Data will be kept safe by locking hard copies in locked cupboards in the researcher's office and electronic data will be password protected. (As soon as data has been stored on a password protected computer it will be deleted from the recorders.) Data will be stored for five years.*

7. **What will happen with the findings or samples?**

- *The findings of this study will only be used for this study, not for follow-up or additional studies.*

8. **How will you know about the results of this research?**

- We will give you the results of this research after completion of the study.
- You will be informed of the findings by the researcher through a feedback session and in writing.

9. **Will you be paid to take part in this study and are there any costs for you?**

This study is funded by the researcher.
No, you will not be paid to take part in the study
Refreshments will be served.
There will thus be no costs involved for you, if you do take part in this study.

10. Is there anything else that you should know or do?

- You can contact A Mphephu. at 0765940710 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I ..... agree to take part in the research study titled: Professional nurses' experience when providing nursing care to women experiencing intimate partner violence: a caring presence study.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of participant **Signature of witness**

Declaration by person obtaining consent

I *(name)* ..... declare that:

- I clearly and in detail explained the information in this document to the participants.
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(AVHATAKALI MPHEPHU)* declare that:

- I explained the information in this document to the participants **or** I had it explained by who receive the consent, who I trained for this purpose.
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them or I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of researcher **Signature of witness**

Amended:

Informed consent documentation for professional nurses in Thulamela sub-district, Vhembe district of Limpopo

TITLE OF THE RESEARCH: Professional nurses' experience when providing nursing care to women experiencing intimate partner violence: a caring presence study

ETHICS REFERENCE NUMBERS: NWU-00444-19-A1

PRINCIPAL INVESTIGATOR: Prof Emmerentia du Plessis

POST GRADUDTE STUDENT: Avhatakali Mphephu

ADDRESS: Limpopo, Vhembe, Lwamondo Area, Tshishushuru Village Stand No 186

CONTACT NUMBER: Cell 0765940710/ 0646802341

You are being invited to take part in a **research study** that forms part of a masters' degree in Psychiatric nursing.

Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary,** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00044-19-A1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1. What is this research study all about?

- *This study will be conducted at Limpopo, Vhembe region, Thulamela sub-district in July to August 2020 and will involve a 30-45 minute interview with you via WhatsApp video call. Professional nurses will be included in this study.*
- *We plan to explore your experience when providing nursing care to patients who have experienced intimate partner violence.*
- *The aim of this research is to explore and describe the experience of professional nurses working at primary healthcare clinics and community healthcare centres, OPD and ED in the rural area of the Limpopo Province, Vhembe district, Thulamela sub-district, when providing care to women experiencing IPV in order to make recommendations for nursing practice, education and research.*

2. Why have you been invited to participate?

- *You have been invited to be part of this research because you are a professional nurse working in a primary healthcare clinic, community health centre, outpatient department or emergency department in the Limpopo province, Vhembe district, Thulamela sub-district rural area. Both male and female professional nurses, providing nursing care to patients who experience intimate partner violence are included. You will be free to use Tshivenda or English, or both.*
- *You will not be able to take part in this research if you have less than two years' experience working in a rural area of the Limpopo province, if you are an enrolled nurse, enrolled nursing auxiliary or a student nurse, and if you currently work in the Thohoyandou area.*

3. What will be expected of you?

- *You will be expected to:*
- Participate actively in an individual interview with the researcher, through a WhatsApp video call, which will take about 30-45 minutes of your time. If you provide permission, I would appreciate it to record the interview and the question are as follows:
  - What is it like to provide care healthcare to women experiencing domestic violence?
  - What makes it easy for you to attune to and connect with women experiencing domestic violence?
  - What makes it difficult for you to attune to and connect with women experiencing domestic violence?
  - How would you like to be guided to provide care through relationship to women experiencing domestic violence?

4. Will you gain anything from taking part in this research?

- *You will not directly gain from this study. The findings will be used to write recommendations for professional nurses to provide nursing care in a relational and caring way to patients who experience intimate partner violence.*

5. Are there risks involved in you taking part in this research and what will be done to prevent them?

- *The risks to you in this study are that you may have fear of the unknown about the confidentiality of what you share during the interview, you may be bored and get fatigue during interview, you may fear that you will have to spend money for participation in the study. In order to put you at ease and to protect you, no identifying information will be shared with anyone outside of this research project, and the researcher will provide you with 500MB data to use during the WhatsApp video call and a small token of appreciation. WhatsApp video calls are private, and no one will be able to hack into the call, only you and the researcher will have access to the call while in process.*
- *In case participating in the interview triggers difficult emotions, you will be referred to a psychologist for counselling. Please make the researcher aware if you need such a referral.*
- *All the risks related to the COVID-19 pandemic have been minimised by observing safety precautions as explained in this document, and by opting to conduct the interview via WhatsApp video, rather than having a face-to-face interview.*
- *There are more gains in this study than there are risks.*

6. How will we protect your confidentiality and who will see your findings?

- *Anonymity of your personal information will be protected by the researcher by removing all identifying data from the WhatsApp video calls. The video call will not be shared with anyone, but the words you speak and aspects of your body language, e.g. sighing, crying and silences will be typed in a word document, for analysis of the meaning of that you shared, together with all other interviews that will be held.*
- *Your privacy will be respected by the researcher by conducting the interview with you while she is in a quiet, private room with no one else present or able to hear what you are discussing.*
- *Your results will be kept confidential by the researcher. Only the researcher, the research supervisor and a co-coder will be able to look at what you shared during the interview (typed data).*
- *Data will be kept safe by saving it on a password protected computer. As soon as the recording has been stored on a password protected computer the video recordings will be deleted from the researcher's phone. As soon as the conversation is typed (transcribed) it will be deleted from the computer and only the transcription will be saved on the researcher's computer, which is password protected. Transcripts will be analysed to answer the research question and reach the research objectives, and data will be stored for five years.*

7. What will happen with the findings?

- *The findings of this study will only be used for this study, not for follow-up or additional studies.*

8. How will you know about the results of this research?

- We will send you the results of this research after completion of the study, by sending you a pdf document via WhatsApp.

9. Will you be paid to take part in this study and are there any costs for you?

This study is funded by the researcher.
No, you will not be paid to take part in the study
You will be provided with 500MB of data, and a small token of appreciation will be given to you by the independent person, after you have participated.
There will thus be no costs involved for you, if you do take part in this study.

10. Is there anything else that you should know or do?

- You can contact A Mphephu at 0765940710 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

If you voluntary agree to participate, the informed consent process will be as follows:

By the time of providing informed consent, you should have been provided with both an electronic copy of this document (sent to you as a pdf document via WhatsApp), and a printed copy of the informed consent documentation. The printed copy should have been wrapped in plastic bags, and left in the independent persons' offices for a period of three days, e.g. in a locked cupboard. The independent person was asked to open the cupboard, and the researcher put the informed consent documentation in the cupboard, observing all prescribed safety measures, e.g. social distancing, wearing a mask and sanitising hands. Screening was done on the premises before anyone was allowed to enter the premises. After a period of three days, the independent person would have opened the cupboard, and invited you to fetch the informed consent documentation while you were on duty. The same safety measures should have been followed, and the cupboard should be sanitised after the documentation is removed.

Written, voluntary informed consent will now be obtained as follows:

- Three days after providing the informed consent documentation via WhatsApp, and on the same day or after you fetched the printed copy from the independent person's office, the researcher will phone you via a WhatsApp video call to discuss the research and the informed consent documentation.
- A witness will be present with the researcher in one place, and you will be asked to have a witness present at another place. This is done to ensure that the process of obtaining informed consent is fair and safe for you, and that you give informed, voluntary consent.
- Social distancing will be maintained in the two different places, and the researcher and her witness in one place, and you and your witness at a separate place, e.g. a private, quiet room at your workplace or a private room in your house, will wear appropriate masks.
- If you agree to participate, you will be asked to sign the printed copy of the informed consent documentation, co-signed by the witness.
- The researcher will then sign their copy of the informed consent documentation, co-signed by her witness.
- Four parties will thus sign at the same time, but in two different places.

- Take note this is seen as delayed consent, and informed consent will be confirmed in future by signing the form together when both parties are allowed to be present, e.g. during lockdown level 2 or 1.
- After signing, you will be requested to take a photograph of your signed informed consent document and send it to the researcher via WhatApp. Please keep the original document until it is allowed that you and the researcher meet in future.
- After signing, you may choose to immediately continue with the interview, or arrange a date and time with the researcher that will be convenient for you for the interview. If you choose to have the interview at a later date, informed, voluntary consent will be verbally confirmed with you before the interview starts.

Declaration by participant

By signing below, I ..... agree to take part in the research study titled: Professional nurses' experience when providing nursing care to women experiencing intimate partner violence: a caring presence study.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of participant **Signature of witness**

Declaration by researcher

I *(AVHATAKALI MPHEPHU)* declare that:

- I explained the information in this document to the participants.
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them or I was available should he/she want to ask any further questions.
- The informed consent was obtained by myself, and will be confirmed at a later stage when face-to-face contact with the participant is allowed.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of researcher **Signature of witness**

ANNEXURE E: INTERVIEW SCHEDULE

The researcher used a semi-structured interview with open-ended questions with probing question.

The ground rules for the interview (for researcher):

- Introduction
- Speak in a medium speed, not too fast, not too slowly
- Pause often
- Avoid over-talking, that is: give participants time to listen, think and speak
- Allocate time for questions and answers.

The opening:

- Establish rapport: shake hands and introduce yourself
- Purpose: explaining why the researcher wants to conduct the interview
- Motivation: explain where you want to use the information and who will benefit from this information
- Timeline: explain how long the interview will take (Indian Scribes; 2018)

INTERVIEW SCHEDULE

- What is it like to provide care healthcare to women experiencing domestic violence?
- What makes it easy for you to attune to and connect with women experiencing domestic violence?
- What makes it difficult for you to attune to and connect with women experiencing domestic violence?
- How would you like to be guided to provide care through relationship to women experiencing domestic violence?

INTERVIEW SCHEDULE IN TSHIVENDA

- Hu itea mini kana vhadipfa hani musi vha tshi khou thusa vhafumakadzi vha no khou tambudziwa mitani?
- Ndi mini zwine zwa nga leludza u nekedza thuso kha vhafumakadzi vha ne vha khou tambudziwa mitani?
- Ndi mini zwine zwa ita uri zwikonde u nekedza thuso yo fhelelaho kha vhafumakadzi vha ne vha khou tambudziwa mitani?
- Vha nga takalela u pfumbudziwa u fhata vhushaka havhudi na u isa dzilafho lo fhelelaoho kha vhafumakadzi vha no khou tambudziwa mitani?

ANNEXURE F: EXAMPLE OF FIELD NOTES

Descriptive notes

One-to-one interview was done on 23 September 2020, which was Wednesday as the hospital management allowed me to conduct interview on Wednesdays where there are enough staff on duty, and this is one of the interviews with one of the professional nurses working in a hospital ED. During data collection, the safety measures for COVID-19 were followed: Screening was done on the premises before anyone is allowed to enter the premises, social distancing of at least 2 metres, wearing of appropriate face masks, regular hand washing with an 80% alcohol-based sanitiser hand rub, no touching of face, no hands shaking, no hugging, the researcher had to sanitize the chair, table and lock handles after each participant leave the room, and the researcher arranged tokens of a pen and small bottle of sanitizer in a box a week before data collection, each participant took one token to avoid sharing during interview.

For this participant, the interview was well done, she was fully participating and seemed to have read through her informed consent, knowing what was expected of her though I had to clarify on some of the questions. The interview was conducted between 09h00 to 10h00 and lasted for 47 minutes.

The only interruption was when some of the clients knocked at the door for vital signs as the room was on the entrance of the ED and they used to be assessed in that room.

Reflective notes

The participant looked to be free, ready and willing to provide the experience she had when caring for women experiencing IPV. Sometimes when explaining she used frown to reveal the impact and pains that she experienced when caring for women experiencing IPV. At times she shook her head and uses her non-verbal communications to emphasizes her feelings.

Demographic notes

One-to-one interview was conducted on the 23 September2020, it was on Wednesday morning between 09h00 and 10h00 and the interview done for 47 minutes with a female professional nurse, aged 35 working in a hospital ED for more than ten years. A room was big enough to accommodate a distance of 2meter between the researcher and the participant, a “do not disturb” note was pasted on the door, unfortunately, those who cannot read knocked at the

door. The room was conducive for interview except for those few who knocked at the door during interview.

ANNEXURE G: EXAMPLE OF A TRANSCRIPT

Participant/nurse: 8

Researcher: Good afternoon

Participant 8: Good afternoon

Researcher: How are you today?

Participant 8: I am fine.

Researcher I'm fine, to remind you I am Avhatakali Mphephu, I am a student nurse at university of North West, Potchefstroom campus so, I am here to collect data, for the research on the topic: professional nurses' experience when caring for women experiencing domestic violence; as you have seen from the consent form that you have already signed, hoping that you have signed after you already gone through it and you know what is expected from you.

Participant 8: Yes

Researcher: the consent form and that you have signed for me

Participant 8: Yes

Researcher: So, before we started with our interview, I would like to request your consent to record this interview

Participant 8: Yes, I do agree.

Researcher: ok, thank you for your consent, one thing for sure is in the interview I am not going to ask you for your personal information, like your net or your demographic data for the sake of privacy and confidentiality of the information you are going to give.

So, if I can ask, how long have you been working in this OPD?

Student: 3 years

Researcher: you remain the relevant candidate for this, because I am looking for a professional nurse who have 2 years plus experience

Researcher: Can we start with the interview questions?

Participant 8: yes, we can start.

Researcher: The first question is: what is it like to provide health care to women experiencing domestic violence? This is about your experience while working in OPD is not something you have read about, what is needed here is what you have experienced while caring for those women experiencing domestic violence.

Participant 8: My experience while working with women experiencing domestic violence. I can say it's a sad experience because seeing women coming in being beaten by their spouses and those people they loved them in return they do not expect to be beaten up or violated in any other way whether emotional or physical what they expect is love, that's make it very difficult to deal with such woman because they also do not want to expose their spouse.

Researcher: You mean women?

Participant 8: Women do not want to expose their spouse base on the fact that they loved them so that how sad my experience is.

I remember one time came in a lady she was accompanied by her spouse they came in the lady look so dirty like she was rolling on the mud, when you ask her what happened, her response was She just fell was she was trying to get something outside and because it was raining she slipped and fall but you could see in her face that it was more, and the dirt that was on her you could see that she was beaten up and roll, and what I did was to ask the spouse to go outside so that I can try to find out what really happened.

Researcher: maybe if I can ask there was it easy for the spouse to go out?

Participant 8: It was not easy at all because he insisted that he needs to be there for her so that he can give her moral support. By then I explained to him that sometimes we need privacy and there are some questions that does not need you to be around and even if you're her spouse there are thing that doesn't need you to be around

That how I managed to let him go outside, but he keeps on coming back every moment to check what is she saying, is she going to expose me?

But I managed to convince the lady to speak up because I could see she also had some bruises and you could see she did not sustain them from just falling, until she speaks and say her

husband is the one who violated her, that is how I managed to find that information though it was not easy it took me more time to convince her to speak up.

I had to be there for that patient, listen very attentively while she was trying to speak up, she was also crying, I had to comfort her throughout. The experience is not good experience but then we have to be there for those patients.

Researcher: Maybe if I can ask from what you have just said at the end did you manage to help the patient?

Participant 8: Yes, I believe so, after she told me what happened I decided to tell the doctor who was about to examined the patient , what was the reason behind for the patient to be here, so after that we decided to refer the patient to the trauma centre where they deal with this issue of domestic violence and then we ended up even involving the police , when I do my follow up that man was arrested ,and the lady was happy because she said it was not for the first time and she was happy that she got the man arrested for what he did.

The lady was treated for the injuries she sustained, and she was referred to the psychologist wherein she was getting all that emotional support she needs, because she was having fear of what if the husband kills her when she come back or beat her again.

Researcher: In other words, you mean to say collaborate all the multi-disciplinary team.

Participant 8: Though some of the case we do not win because some people are not ready to talk about it

Researcher: If I can interrupt there are there some of the cases that passes without noticing that it is domestic violence?

Participant 8: Yes, it happens a lot of time ,is a common thing because for instance the case that I was taking about ,if I didn’t have time to probe ,so that the lady can speak up ,it easy going to be treated as If I didn't have to probe so that the lady can open up it was going to be the same story, that lady was just going to treated as if she just fell, and given medication and go home due to the lack of time and shortage of stuff, most of the time we do not have time to ask lots of questions, we just take what the patients are telling us,

If someone come with the blue eye and say ooh I was hit by the corner of a wall, we just going to treat the eye off they go home, only to found out that she was beaten by the spouse, it

happens a lot, sometimes you find out is the young individual, that came in and say she is experiencing some vaginal bleeding, and you think maybe it's menstruation starting only to find out that she experienced some sexual abuse, and just because there was no proper questioning and assessment.

There was another case that I experienced, the young woman of the age of 16, this one was sexual base this lady was staying with the elder sister and the husband of the elder sister, just because the parents died while she was still young she was forced to go stay with the elder sister but the sister's husband decided to abuse her sexually all in the name that I give you food, I give you shelter, she you tell anyone I will throw you out of my house together with your sister,

But then she went and open up to the aunt and the aunt said to her traditional if that happens you do not tell anyone as long as you are fed and you have a place to stay, until one day she decided to open up to the sister and the sister brought the lady to our OPD and we decided to call the aunt to come in to explain why did she allow such thing to happen.

We did our assessment but by then she was pregnant already and it was a sad thing, she was helped and referred to psychology.

Researcher: I hear you mention traditionally do you mean cultural is acceptable?

Participant 8: Yes, in our culture they see nothing wrong with a man beating up his wife, they say if he is beating you up is because you are not being submissive and he is disciplining you is not any form of domestic violence, they do not believe in such thing.

Researcher: Okay

Participant 8: And I think that was what happened to this case, they saw nothing wrong with that, as long as he is providing you with food and shelter or even if he can took you as his second wife

Researcher: when you explaining this story, I saw facially you are frowning like does this means this issue of women being abused bothering you too much?

Participant 08: It’s quite disturbing especially when you are also a woman, seeing other women going through such pain , it shows us that we are not safe in the hands of people that we say we love all we expect from the is to nature us build family with such people but at the end of the day they are the ones who are hurting us so it is not nice, if is like in the family and a husband is

beating up a wife in front of the kids ,what does it do to such poor kids watching such happens in front of them ? It really destroys the future of our young ones who are growing in such events happening in front of them.

Researcher: referring to the 1st question do you have anything you want to share with us?

Participant 8: With the experience?

Researcher: Yes

Participant 8: I think I have said all I can think of at the moment.

Researcher: Okay, can we proceed to the 2nd Question?

Participant 8: Yes

Researcher: The 2nd question read as follows: what makes it easy to attune to and connect with women experiencing domestic violence?

Participant 8: Like I said during the 1st question every day when watching news or on social media you see a static increasing of women being violated, so the knowledge that I have, makes me to have this interest to help such woman experiencing the violence, I just opened up and make time to be with them and try to listen what really happening in their life , if I am not busy , if we have enough stuff in the ward , I make sure I put my all when attending to this women because I know is not safe out there not only in the community even in the comfort of our own home , because they ae being violated everyday so I make sure that when woman comes in being beaten up I make sure I connect with them all the way, I don't judge them ,I always try to be neutral and when they are crying I ty to comfort them

Give them that smile to feel appreciated and it means I have to hold their hand during the assessment I will do that, so being a woman living in South Africa with all this fears of what is happening that's what makes me to want to be close to those victims, let's say is those that are married and she said I am tolerating such behaviour because I am married and I do not want to go out of the marriage, What will my kids eat? I try by all means to empower those women that it is still possible for you to prosper, you can still raise your kids on your own if that what you have to do foe this violence to stop.

So, my aim is to see every woman happy and not violated by anyone all over the country, that's what makes me to want to be close to those victims so that I can help them to come out of that darkness

Researcher: Do you have anything to add on that?

Participant 8: No

Researcher: If not can we proceed to the next question?

Participant 8: Okay

Researcher: What makes it difficult to attune to and connect with women experiencing domestic violence?

Participant 8: Most of women they are not ready to open up, that's the one thing that makes it difficult, they not ready to open up before the rely on those people abusing them for money, most of those women are unemployed, they depend on those man because they are bread winners, because they know if they open up they will lose what they benefit from those man and that's the thing that's makes it difficult.

Researcher: Does that mean issue of not being employed contribute to this domestic violence?

Participant 8: I think so in my point of view it also does, because when you ask why did he beat you up, they say I was asking money, so he said you a troublesome every time I get home you ask money so yes it also contribute. And the other thing is you find out that the husband is the one accompanying them to the consultation rooms, so they do not want to speak up in front of their husband.

Researcher: So, if the husband is there it makes it difficult for you to connect with these women?

Participant 8: Yes

Researcher: Okay

Participant 8: The other issue is the space you find out that the cubic I am using while speaking to this patient the next patient could hear, so it makes it difficult for me to connect with this other

patient, because they will be having fears of being judged, what if I say this they will say I am being abused.

The issue of time and shortages because in our hospital we have the issue of shortage of doctors, we spend less time with them , trying to push the que outside, you find out that when you about to move to the next patient, this one start to open up, and you tell them you had your chance but you didn't want to talk and is not because we don't care but is because of the shortage of staff.

Researcher: Do you have anything to add on what makes it difficult?

Participant 8: I think the other thing is lack of assessing skills if I can put it in that way, we nurse we short proper skills to probe or assessing the patient. We need more experience and knowledge in order to be able to assess the women correctly.

Researcher: Okay

Participant 8: I see that is a problem when you have to deal with such cases.

Researcher: Do you have anything to add on that?

Participant 8: Even a fear, like what if this woman tells me she is being abused, what am I going to do? Will I also fail this woman too? Will I be able to help this woman, the thought of failure also comes in, what if she opens up to me and I am unable to help her further.

Researcher: You mean you do not have enough management skills?

Participant 8: Since like we have one psychologist in here and you find out that she is not available for a week or she is on leave, what do you do with the patient, you need to wait for a month so that your problem can be attended to or weeks, so yah that all

Researcher: Okay, can we proceed to the last question.

Participant 8: Yes

Researcher: How would you like to be guided in order to provide care through relationship to women experiencing domestic violence?

Participant 8: I think as nurses we need more of in-service training or workshop on how to asses these women, how to refer them for further help, in general on how deal with such cases the

management from when they reach our offices, until she is discharge from hospital and thing to avoid for such event not to happen again, The issue of this domestic violence should be educated from the level of primary up until to the university , it should be at all the curriculum , cause this issue can happen to anyone of any age, it doesn't happens to adults only , even our 5 years girls are being abused even our 3 years girls are also being abused, they need to be educated that if you see a man do such and such a thing it means that they are abusing , so if the community have such a knowledge when they come to us it became easier , they can also trust us , and they will know if I tell the nurse what I am going through it mean that I will get to proper institution where I will get help and that thing will make our community where to go and when to get help.

And this issue also included on the nurses curriculum it means our student nurses will also have knowledge with such issues when they came to practice they will know where to go about ,and we should have more health awareness campaign about such issues like to go to churches, to chief kraals when they are having their gathering ,like to the community, and here before they start attending to the patient we can let them know that there is help out there , they should not keep thing to themselves until they are killed or they are seriously injured.

Researcher: Do you have anything to add on that?

Participant 8: I think there is a need to be a collaboration between the department of health , department of Justice ,Department of social development and department of education because all these things work hand in hand , because there is student who is being abused and the teacher should be able to communicate with someone in the department of health or in the department of Justice that I have a learner who is going through such thing , so that they can get early health and for social worker going out the community must be able to communicate with the department of Justice to say ,I have observe this and this how do we go about it ,even the police if there is a case reported to them they should also communicate with department of social development together with department of health .this is not an issue of one department we work hand in hand , because to the hospital ,to the community ,the department of Justice.

Researcher: Do you have something to add on that?

Participant 8: Yes, and maybe if it happened that we also get a proper infrastructure in future wherein we can conduct proper assessments with our patients and have a counsellor who is always available, I think that it will help.

Researcher: If that's it, I would like to thank you for your time, I know that are were very busy and tired thank you very much for your time and thank you for your information I have a lot from your experience.

Participant 8: Is a pleasure, I hope this will help someone someday.

Researcher: Thank you.

ANNEXURE H: CONFIDENTIALITY AGREEMENT (EXAMPLE)

CONFIDENTIALITY UNDERTAKING

entered into between:

Co – Coder / Mediator / Independent person

I, the undersigned

_____

hereby undertake in favor of the NORTH-WEST UNIVERSITY, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borcherd Street, Potchefstroom, 2520

(hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

2 Preamble

2.1 In performing certain duties requested by the NWU, I will have access to certain Confidential Information provided by the NWU in order to perform the said duties and I agree that it must be kept confidential.

2.2 The NWU has agreed to disclose certain of this Confidential Information and other information to me subject to me agreeing to the terms of confidentiality set out herein.

3 Title to the Confidential Information

I hereby acknowledge that all right, title and interest in and to the Confidential Information vests in the NWU and that I will have no claim of any nature in and to the Confidential Information.

4 Period of confidentiality

The provisions of this undertaking shall begin on the Commencement Date and remain in force indefinitely.

5 Non-disclosure and undertakings

I undertake:

5.1 to maintain the confidentiality of any Confidential Information to which I shall be allowed access by the NWU, whether before or after the Commencement Date of this undertaking. I will not divulge or permit to be divulged to any person any aspect of such Confidential Information otherwise than may be allowed in terms of this undertaking;

5.2 to take all such steps as may be necessary to prevent the Confidential Information falling into the hands of an unauthorised third party;

5.3 not to make use of any of the Confidential Information in the development, manufacture, marketing and/or sale of any goods;

5.4 not to use any research data for publication purposes;

5.5 not to use or disclose or attempt to use or disclose the Confidential Information for any purpose other than performing research purposes only and includes questionnaires, interviews with participants, data gathering, data analysis and personal information of participants/research subjects;

5.6 not to use or attempt to use the Confidential Information in any manner which will cause or be likely to cause injury or loss to a research participant or the NWU; and

5.7 that all documentation furnished to me by the NWU pursuant to this undertaking will remain the property of the NWU and upon the request of the NWU will be returned to the NWU. I shall not make copies of any such documentation without the prior written consent of the NWU.

6 Exception

The above undertakings by myself shall not apply to Confidential Information which I am compelled to disclose in terms of a court order.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at Potchefstroom this _____ 20____

Witnesses:

1

2

(*Signatures of witnesses*) (*Signature*)

ANNEXURE I LETTER TO CO-CODER

Avhatakali Mphephu

P.O. box 2459

Thohoyandou

0950

09 October 2020

Dear Sir/Madam

REQUEST FOR CO-CODER

The above subject matter refers:

I am currently studying for Master's Degree at the North West University. One of the requirements for this course is that I conduct research.

I herewith kindly request you to act as co-coder. The co-coder is expected to assist with co-analysing the collected data. You will also be expected to sign a confidentiality undertaking.

With regards

Avhatakali Mphephu