DEVELOPMENT OF A PROGRAMME FOR NURSES TO MANAGE SURVIVORS OF SEXUAL AND GENDER-BASED VIOLENCE IN PRIMARY HEALTH SETTINGS

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A dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Nursing.

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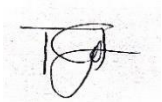
DECLARATION

I, Adele Louise Greasley declare that this research report is my own, unaided work, and that all the sources quoted have been indicated and acknowledged by means of complete references. It is being submitted for the degree of Master of Science in Nursing at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other University.



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(Signature of candidate)

____4th_day of September_____2022__in The Faculty of Health Sciences

Protocol number: M200636

DEDICATION

This dissertation is dedicated to every survivor of sexual and gender-based violence:

May you know that your very existence counts and that you were born for a purpose.

“For you are fearfully and wonderfully made” Psalm 139:14

ABSTRACT

Background: Sexual and gender-based violence (SGBV) is a world-wide problem and South Africa is no exception. In a report released by the World Health Organisation in 2018 it was estimated that almost twenty-three percent of adults suffered physical abuse in their childhood, and that as many as thirty-five percent of women globally will experience either sexual or physical violence during their lifetime. Evidence indicates that most survivors of SGBV will look to nursing services for their first port of call. The literature reveals that nurses generally feel ill-equipped to deal with these survivors because there is a lack of adequate training, which will impact on their level of appropriate care, especially with regards to their lack of knowledge about referring survivors for further management.

Purpose: The purpose of this study was to develop the outline of a programme which would assist nurses in recognizing and managing these survivors, as most nurses felt ill-equipped to recognize and manage these patients effectively. The training currently provided does not address these issues adequately, and no protocols or guidelines have been established for healthcare providers in South Africa.

Research Design: This study used qualitative methodology in four sequential phases. Qualitative research is a research method which is used to explore real world issues. It gathers information on the meanings of phenomena, that have been experienced by individuals in their natural environments. It focuses on obtaining people's stories and insights. (Brink, H., van der Walt, C., van Rensburg, G., 2018). Phases one to three were used to inform phase four of the study where a programme was developed using the data from the first three phases guided by the ADDIE model.

Methodology: The methodology that was used in this qualitative study was to conduct in-depth interviews with experts on the subject who are involved in the management of SGBV in South Africa, have focus groups with nurses at primary health care units who deal with the community on a daily basis and who have experience in managing survivors of SGBV, to establish the content that should be included in this programme, including the format of such a programme, and have in-depth interviews with educators with at least two years' experience in online and/or didactic teaching experience, to solicit their opinions on content, the best

methods of delivery and effective presentation methods for a programme to assist the nurses. The interviews were digitally recorded and analysed using Braun and Clarke's phases of thematic analysis. The programme was then developed according to the ADDIE model.

Sampling method: Purposive sampling was used in phase one and three of the study and convenience sampling was used in phase two of the study.
In the first phase experts from five different NGOs were interviewed. In the second phase, the researcher invited all nurses who were available to be part of the study. Six (n = 6) academics took part in the third phase of the study, all of whom had at least a master's degree and experience in nursing education.

Results: The data was analysed under two themes: Content that should be included in the programme which included the theoretical basis of SGBV, the recognition of SGBV, the role of the nurse and support systems and teaching and learning which included the curriculum to be covered and the process required to deliver the information. The nurses which were currently practicing felt underprepared to identify and manage survivors of SGBV. They felt that although some had a minimal amount of exposure to the subject of SGBV in their third and fourth year, they still felt ill-equipped. An important point made was that they were trained on dealing with medical issues and not trained to deal with emotional issues. The Registered nurses that were already in practice indicated a need for a CPD programme to be introduced, as they themselves had not been trained in their undergraduate programme.

Recommendations: The researcher felt that a training programme should be designed for undergraduates continuing on to trained nurses, to ensure they receive up to date information on how to identify and manage survivors of SGBV. The nursing education system should be adjusted to include training material in the subject.

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To my Heavenly Father – through You all things are made possible. Thank you for carrying me through all the tough times, for imparting wisdom and guidance, for giving me purpose in a hurting world, and for providing me with this incredible opportunity, I am so grateful

Finally, to all my family and friends who have prayed for me and believed in me – there are no words to express my excitement and joy at being able to stand at the end of this journey and look back with gratitude, in seeing all the support I have received. I have the most supportive family and love you all dearly

“**It is now more dangerous to be a woman than a soldier in conflict**”

Major General Patrick Carnmaert, former UN Peacekeeping Operation Commander in DRC 2020

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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

In this chapter a brief overview of the study will be given which includes a background to the study, the problem statement, research question, the purpose and objective of the study. Key operational definitions are included.

1.2 BACKGROUND

Sexual and Gender-based violence (SGBV) is an umbrella term given to any harmful act that is committed against a person's will, which includes sexual, physical, mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty (World Health Organisation, 2013).

In a report released by the World Health Organisation (WHO), it was noted that sexual and gender- based violence was a global concern (World Health Organisation, 2016). In 2018 the WHO released statistics that estimated that almost twenty-three (23%) of adults suffered physical abuse in their childhood, and up to as many as thirty-five (35%) of women globally will experience either sexual or physical violence during their lifetime (World Health Organisation, 2018). According to the United Nations Population Fund, a woman is raped every 83 seconds, and only one in twenty incidents are ever reported to the police. Of concern to the WHO (2016) is that, in relation to population density, the African and South-East Asian regions have the lowest density of workers in the health sector (Health Systems Trust, 2008), when compared to the regions of America and Europe. Worldwide, there is evidence that most survivors of sexual and gender- based violence (SGBV) will look to nursing services for assistance as their first port of call (McLindon, E., Fiolet, R. and Hegarty, K., 2021); (Maquibar, A., Hurtig, A-L., Vives-Cases, C., et al., 2018) (Lovi, R., Hurley, J. and Hutchinson, M., 2018).

The World Health Organisation (World Health Organisation, 2013) states that intimate partner violence and sexual violence are the most commonly seen forms of SGBV, and that social and cultural norms have a great influence on human behaviour and can have a direct influence on violent behaviour.

Nurses need to have the skills to identify survivors of SGBV when they seek assistance, to empower them to provide the necessary care (Randa, M.B., Mokoena, J.D. and Makgatho, S.,

2019).

In a cross-sectional study on domestic violence instruction in nursing and midwifery programs done in Australia, nurses stated that they felt underprepared to deal with survivors of SGBV and that they required more skills and practical knowledge on what and how to deal with it (Doran, F and Hutchinson, M., 2019). All over the developed countries, and in developing countries, the sentiments are similar, viz. staff often feel ill-equipped to deal with patients suffering from any form of SGBV (Aguiar, F.A.R., Dourado, J.V.L., de Sousa, N.S., et al., 2021); (Mgopa, L.R., Rosser, B.R.S., Ross, M.W., et al., 2021); (Colucci, A., Luzi, A.M., Belasio, E.F., et al., 2019); (Doran, FA and Hutchinson, M., 2019). If the management of SGBV was included in the syllabus from first-year undergraduate level, it would improve the situation for both nurses and survivors, as nurses would feel empowered with the correct knowledge in how to manage survivors, and the survivors would feel understood and protected.

Nurses have a professional obligation to advocate for patients under their care as stipulated in the SANC's Code of Ethics (The South African Nursing Council, n.d.). Many nurses are willing to help survivors of SGBV but feel unsupported by the Department of Health (Sprague, C., Hatcher, A.M., Woollett, N., et al., 2017). Guidelines and obligations have been established for the justice, legal and police departments in South Africa, on how to address SGBV, yet no protocols or guidelines have been established for health providers (Government of South Africa, 1996, 1998).

There is international recognition that it is the responsibility of nurse educators and employers to teach nurses how to both identify and manage SGBV survivors, (Kaufman, M.R., Williams, A.M., Grilo, G., et al., 2019); (Lanham, M., Ridgeway, K., Dayton, R., et al., 2019) but there is little to no training material that exists that will effectively accomplish this. There is also no specific model or framework outline that can be applied when dealing with SGBV survivors (Randa, M.B., Mokoena, J.D. and Makgatho, S., 2019).

In a recent study done in Spain it was found that out of one hundred and fifteen (115) training programmes for nurses, ninety-two (92) included content on SGBV and explained how the health sector addressed the management of these patients. Only thirty-one (31) out of the ninety-two (92) courses explained how one could identify SGBV. Only one had a training programme that included SGBV right throughout the 4 years of training for nurses (Maquibar, A., Estalella, I., Vives-Cases, C. et al., 2018). Even though these nurses had received training, they were concerned that they still lacked the skills or ability to identify the cases, especially

when false accusations had been made by women against men. They therefore felt they needed additional training. It was agreed by the participants in this study that it was essential for all nurses to be trained in SGBV from first year to their final year, as they were the ones most commonly dealing with these patients (Maquibar et al., A., Hurtig, A-K., Vives-Cases, C. et al., 2017).

In Italy, a course was developed that combined a blended training programme of residential training and distance training to try and prepare health care professionals (61% were nurses and 27% Doctors) to deal with SGBV and to manage the survivors affected by it. From this research, it was identified that most women who are targets of violence will go to emergency rooms for assistance (Colucci et al., 2019). Medical professionals also urgently needed additional training in how to deal with survivors of SGBV, and to strengthen their skills (Colucci, A., Luzi, A.M., Barbina, D et al., 2019).

In South Africa, registered nurses are traditionally trained at universities or colleges and cover a section on trauma related nursing. This does not prepare them to deal with SGBV survivors, and they often either ignore or detach themselves from the situation, when faced with these patients (van der Wath, A., van Wyk, N. and van Rensburg, E.J., 2016). Nurses also need to know where to refer the survivors to for them to get legal aid and counselling services (Randa, M.B., Mokoena, J.D. and Makgatho, S., 2019).

Training programmes for healthcare professionals are not preparing nurses and doctors to respond adequately to SGBV survivors (Muganyizi, M.A.P., Mpembeni, R., Darj, E., et al., 2016).

Currently all the expertise is confined to other support centers such as the Thuthuzela centres and Rape or Trauma centers in South Africa. The Thuthuzela centres are facilities set up by the government as a one stop facility, aimed at minimising secondary victimisation and trauma. The nurses who deal with the survivors who arrive at the Community Health Clinics do not have this level of expertise.

In view of the limited formal training on recognition and management of SGBV survivors it is important to develop and provide a programme to South African nurses which is developed to prepare and train them to deal with SGBV survivors in a sympathetic and knowledgeable manner, rather than being hesitant, for fear of not knowing the correct protocol (Aguiar, F.A.R., Dourado, J.V.L., de Sousa, N.S., et al., 2021). Such training would need to be in the form of a continuous

professional development programme to assist the current nursing workforce.

1.3. STATEMENT OF THE PROBLEM

Sexual and gender-based violence is widespread throughout society with an estimated twenty-three (23%) of adults having suffered abuse as a child, and a third of women having suffered abuse at some time during their lives (World Health Organisation, 2018). In South Africa, the most common form of SGBV is rape (Sigsworth et al., n.d.), and up to fifty-one (51%) of women have been affected by SGBV (Machisa, M.T., Christofides, N. and Jewkes, R., 2017). The need for support of survivors of SGBV is self-evident and many non-governmental organisations have developed training programmes, helplines, and drop-in centers to assist the community in this regard. While support is available for survivors of violence, the first point of contact for survivors is usually a health facility. Nurses are the primary providers of care at the health facilities and therefore need to know how to identify and support survivors of SGBV. Nurses however have limited access to existing programmes, and training in the subject is not as part of the undergraduate nurse's curriculum. If such a programme could be developed, nurses' ability to support survivors of SGBV will improve, and nurses will feel supported and assisted in their roles in the health facilities.

1.4. RESEARCH QUESTION

How should a programme to prepare nurses to manage survivors of sexual and gender-based violence in the Primary health settings be developed?

1.5. PURPOSE OF THE STUDY

The purpose of this study was to identify how a programme for nurses could be established to teach them to manage survivors of SGBV in Primary health settings. This was done by collecting information from experts, the nurses, and the educators, the intention was to develop a programme based on all the stakeholders' opinions thus providing a valid and useful programme.

1.6. OBJECTIVES OF THE STUDY

- To solicit opinions of gender-based violence experts on content for a programme to manage survivors of SGBV
- To solicit opinions of nurses on the content and format of a programme for the primary management of SGBV survivors
- To solicit opinions of educators on content, best method of delivery, and effective presentation methods of a programme on SGBV
- To develop the outline of a programme for nurses on the recognition and management of SGBV

1.7. OPERATIONAL DEFINITIONS

- Sexual and Gender-based violence (SGBV): This is an umbrella term given to any harmful act that is committed against a person's will, which includes sexual, physical, mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty (World Health Organisation, 2013).

- Intimate Partner Violence (IPV): Refers to sexual, physical, or psychological harm which occurs in an intimate relationship. It can occur via a former or current spouse or partner. This form of violence also occurs among same sex couples or in heterosexual relationships and does not necessarily accompany sexual intimacy. However, it is well known that there is a much larger burden of partner violence perpetrated by men against women.

- Primary health care clinics (Community Health Centers): Clinics that offer a basic level of health care that includes programs directed at the promotion of health, early diagnosis of disease or disability, and prevention of disease.

- SGBV survivors: Those persons who are currently or have been subjected to any form of sexual or gender-based violence

- Nurses: Nurses of all categories who work in health facilities providing first contact care for patients.

- Experts: Experts are managers of centres assisting survivors of SGBV, with at least

five years' experience in the field.

- Thuthuzela centres: These centres are attached to around fifty-four (54) hospitals in South Africa and offer a one-stop facility which is designated to offer medical and forensic services to rape survivors and to other SGBV survivors. It is an emergency centre established by the National Prosecuting Authority Sexual Offences and Community Affairs unit

1.8. OVERVIEW OF CHAPTERS

Chapter one	Introduction to the dissertation
Chapter two	Literature review
Chapter three	Methodology
Chapter four	Findings and Discussion
Chapter five	Development of the programme
Chapter six	Summary, main findings, limitations, recommendations, and conclusion

1.9. CONCLUSION

In this chapter the background, problem statement and purpose of the study with stated objectives have been described. In the following chapter a literature review of local and international studies has been reviewed.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

In this chapter, a review of the literature related to the meaning and extent of gender-based violence, and international efforts to prevent and manage SGBV is presented. In addition to this, the role of the nurse in preventing and managing gender-based violence and the need for education to prevent and manage SGBV will be explored.

2.2. THE MEANING OF SEXUAL AND GENDER-BASED VIOLENCE

Sexual and gender-based violence is a world-wide scourge which has a profound impact on the health of the individuals affected, both physically and mentally (Maquibar, A., Hurtig, A, Vives-Cases, C., et al., 2017), and is a human rights violation (García-Moreno, C., Hegarty, K., d' Oliveira, A.F.L., et al., 2015). The United Nations explains violence towards women as being “any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."(World Health Organisation, 2021a). Intimate Partner Violence (IPV) is a form of Gender-based violence and is the most common form of violence perpetrated against women. IPV refers to controlling behavior by an intimate partner/ex-partner that causes sexual, physical, or psychological harm. This is regardless of the person’s relationship to the survivor, and it can occur in any setting (World Health Organisation, 2021a). Sexual violence is trying to obtain a sexual act, that uses coercion by any person, regardless of their relationship to the survivor, in any setting. It includes rape which is defined as “the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object, attempted rape, unwanted sexual touching and other non-contact forms" (World Health Organisation, 2021b).

Domestic violence may include violence perpetrated against children and older people and is not only confined to intimate partners. IPV can be experienced by men and women in same-sex and heterosexual relationships too, but it is experienced more by women (Dardis, C.M., Dixon, K.J., Edwards, K.M. et al., 2015).

Honour-based violence (HBV) is where violence is perpetrated against women who have allegedly brought shame to their family name by their sexual behavior (Idriss, M.M., 2018). This is another form of gender-based violence which is causing concern in the United Kingdom. The House of Commons Home Affairs Committee stated that there needs to be an improvement in the responses by police officers and health care personnel, and sadly, survivors of this form of violence feel that hospitals and health personnel's response to them has failed them (Idriss, M.M., 2018).

2.3. THE EXTENT OF SEXUAL AND GENDER-BASED VIOLENCE

In 2017, eighty-seven thousand (87 000) women/girls were killed globally, and of those, fifty thousand (50 000) were by an ex/partner or family member (World Health Organisation, 2020). The 2021 statistics of the WHO show that violence in intimate partner relationships can start from as early as the age of fifteen years old (World Health Organisation, 2021a). Violence perpetrated against girls younger than fifteen years old is often in the form of a sexual assault. (World Health Organisation, 2021a). The World Health Organization stated that in 2021 around seven hundred and thirty-six million women, which equates to one in three women, would be subjected or exposed to physical or sexual violence by the time they are twenty-four years old by a non-partner or an intimate partner. An equally disturbing fact is that this figure has not changed significantly for the past ten years (World Health Organisation, 2021b) despite what is being portrayed in the media, as significant progress having been made in the fight against Gender-based violence. Globally the percentage of women murdered because of IPV is thirty-eight (38) percent (World Health Organisation, 2021a), and an average of one hundred and thirty-seven (137) women die at the hands of a family member daily (UN Women, 2021). The pandemic of Covid 19 has worsened the levels of violence perpetrated against women, as women have been forced to stay indoors with their perpetrators. John Neetu (Neetu, J., Casey, S.E., Carino, G., et al., 2020) stated in a recent publication in 2020 that the Covid-19 pandemic has laid bare all the health systems' disparities. Humanitarian crises and displacement of people are also aggravating factors for an increase in violence (World Health Organisation, 2021b). Human trafficking is a global problem and linked to SGBV as many of these survivors are subjected to several forms of abuse simultaneously (Scannell, M., MacDonald, A.E., Berger, A., et al., 2018).

In the United Kingdom (UK), a woman is killed by a man every 3 days, a statistic that has remained unchanged for the past 10 years (Doran, F and Hutchinson, M., 2019). In an article released by Amnesty International United Kingdom, 2020, it was reported that in Wales and

England, two women are killed by men on a weekly basis, however it is estimated that only twenty-four percent (24%) of cases are actually reported. (Amnesty International UK, 2020). Australia exhibits similar statistics of one in three girls from the age of fifteen, experience SGBV however, because as not all cases are being reported, the prevalence is much higher. In women under the age of forty-five, SGBV causes more premature deaths and ill health than any other risk factor that is known (Doran, F., and Hutchinson, M., 2019). There are high levels of IPV in Latin America, the Caribbean countries and in the rural parts of Peru (Stewart, D.E., Aviles, R., Guedes, A., et al., 2015). Approximately twenty-four percent of woman have reported experiencing serious physical violence by an intimate partner and about half of US women say they have experienced psychological aggression. The rates of IPV are the same levels in the LGBTQ (lesbian, gay, bisexual, transgender, or queer) community. Fourteen percent (14%) of all men also reported having experienced serious physical violence (Karnitschnig, L., Bowker, S. and Flagstaff, A.Z., 2020). The Governor of Puerto Rico declared a state of emergency around gender-based violence in January 2021, due to the sharp increase in related deaths (Piquero, A.L., Jennings, W.G., Jemison, E., et al., 2021).

In North America, the calls for help to crisis lines tripled in number during Covid lockdowns, and some areas such as Alberta, saw a thirty to fifty percent increase in the number of calls for help. In an article published by the Berkeley Political Review, a nonpartisan magazine and website in based in California, they reported on the disturbing statistics that in Mexico alone in 2018, three thousand five hundred and eighty women (3580) were killed, and ninety-eight percent of that statistic were murdered by men.

In African countries including Kenya, Zambia and Eswatini the prevalence of gender- based violence is a similar problem. Sexual violence prevalence is stated about thirty-two percent for women before the age of eighteen years old, and eighteen percent for men in the same age group (Temmerman, M, Ogbe, E., Manguro, G., et al., 2019).

Interpersonal or domestic violence is the cause of a significant burden of disease in South Africa, only second to HIV/AIDS (Gordon, C., 2016). In 2018 The World Health Organisation stated that up to eighty million women aged between fifteen and forty-nine years old have been affected by IPV in Africa. In the National Development Plan, which was established in 2012, it was stated that South Africa is facing a quadruple burden of disease, one of which is injuries, violence, and trauma. Some of the highest risk factors causing this are alcohol abuse, unsafe sex, and interpersonal violence. (National Development plan for South Africa, 2012). It was acknowledged then that the health system in South Africa was inadequate and not meeting the needs of the people, even though there was established policy and considerably high spending on healthcare as a component of the Gross Domestic Product. Our Primary Health care system

is still inadequate and much of our population is unable to adequately access basic healthcare. Prior to 2012 trauma data was not collected in the District Health Information system (Lutge, E., Moodley, N., Tefara, A., et al., 2016). It is a well-documented fact that trauma leads to a wide range of general medical, psychiatric and gynecological problems (Gordon, C., 2016), which can drive survivors to seek for healthcare assistance, often in emergency or primary health care settings They may also seek help with problems that don't seem to be related to violence, for example general body pain, headaches and anxiety (Lutge, E., Moodley, N., Tefara, A., et al., 2016). No protocols have been established in South Africa for the recognition, management, and treatment of survivors of IPV, which results in survivors entering healthcare institutions, not being identified and therefore being inconsistently and incorrectly managed (Rees, K., Zweigenthal, V., and Joyner, K., 2014). South Africa has the highest rate of reported femicide in the world, six times higher than the global average (Gordon, C., 2016). In a press release on the 20 August 2021, the South African Police released new statistics on crime, revealing a seventy-two percent increase in rape cases. There is also a backlog in the DNA laboratory of over three-hundred thousand cases, which means that survivors of this form of crime may wait for over three years until their perpetrators could be linked to the crime, should they even report it. To add to this situation, is the fact that when these SGBV cases eventually culminate into a court case, there is currently an average of only a seven to eight percent conviction rate (Action Society, 2020). The South African Government has passed three new laws in September 2021 which will assist in the fight against SGBV, however laws in themselves will not assist survivors of SGBV alone. Nurses need to be trained to recognise and manage these survivors so that they can assist in the process of treating this epidemic, instead of feeling inadequately prepared. Despite South Africa having a Constitution (South Africa et al., 2015) which emphasizes gender equality, there is a belief entrenched in cultural and social norms, that men may exert their power over women as a display of their masculinity. In many cultures SGBV is considered a private matter and many women do not feel free to report such matters (Randa, M.B., Mokoena, J.D., and Mokoena, J.D., 2019). However, statistics tell us that eighty-five percent of these survivors will approach health care services at some point for conditions which may or may not relate to SGBV, and it is critical that nurses are trained to look for the warning signs and ask direct questions. This is often the survivors first point of contact for help and may in fact be their last. Nurses need to be well trained in assisting these patients. Training Institutions, however, do not have structured training on SGBV as part of their curriculum, which should be enabling nurses to recognise and manage survivors of SGBV.

Dr Tedros Adhanom Ghebreyesus, the Director-General of the World Health Organization stated that in every culture and country, violence is perpetrated against hundreds of thousands of women and is endemic in every culture and country (World Health Organisation, 2021).

2.4. INTERNATIONAL EFFORTS TO PREVENT AND MANAGE SGBV

Although several countries have started addressing violence against women, there are varying degrees of success. Trying to integrate violence against women into the different health systems has been very slow (García-Moreno, C., Hegarty, K., d'Oliveira, A.F.L., et al., 2015). There are several cultural and social barriers such as limited resources in a country like India and a problem of high staff turnover (García-Moreno,C., Hegarty, K., d'Oliveira, A.F.L., et al., 2015).

In Italy, there are several anti-violence centres that have been established, but sadly, it is only half of what is required by the country (Autiero, M., Procentese, F., Carnevale, S., et al., 2020). In Southern Italy there is only one public service centre within that entire region. Healthcare personnel report burnout in their work circumstances, and say they experience a multitude of emotions such as anguish, nausea, sadness, and resignation when faced with survivors that have experienced violent situations. This was because they lacked training in how to approach the survivors and possibly where to refer them for help, even though they had good listening and relational skills.

In the Spanish health care system, the Government has taken a firm stance against violence perpetrated against women. They have established a commission which coordinates actions and monitors the delivery of effective healthcare across all regions. Specific funding has been given by Government (The Ministry of Health) to ensure its efficacy in the stance against SGBV (García-Moreno,C., Hegarty, K., d'Oliveira, A.F.L., et al., 2015).

Policies have been put in place in Kenya and they have established a SGBV Recovery centre in Mombasa to address the violence. This is a centre which meets all the needs of a survivor, whether it may be psycho-social support, legal assistance or medical care and counselling. However, many survivors cannot access these facilities due to their physical locality which brings into question how effective they are. The staff at these centres are well-trained and able to assist those that do manage to access them (Bryant, R., Schafer, A., Dawson, K.S., et al., 2017). However, there are significant numbers of patients who do not return for a second visit, which is mainly due to its inaccessibility, but also due to a lack of trained nursing staff in ensuring survivors understand the importance of returning for check-ups and support (Temmerman, M., Ogbe, E., Manguro, G., et al., 2019).

The South African Government is currently collaborating with various stakeholders such as trade unions and the private sector to try and implement the National Strategic Plan on Gender-based violence and Femicide. This implementation plan was established from the 1st National Summit on SGBV which was held in South Africa in 2018 (Government communications, 2021). The UN Women Executive Director, Phumzile Mlambo-Ngcuka expressed her concern that this ubiquitous violence perpetrated by men against women has remained unchanged, and in fact is at its most severe for young women who are possibly young mothers (World Health Organisation, 2021a). The Domestic Violence Act 116 of 1998 provides for the issuing of Protection Orders with regard to Domestic violence, and for matters connected herewith.

2.5. THE ROLE OF THE NURSE IN PREVENTING AND MANAGING SEXUAL AND GENDER-BASED VIOLENCE

Women who experience SGBV also commonly have low birth-weight babies and double the rate of abortions. It is critical that nurses understand the correlation between the ill health women experience due to their exposure to violence (Doran, F. and Hutchinson, M., 2017). However, in Australia, nurses complain about a lack of education in this field and are unclear as to their role in managing the survivor. There appeared to be a lack of understanding about the cycle of abuse, and in fact a need to challenge assumptions and pre-existing beliefs that many students held about DV. Of great concern on one study, was the belief by some of the male students that forced sex was not a form of DV (Doran, F. and Hutchinson, M., 2017). There is a lack of education programmes for undergraduate students, as well as post-graduate students, on the recognition and management of IPV survivors for nurses and midwives (Crombie, N., Hooker, L. and Reisenhofer, S., 2017). Many nurses felt that the subject was taboo and felt discomfort in having to ask about it (Wyatt, T., McClelland, M.L. and Spangaro, J., 2019).

In a study done in the Netherlands it was recognized that medical staff at the frontline need to be educated to recognize possible signs of SGBV, to be able to identify which individuals are at risk and be able to assist in such a way that the survivor is always protected. The issue was raised about workers at the front line also being privy to counselling for themselves to debrief effectively especially as for many health workers, IPV was considered a private discussion and one of low political importance in many of their societies (van Gelder, N., Peterman, A., Potts, A., et al., 2020). There is little coverage of SGBV in nurses' studies in Turkey and nurses still feel inadequate in approaching women who have been exposed to violence (Yilmaz, E.B. and Yüksel, A., 2020). There is a need to address nurse's attitudes towards the subject of violence especially towards male students that felt that violence against women was acceptable (Yilmaz,

E.B. and Yüksel, A., 2020). This attitude would clearly affect the nurse's ability to recognize and manage a survivor of SGBV. Many nurses normalize violence and feel somehow that violence against women in certain contexts, is justified. This highlights the inability of the current education curriculum in educating nurses on the subject. It is critical for educators to be well trained and have excellent, current knowledge and skills in the subject, which is necessary to assist the student in transferring their theoretical knowledge into practical application (Yilmaz, E.B and Yüksel, A., 2020).

In Spain the government has stated that all healthcare disciplines must include some content on the identification and management of IPV survivors, and it is measured as a competency for nursing graduates (Maquibar, A., Estalella, I., Vives-Cases, C.,et al., 2019). This is a refreshing approach to developing nursing staff to be competent in addressing and treating survivors of violence, although it must be noted that there are variations in the topics taught across the various universities, and there is a need for some form of standardization on the topics covered (Maquibar,A., Estalella, I., Vives-Cases,C.,et al., 2019).

Although there is limited undergraduate training on IPV in India, especially with regards to legal responsibilities and local support services, the nurses did indicate that they felt their role in identifying these survivors was very important (Poreddi, S.S.N., Gandhi, S., Marimuthu, P., et al., 2021). India has very high rates of SGBV, and nurses need to be trained efficiently to recognize the relative signs (Maquibar, A., Estalella,I., Vives-Cases, C., et al., 2019) (Ghoshal, R., 2020). Interestingly, in Saudi Arabia nurses' practice in identifying and managing patients that have experienced SGBV has not been researched. In this first study it was established that there is limited training for nurses in this regard, and in fact very few nurses in Saudi Arabia believe that they even have a responsibility to ask screening questions about SGBV (Alhalal, E 2020).

In Kenya despite the establishment of centres to assist survivor of SGBV, there remains a lack of trained nursing staff in ensuring survivors understand the importance of returning for check-ups and support (Temmerman,M, Ogbe, E., Manguro, G., et al. 2019). In Tanzania, the Ministry of Health and Social Welfare has developed a course to train healthcare workers on SGBV screening tools. However, most nurses have not yet been trained properly (Muganyizi, P., Mpembeni, R., Darj, E., et al. 2016).

In South Africa, nurses are known to experience what is known as 'compassion fatigue' when they are faced with situations which they feel ill-equipped and overwhelmed to deal with effectively (van der Wath, A., van Wyk, N. and Janse van Rensburg, E., 2016). They, however, play a critical role in preventing secondary trauma and recognising, managing, and treating

survivors of domestic violence. It would be helpful to include reflection skills and emotion regulation in assisting nurses develop coping skills in their training courses (van der Wath, A., van Wyk, N. and Janse van Rensburg, E., 2016). Nurses have stated that their lack of key skills and knowledge were the primary barrier to giving suitable care to these survivors (Randa, M.B., Mokoena, J.D. and Makgatho, S., 2019).

The role of the nurse is a vital and extremely critical one. Nurses in primary health care settings are perfectly positioned to recognize the manifestations of SGBV and refer the survivors to a source of help that is appropriate (Ali, P., 2017). Survivors often approach these departments for issues which may or may not look related to the violence they are being exposed to. They may present with physical or psychological issues such as headaches, abdominal pain, joint pain, anxiety, suicidal thoughts, premature labour amongst others (van der Wath, A., van Wyk, N. and Janse van Rensburg, E., 2016). Healthcare professionals, especially nurses also play a vital role in preventing secondary traumatization and being able to identify the type of violence, acknowledge it and manage survivors in an effective, empathetic, and knowledgeable way (Alshammari, K.F., McGarry, J. and Higginbottom, G.M.A., 2018). Nurses respond in different ways when dealing with survivors of IPV if they feel ill equipped. They will avoid dealing with the patient or avoid the subject when dealing with a medical history, and they can either battle to regulate their own emotions, or they will possibly seek help and support from others (van der Wath, A., van Wyk, N. and Janse van Rensburg, E., 2016).

To successfully help survivors of violence, we need a public health system which is coordinated and comprehensively integrated in a multi-sectoral way, working closely with our legal departments and courts to assist survivors of SGBV. We have a responsibility as healthcare workers to be well trained in recognising and managing survivors of violence. However, in the current situation in South Africa there is no or very little reference to gender-based violence in the curricula for our undergraduate programmes. There are also no current CPD programmes on SGBV management. As a result, it could be a useful solution to develop a programme as a Continuing Professional Development programme, which could be presented online or in person, and which should be compulsory for all nurses to attend. This programme should be taught country- wide and could also be presented in a blended learning format. There is a need for a practical component to be implemented in the training, so that students can practically apply their knowledge of dealing with a traumatized patient (Yilmaz, E.B and Yüksel, A., 2020).

Health systems need to play a key role in their multisectoral responses toward women being

subjected to violent behaviour, and gender-based violence should have top priority in all health policies so that there are adequate funds set aside to build capacity in health care workers with effective training (García-Moreno, C., Hegarty, K, d'Oliveira, A.F.L., et al., 2015).

Healthcare students often understand the seriousness of SGBV but battle to recognise it in their patients and when they do recognise it, they are unsure about how to respond. Medical and nursing students feel that the amount they are taught about SGBV or Domestic Violence (DV) during their training as undergraduate students is inadequate (Potter, L.C. and Feder, G., 2018); (Alshammari, K.F., McGarry, J. and Higginbottom, G.M.A., 2018).

Although there are mandatory Continuing Professional Development (CPD) programmes on SGBV in the UK, there is a need to add this training to the undergraduate programme from the first year (Bradbury-Jones, C and Broadhurst,K., 2015). Some areas in the UK have started integrating domestic violence into their curricula, but this needs to be done in a consistent manner across all curricula and counties (Bradbury-Jones, C and Broadhurst, K., 2015). There is a need to influence future nurses in terms of their professional stance toward SGBV and for this to influence future clinical practice (Alshammari, K.F., McGarry, J. and Higginbottom, G.M.A., 2018).

Women are often extremely afraid to seek help, which places more importance on nurses being able to ask the correct questions and identify survivors of violence should they ever enter a healthcare facility looking for assistance (Idriss, M.M., 2018).

Some of the healthcare professionals in Latin America and the Caribbean normalize violence, and the patient's presenting conditions, can often be trivialized. There appears to be negligence and ignorance which could be seen as willful on the part of these healthcare professionals (Tsapalas, D., Parker, M., Ferrer, L., et al., 2021). Although there are some national policies in place which are relatively comprehensive, the consistent application of the policies with supportive legislation is lacking (Kafonek, K and Richards, T.N., 2017), and there is a need to further strengthen the collaboration across the various medical sectors as to how they are monitoring and evaluating services. No guidelines have been established, for example, on how forensic evidence should be collected (Stewart,D.E., Aviles, R., Guedes, A., et al., 2015). There is a lack of training in the healthcare sector in all the different aspects of providing care to survivors (Wyatt, T., McClelland, M.L. and Spangaro, J., 2019), especially with regards to training nurses on screening for SGBV. Nurses feel uncomfortable to ask the pertinent questions, and do not feel they are prepared sufficiently during their training as to how they should attempt to ask the pertinent questions, and of concern is that many feel that the subject is taboo to discuss, which stems from cultural norms (Wyatt, T., McClelland, M.L. and Spangaro, J., 2019). The Institutions of Higher Education require guidance in developing and

implementing programmes against SGBV (Kafonek, K. and Richards, T.N., 2017). In the United States there was a seven and a half percent (7.5%) increase in the number of domestic violence calls for help, during the initial twelve weeks of lockdown (Leslie, E. and Wilson,R., 2020). In one study across Latin America and the Caribbean, it was noted that health care workers were normalizing violence based on cultural beliefs (Tsapalas, D., Parker, M., Ferrer, L., et al., 2021). Nurses need to display understanding and empathy, to eradicate SGBV. Specialty nurses such as forensic nurses play an extremely important role in detecting Human Trafficking survivors, as the nursing staff require highly skilled assessment skills to pick up the possible red flags from a survivor (Scannell, M., MacDonald, A.E., Berger, A., et al., 2018). It is critical that nurses can recognize and manage survivors of abuse. In times of crisis like Covid 19 or after Hurricanes like Katrina, it is an interesting phenomenon to notice that violence increases up to three times the norm during that period (Bradley, N.L., DiPasquale, A.M., Dillabough, K., et al., 2020). Nurses need to actively develop their knowledge on the subject and know which resources are available in their areas, that they could refer women to for assistance (Bradley, N.L., DiPasquale, A.M., Dillabough, K., et al., 2020). Although different campaigns have been released in these areas, including nurse-family home visits, the nurses in this area still felt that they required additional guidance on how to efficiently address SGBV, and in fact felt that they did not feel they had sufficient knowledge on the subject (Jack, S., Kimber, M., Davidov, D., et al., 2021).

2.6. CONCLUSION

In this chapter a background has been given drawn from the literature relating to the extent of SGBV and the efforts made to prevent and manage the problem. It has also motivated for the need to improve the education and training of health professionals, and nurses in particular, to manage this scourge. In the next chapter the methodology used in this study will be described.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

In this chapter the research methodology applied to this study is explained, which includes the research setting, the sampling process, data collection methods and analysis. Reliability and validity as well as ethical considerations are included.

3.2 RESEARCH DESIGN

This study used qualitative methodology in four sequential phases. Qualitative research is a research method which is used to explore real world issues. It gathers information on the meanings of phenomena, that have been experienced by individuals in their natural environments. It focuses on obtaining people's stories and insights. (Brink, H., van der Walt, C., van Rensburg, G., 2018). Phases one to three were used to inform phase four of the study where a programme was developed using the data from the first three phases using the ADDIE model as a tool guide.

3.3 RESEARCH SETTING

Participants from three different, but related, research settings were included. In the first phase interviews were conducted within five NGOs (Non-governmental organizations).

The NGO's all provide services to or on behalf of survivors of sexual and gender-based violence and provide specialist services for this purpose. All NGO's were National Organisations, although they were interviewed in Gauteng. The services they offered were as follows:

- NGO number one is an institution that aims to preserve family life with remedial and preventative services
- NGO number two works with survivors that need justice done and they work against any long-term violence issues that are generational
- NGO number three is a 24 hour telephonic organisation that offers counselling and referral in all areas that would support a SGBV survivor
- NGO number four and five work as trauma counselling centres to address any

needs a SGBV survivor may need

In the second phase, interviews were conducted at a Primary Health Care Clinic. These clinics are the first level of contact for patients in the District Health system. In the third phase, interviews were held with members of the nursing department at a university in Gauteng.

The selected primary health care clinic is situated in an urban area of Gauteng which provides a walk-in service for people with health-related needs including but specializing in sexual and gender-based violence support.
The nursing department in the selected university provides training not only for under-graduate and post-graduate nurses but also runs short courses for nurses in a variety of subjects and specialties including women's health.

3.4 POPULATION AND SAMPLING

3.4.1 Population

Population refers to the units that need to be investigated to obtain the necessary information. The population parameters refer to the size, nature, and unique characteristics that the population share (Du Plooy-Cilliers, F., Davis, C. and Bezuidenhout, R., 2014). The units in this study refer to the participants who either provide a service to survivors of SGBV and/or teach others to recognize and manage survivors of SGBV and are described in the previous section on the research setting.

3.4.2 Sampling

Sampling refers to how a researcher chooses people to participate in the research based on the population outlined according to their parameters (Brink, H., van der Walt, C. and van Rensburg, G., 2018). This helps to refine the available participants from the population. The participants were carefully selected from various settings because they had experience in dealing with survivors of SGBV or had experience in teaching in a blended learning environment. Purposive sampling was used in phase one and three of the study and convenience sampling was used in phase two of the study. Purposive sampling is a type of non-probability sampling and is based on the evaluation of the researcher with regards to objects or participants that represent the study phenomena and are specifically knowledgeable about the subject being studied (Brink, H, van der Walt, C and van Rensburg, G., 2018). Convenience sampling is commonly be known as "availability" or " accidental" sampling and encompasses those objects or participants who are available to

participate in the study (Brink, H, van der Walt, C and van Rensburg, G., 2018).

In the first phase experts from five NGO's were interviewed. They were selected due to their experience in dealing with survivors of SGBV, and the well-known organisations that they represent. The researcher sampled the organization and gave them individual codes, for example, an expert was named E1. The researcher requested to interview senior members of each organization who had a minimum of 2 years' experience in the field. All five NGOs were National Organisations and interviewed in Gauteng. They were selected for the first phase of the study and one person from each took part in the study, besides one organization that selected two staff members to be interviewed simultaneously. The sample size for this phase was five (n = 5).

In the second phase, the researcher invited all nurses who were available to be part of the study at a Primary Health Care Clinic that deals with survivors of SGBV on a daily basis. This was established by the researcher contacting the Registered Nurse in charge. The manager of the clinic however decided that the entire team should participate as they all had a part to play in supporting survivors of SGBV. As a result, two Registered Nurses, a Linkage Officer, an enrolled nurse, a counsellor, and a cleaner took part. The medical doctor and an additional registered nurse who were not available for the focus group were interviewed individually after the focus group. The sample for the second phase was therefore eight (n = 8). The access to some nurses was limited as they were transferred out of the research setting due to unforeseen circumstances. Data saturation was reached when no new data was forthcoming and the participants were re-iterating the same data.

Six (n = 6) academics took part in the third phase of the study, all of whom had at least a Master's degree and experience in nursing education. One is a nurse specialist in psychiatric nursing, one a midwife, one an advanced midwife, one with expertise in policy development and implementation, one in child nursing and one in curriculum development. The participants therefore contributed different but relevant expertise related to gender- based violence and/or curriculum development and education.

3.5 DATA COLLECTION

Although all three phases were originally planned to consist of face-to-face interviews or groups, the Covid-19 pandemic restrictions prevented this happening in phase one and two. It was however possible to hold the focus group in person using while complying to social distancing regulations and requirements. All three phases used qualitative methods. This has been combined into one section.

As three different groupings of participants were included in this study to obtain a broad perspective for developing a programme, data saturation was not considered as necessary for each of the groups of participants. Rather, the researcher followed the suggestion in Saunders et al (2018) that data saturation relates to the data provided by individual participants rather than to the dataset as a whole. The researcher therefore probed each of the participants whether in a focus group or individually interviewed, until the researcher believed she had a full understanding of the participant's perspective and that she had sufficient information to meet the research objectives. The data set comprising all three groupings was analysed as a whole. Participants were coded to maintain anonymity e.g. L3.

3.5.1 Phase one - Semi-structured interviews

The objective of this phase was to solicit opinions of gender-based violence experts on the content for a programme to manage survivors of SGBV. All these interviews took place after Ethics' approval was given and ranged from April 2021 to the middle of July 2021. The interviews lasted various times ranging from twenty-three minutes, fourty-seven seconds to one hour three minutes and thirty-seven seconds.

All individuals were contacted by the researcher telephonically after an initial email had been sent to them, and a mutually convenient time was arranged for the interview. Data collection commenced after ethical clearance was obtained. At the time of first contact, the information sheet (see Annexure 1) was emailed to the participant and consent to participate in the interview (See Annexure 2) was obtained prior to the meeting. In addition, consent to record the meeting (See Annexure 3) was sent and obtained.

Due to Covid-19 regulations prevailing at the time. the interviews in this phase were conducted using Zoom. Zoom meetings are video and audio conferences that facilitate people communicating online. This did not commonly pose problems, but there were occasional connectivity issues which meant words needed to be repeated which caused some frustration. The experts were, however, very positive about this research and eager to give their opinions which assisted in overcoming these difficulties.

The following questions were asked during these interviews (See Annexure 4):

1. Based on your experience of dealing with survivors of sexual and gender-based survivors, could you give me a description of the topics that should be covered in a programme which would assist nurses when dealing with survivors of SGBV?
2. In your opinion, what would be the best way to reach more nurses with a view to training them on the management of SGBV survivors?

3. What is, or should be, the role of primary health care nurses in improving the management of these survivors?
4. What other recommendations could you advise one to be mindful of when training nurses in a programme?
5. Is there anything you would like to add?

3.5.2 Phase two- Focus groups

The objective of this phase was to solicit opinions of nurses on the content and format of a programme for the primary management of SGBV survivors. All these interviews took place after Ethics Clearance was received and ranged from the beginning of October 2021 to the end of October 2021. The interviews ranged from fifty-one minutes forty-seven seconds to one hour three minutes and twenty seconds.

The researcher contacted the District Manager for consent to interview staff members in the clinic by email (Annexure 9). A follow-up call was made to ensure the dates and times of the staff's availability. The inclusion criteria were that they were nursing personnel dealing with survivors on a daily basis and had experience in the management of these survivors. The researcher was given permission in writing and given the name of the medical doctor in charge of the clinic to interview. The Registered Nurse in charge selected the nursing staff to be interviewed according to the inclusion criteria provided by the researcher.

Due to the Covid-19 restrictions being lifted during this period, this focus group took place in person with strict social distancing and sanitizing measures adhered to.

The following questions were asked during this focus group:

1. What do you understand by the term sexual and gender-based violence?
2. How able do you feel to assist survivors of SGBV?
3. If we were to offer a programme to help you manage survivors of SGBV, what would you like to see included?
4. What method of delivery would you prefer for such a programme?
5. What support would help you in dealing with SGBV survivors?

The Doctor and an additional Registered Nurse who were unable to attend the focus group were also interviewed as part of this phase using Zoom. The focus group sat in a circle with appropriately distanced space between each chair. Every person wore a mask and used sanitizer prior to and after the meeting. The researcher explained that discussions held during this interview should stay within the group so that confidentiality is maintained within the

group. The participants were each given a number so that they could identify themselves (e.g. as participant 2) before they responded to any question to facilitate the transcription. Every participant signed a consent form giving the researcher permission to interview them (Annexure 2) and to record them (Annexure 3). The focus group was given the set of questions prior to the meeting being held (Annexure 6) and was also given a printed version of the questions on the day the focus group was held.

When this study was planned, it had been hoped to include nurses from an emergency department at an academic hospital, but this was not possible due to the department being unexpectedly closed. This study was then amended to include only primary health care nurses caring for SGBV survivors, and not those working in a casualty department.

3.5.3 Phase three-Semi-structured interviews

The objective of Phase three was to solicit the opinions of purposively selected educators on content, best method of delivery, and effective presentation methods of a course on SGBV. All these interviews took place after Ethics' approval was given and ranged from the tenth of December 2021 to the twenty-third of December 2021. The interviews ranged from forty-five minutes to one hour and 20 minutes.

The educators were contacted by email and invited to be part to be part of the research. The inclusion criteria for the educators were based on their experience in the subject, the experience in dealing with best methods of delivery of such a programme, and their experience in educating undergraduate students. A follow up email was sent to those who responded positively, which included the questions to be asked (Annexure 7), together with the consent forms which were required to be completed before the interviews took place (Annexures 2 and 3). Once those forms were received, a Zoom invitation was sent to each educator.

Due to Covid restrictions being back in place, the purposively selected educators had to be interviewed via Zoom. The following questions were asked during these interviews:

1. What is your opinion on the subject material that should be covered in a programme for nurses on the management of SGBV?
2. Do you foresee any problems with developing a programme of this nature?
3. What would be the best method of offering a CPD programme on the management of SGBV for nurses?
4. Do you have any other ideas on keeping nurses' training up to date in this regard, for the foreseeable future?

3.6 DATA ANALYSIS

The data from all three phases used Braun & Clarke (Braun and Clarke, 2013) for analysis purposes.

All three phases were analysed separately by the researcher, after which the data was merged to create common themes and sub-themes.

The recordings from all three phases were emailed by the researcher and transcribed verbatim by a commercial transcription company. On receipt of the transcriptions the researcher read the transcriptions and checked that they had been recorded correctly and cleaned the data where necessary which included adding words that the transcription company had not heard correctly or had misunderstood. An agreement of confidentiality was signed with the transcription company before any data was sent to them.

The analysis of the interviews and focus group were all done using Braun and Clarke's (2013) six step process of content analysis, viz:

- Familiarisation with the data has been achieved as the researcher has read through the transcripts repeatedly to establish themes and similarities. All transcriptions were copied into 3 columns, with the script being on the left, and the middle column allowing for themes to be identified and the third column identifying who had stated that information by means of a code e.g., E1 being the code for Expert number 1.
- Coding where preliminary codes were assigned to the different participants and to similar ideas or concepts. Similar ideas were colour coded, for example, all scripts relating to the theme of "lack of training" were colour coded red, and the theme relating to legal matters was colour coded blue.
- Searching for themes amongst the coded data. This was done consistently through every transcript received.
- Reviewing themes to check for consistency and/or similarities
- Defining and naming themes and the sub-themes if there were any. All related themes were then grouped together in Word.
- Writing up of the completed coded interviews was completed. I have added a sample of an analyzed interview as Annexure 8 as an example of my data analysis.

3.7 TRUSTWORTHINESS

Trustworthiness was ensured by using Lincoln & Guba's (1985) five principles as a guide:

Credibility: Credibility refers to a belief that the data is found to be true and that the way that it is interpreted is also based on truth. It is established by asking various questions (triangulation), consistent observation, debriefing with peers, and assessing the intentions of the participants (Brink, H, van der Walt, C & van Rensburg, H, 2018). One of the techniques employed to strengthen credibility was that of member checking. This was done by presenting the findings to those involved which gave them an opportunity to verify or negate the findings. During data collection, the researcher listened deeply to the participants and raised questions and probed to ensure that the participants thoughts were developed which strengthened the findings. In addition, both methods triangulation and triangulation of sources was used as two different qualitative methods to collect data- interviews and a focus group-from three different groupings of participants.

Dependability: Dependability refers to the data stability remaining after being tested over time (Brink, H, van der Walt, C & van Rensburg, H, 2018). Dependability establishes whether the research study's findings are consistent and repeatable. The researcher's supervisor assisted the researcher by challenging how the data analysis and interpretation were done and assisted in the analysis in this respect. The dissertation provided an in-depth methodological description to allow the study to be repeated.

Confirmability: Confirmability ensures that the data represented, reflects the views of the participants, and has not been altered in any way to reflect possible bias of the researcher (Brink, H, van der Walt, C & van Rensburg, H, 2018). All interviews were recorded and transcribed verbatim to ensure that the participants words were captured to avoid researcher interpretation and boas. An audit trail of all the data including digital recording, transcripts and analysis has been kept in a secure location that only the supervisor and researcher have access to. The researcher also engaged in reflexivity with regard to her values and interests in an attempt to be aware of these and not influence the findings. Iterative questioning was used during interviews as well as debriefing sessions held with the supervisor. The researcher collected all the data herself and was able to observe the participant's demeanour during their responses.

Transferability: Transferability refers to the viability of being able to apply the findings in various other contexts. (Brink, H, van der Walt, C & van Rensburg, H, 2018). A thick description of data and detailed records of the transcripts of people interviewed, as well as ensuring that data saturation occurs, has ensured transferability. The researcher provided

sufficient information about the participants and research processes so the reader can decide how it might relate to other individuals, although transferability may be questionable in view of the fact this was a local study.

Authenticity: Authenticity refers to how well the researcher reported the information given in a true and fair manner (Brink, H, van der Walt, C & van Rensburg, H, 2018). Adherence to a sampling framework ensured the inclusion of different groupings of participants who had expert knowledge on the subject matter of the study gained from either theoretical or practical experience or both. In this way a representative sample was included.

Trustworthiness has been achieved by submitting findings to the researcher's supervisor, which ensured that processes and procedures followed were acceptable.

3.8 ETHICAL CONSIDERATIONS

There are important codes of conduct which must be adhered to as a researcher to ensure that fair and moral practices have been followed. Ethical clearance was obtained before any data collection was done (Annexure 11). The participants in Phase one were given an information sheet prior to the interviews been held (Annexure 1), and an Interview guide which detailed the questions to be asked (Annexure 4). These participants also signed two forms prior to the interviews, viz a participant consent sheet (Annexure 2) and a form which consented to the interview being recorded (Annexure 3). The participants in Phase three were given an information sheet prior to the interviews been held (Annexure 4), and an Interview guide which detailed the questions to be asked (Annexure 7). These participants also signed two forms prior to the interviews, viz a participant consent sheet (Annexure 2) and a form which consented to the interview being recorded (Annexure 3). In Phase two each participant of the focus group received an information sheet, with the questions that were going to be asked, and the signed individual consent forms which allowed the researcher to interview them and to digitally record the group.

The participants were made aware of all their rights, namely:

- Anonymity: All participants were assigned a code and their names were removed from any documentation. Although the report quotes what was discussed verbatim, it was not in any way linked to the persons participating. However, it was made clear to the participants that anonymity could not be guaranteed.
- Confidentiality: It was clarified with the participants that any information that was shared would only be shared with the supervisor. The participants were also urged to maintain the confidentiality of the discussions of the focus groups to protect the other participants.

- Privacy: All interviews were conducted in a private venue or over Zoom in a private venue. In the Primary Health Care Centre, an empty room was used; the experts were interviewed over Zoom in a private room, and the educators were interviewed over Zoom.
- Right to fair treatment: Participants were informed that they were free to participate or decline to participate. They were informed that they may choose to withdraw at any stage of the study should they choose to do so at no prejudice to themselves. All participants were treated with respect.
- Right to protection from discomfort and harm: Participants were made aware that there was a counsellor on hand to deal with crisis intervention and counselling, if they so required.
- The researcher was given ethical clearance from the HREC (Annexure 11) for purposes of this study.
- All transcriptions were kept in a secure location, to ensure only the supervisor and the researcher had access to the information.

3.9 CONCLUSION

In this chapter I have described the research methodology and in the next chapter I will describe the findings of the first three phases of the study.

CHAPTER 4

FINDINGS AND DISCUSSION

4.0. INTRODUCTION

In this chapter, the findings of the study are presented. An analysis was done of the content of the interviews conducted with the subject experts, health professionals (mainly nurses) in the field, and educators according to Braun and Clarke's Six Stages of Thematic Analysis, namely familiarisation of the data through reading through the transcripts, coding of similar ideas and concepts, searching for themes and reviewing them, checking for consistency and/or similarity and finally, defining and naming all the themes and sub-themes and report writing (Craver, G.A., 2014). Two main themes were identified during this process, namely the Content of a programme to be developed and teaching and learning such a programme. There were six sub-themes which were derived from the data analysed. These will be discussed in this chapter.

Participants quotes have been written in italics to further expand on the reader's understanding of how the participants have responded. The quotes have been written verbatim, firstly with the quote, followed by the participant code number (e.g. L2) where the letter reflects the group of respondent (L = educator; E = expert and N= nurse) and the number reflects the specific participant in the group.

4.1 FINDINGS

Table 4.1 THEMES AND CATEGORIES

Themes	**Sub-themes**
4.1.1 Content of programme	4.1.1.1 Theoretical basis of SGBV 4.1.1.2 Recognition of SGBV 4.1.1.3 Role of the nurse 4.1.1.4 Support systems
4.1.2 Teaching and learning	4.1.2.1 Curriculum 4.1.2.2 Process

4.1 DESCRIPTION OF THE THEMES

4.1.1 Theme 1: Content of programme

This first theme referred to all the aspects the participants indicated should be included in the programme to assist health professionals to manage survivors of sexual and gender- based violence in Primary health settings.

4.1.1.1 Theoretical basis of SGBV

The theoretical basis for the programme includes the background to SGBV, the statistics both nationally and internationally, as well as the definitions for the different forms of abuse, namely, physical, emotional, economic, and sexual abuse, and includes neglect, stalking and human trafficking.

Providing the theoretical background to this programme is vital as it introduces context and informs nurses of the world-wide extent of SGBV, and its prevalence in South Africa, as well as the vital role nurses' play. The nurses and educators emphasized the importance of information on how widespread the problem is, as they themselves were shocked at the prevalence of it in our country and thought that other nurses would be equally unaware of this.

Participant N1 stated, "*Well, I think people, they don't know the statistics".*

During the discussion, when hearing that eighty-five percent of survivors will seek help at one point in time from a healthcare professional, but in reality many times the survivors are not asked direct questions by medical staff, and the real reason for them seeking medical attention is missed, the nurses indicated that this aspect should be included to conscientize nurses and so equip them to assist the survivor, even if abuse is not confirmed, but it is suspected.

Participant L3 stated that " …*the chances are we have all come across survivors but haven't necessarily seen it. That's the concern"*

One of the participants (N1) that deals with survivors daily added this vital view *"When you compare the statistics, ja, you can see that, well with men it's just drop in the ocean, but with women it's a lot. So, if the nurses can be told about the statistics, I mean I think they can take these cases very seriously. Not that they do not take them seriously, but if they can be told about the stats and how pandemic it is, I think they can take it even more seriously than they do now, you know? And also I think more training should be given to them on topics like the etiology of abuse, SGBV".*

Nurses feel they are not trained sufficiently on the different forms of SGBV and they often battle to diagnose survivors coming into health care facilities, as they are unaware of how the different types of SGBV survivors present themselves. It is important for them to be trained on the full definitions of all forms of SGBV, so that they can play an effective professional role in treating survivors appropriately.

Participant N3 said *"That's the difficult part, even though they say they train us, they train us just to examine to see those injuries and to collect evidence. But the emotional part is another thing, you see the person today and you talk to the person, you realise this person is numb".*

Participant L6 also stated that*" I think because for too long in our country we've seen SGBV as a separate topic. But we don't realise that maybe the patient that's coming in with a recurrent UTI (Urinary Tract Infection) that it's not just a medical problem, and they will keep coming back and we're not actually solving a medical problem".*

Participant L5 said "*I think the important thing for them to firstly understand is what exactly SGBV is. I think it would be great to have a module on that. Where they get to understand what it is, how they would identify it, and I think the most important thing is how to assess a patient who has been involved in a form of SGBV, whether its physical abuse, emotional abuse, sexual assault – because the identification, signs and symptoms will obviously be different, especially if there is no physical evidence of injury- you might miss it. But I think it would be important for them to even pick up behavioural signs and symptoms"*

An issue that arose was that some of the nurses are trained Forensic Nurses, which means they could examine the patient physically, take DNA or other body fluid samples, and represent that survivor in court, if needs be. However, it was felt that many nurses don't even know this avenue of training and should be made aware of what it entails.

The educators indicated that the topic of SGBV gets little attention in the formal undergraduate curriculum. There is one module in third year which covers domestic violence, and in fourth year they have a course in trauma counselling and crisis management at the nursing education institution where the participants were employed.

Educator L6 stated that *"in third year we do domestic violence which covers all levels of violence from child abuse to inter-partner abuse. And then in fourth year we do trauma counselling and trauma management".*

The educators believed training in SGBV needs to be far more comprehensive stating that if definitions of all the different forms of abuse were taught to students, they would be able to identify and manage the patients far more effectively.

Nurses agreed that they would really be empowered by receiving the correct training. They considered that being able to identify survivors and being taught the confidence to ask direct

questions would be helpful. One of the participants (E1) mentioned that it was important for the management of hospitals to support the initiative of training of nursing staff to be given the freedom of asking direct questions.

Although all educators interviewed felt it was critical to include the subject of SGBV in the training of nurses, there was concern raised about the time constraints experienced in teaching a formal programme and how it could be adjusted to include the subject of SGBV. Some felt it could be incorporated into existing programmes, however others felt a more deliberate approach should be implemented. Another concern that was raised was the lack of experience of educators in the field of SGBV. It was recommended that an educator experienced in the subject needed to be training undergraduates as it needed much sensitivity and prior exposure to the subject.

One of the educators and one of the experts felt that it would be beneficial for the nurses themselves to go through some self-assessment programme and possible psychosocial counselling, as they had also possibly been exposed to violence and SGBV in their own lives, which triggered feelings of helplessness in themselves, when they had to deal with a survivor of trauma.

Participant L3 stated when talking about nurses "*..but I think for me the concerning thing is that you often find people in their private lives are subjected to some form of abuse- and because they don't understand it they think it's ok and normal, So at all levels, their own lives as well as at the work place, and then with patients – so those three levels. What happens is we give them the information, but we don't help them apply the knowledge."*

Nurses need to be able to compartmentalize the situation they are dealing with in order to be professional and manage the survivor efficiently, but some nurses battle to do that effectively.

Participant E1 stated that *"I don't like compartmentalization, but at least create some distance between the violence that they are observing and their own experience"*

Participant L4 felt that a CPD course programme could cover all the core aspects vital to managing survivors of SGBV. It was felt that it could perhaps include information on forced marriages, which is still such a problem in our society, and how nurses could help in those situations.

Role play with colleagues was thought to be a method that could really benefit trained professionals and those still entering the field, as to how to manage survivors that present with different forms of SGBV.

4.1.1.2 Recognition of SGBV

While the first sub-theme, the theoretical basis of the programme, dealt with signs and symptoms of abuse from a theoretical perspective, this theme concentrated on the nuances of recognition and how to behave while assessing the patient – not just overt signs and symptoms of abuse and dealt with ways nurses need to be assisted in the recognition process. Nurses play a critical role when dealing with patients on a daily basis and being able to identify possible survivors of SGBV and manage them appropriately. Nurses need to be aware of the trauma the survivors are experiencing and give them appropriate space and privacy when talking to them.

Participant E4 highlighted this situation when they said *"I'm speaking based on my personal experience when I go to the clinics and the hospital, and also what I get from the clients. There's no confidentiality there. They just talk to the client in front of everybody and its embarrassing at times".*

Nurses often notice physical abuse easier because there are signs and symptoms on the body like bruising, cuts, or strangulations marks but other forms of abuse can be missed if nurses are not trained to recognize the presenting signs and symptoms especially emotional abuse. Participant E4 went on to say *"Emotional abuse because its silent and its oftentimes trivialized or ja. I think it's more dangerous than the physical abuse because its present in each and on each and every form of abuse. Sexual abuse, emotional is there, physical abuse, emotional is there, financial abuse, emotional is still there, and its silence, people don't see and its often overlooked"*

Nurses require training on stereotypical behaviours from their first year of nursing so that they are empathetic and do not feel any patient deserves this treatment. Participant E5 illustrated this point by saying, " *So, by the time you are dealing with someone that is about to go into the profession, you are dealing with a very different empathetic person that has grown in their understanding and how to handle it"*

Nurses require very specific skill sets so that they can better respond to these types of situations. They need to be able to recognize "red flags", for example, when a perpetrator answers all the questions that are asked of the survivor. As participant L3 said *" Recognising red flags…dealing with what you don't realise is a perpetrator and survivor together – and the perpetrator is answering all the questions you ask. Then finding a reason to separate the survivor cos there are control issues".*

Understanding how one can read body language, within cultural differences and norms is another important point for nurses to understand and pick up quickly. As participant L2 states

"*if you are not aware of what the normal behaviour would be or the normal reaction would be if something happens you won't know how to read the signs".*

A few of the educators interviewed felt that student nurses should be taught how to ask direct questions from the first year of training. It was felt that a checklist of questions could be asked as a standardized history taking. As one nurse (N3) who was interviewed *said, "A lot of the time the patients will not tell you certain things. So if you are sensitized, then at least you will be able...even when they come here for our specialised clinics, they still do not tell you some of the stuff, so it is stuff that you need to ask. Like the person who has been raped will not tell you that they were sodomised as well".*

Another issue raised by participants was the need for nurses to be trained on the impact that SGBV has on survivors, and how it can affect anyone, across cultures, in any walk or sphere of life. As participant N1 stated, *"it can take 33 times for a person to be abused on average before they come and report it".*

Participant L3 stated that it is also critical for nurses to be trained to pick up signs and symptoms of abuse in children ("*particularly children..and sometimes you pick up a gut feeling..but there is general lack of knowledge in the female population about what they can do and cannot do"*), and to treat every patient with the utmost confidentiality and respect, not making them feel judged or stigmatized. Participant L6 agreed saying *"cos' women and children are being abused..they need to be screened..if you ever look at them as you consult them and if you see any marks you have to ask questions"*.

Another aspect that arose during the interviews that gave rise to the suggestion that psychological support is needed, related to the fact that primary health care facilities are often the first port of call for survivors, but there are still many survivors that are referred by the police, and by the time they arrive have already been subjected to secondary trauma at Police Stations which might make them fearful of opening up to anyone.

Participant E4 stated *" …in the Police Stations I get that a lot…I mean….out of ten clients, eight have been secondary traumatised at the police station. In hospitals, yes we do get, but not as much as in the police stations"*

Participants stated that survivors react differently to one another with respect to different traumatic situations of violence, and therefore need to be managed as individuals and there is no "one size fits all" approach.

"We are not going to respond the same. So if they could stop generalizing, treat each and every person as an individual" (E4)

In order to provide adequate psychological support, as mentioned previously, the experts interviewed felt that nurses need debriefing and containment training, so that they are able to

give psychosocial support but still be able to refer the survivor on for longer term counselling.

Nurses need to be able to recognize "red flags" when dealing with all types of patients, understanding all forms of SBV and how to best manage it.

"*…that is key and parcel to being a professional nurse…is that you are dealing with a person at their lowest. So now its adding an additional layer to it..because now they've been traumatised….they weren't sick- they've been traumatised. There's a different dimension/dynamic that comes into play. But if you prepare a student with establishing a therapeutic relationship, focusing on what the needs of the patient is…you need that in any event as a nurse….you are going to teach them how to communicate and maintain the confidentiality and establish that,,but how would you adapt that relationship depending on the scenario" (L1)*

One of the concerns raised by the nurses interviewed is that gender-based violence needs to be a subject that is spoken about often and not be treated as a taboo subject.

4.1.1.3 Role of the nurse

This sub-theme relates to the caring and supportive role of the nurse as well as their instrumental role in managing survivors of SGBV.

Participants interviewed revealed that if nurses were trained sufficiently, for example, to manage a rape survivor effectively, including knowing, whether they should touch her or not, this would empower them and remove stress from their daily practice.

Regarding assessment, participants believed that nurses need to be trained to ask direct, core questions as a part of their screening procedures when they do history taking to ensure they are not missing any form of SGBV. As one of the experts interviewed stated "*So just you know, asking the question, have you been slapped, kicked or punched? You know, do you have pain that happened out of an altercation with, so not asking are you experiencing gender-based violence, but still asking…."*

Nurses need to be able to stabilize the patient medically as far as their physical condition presents, but they also need to be taught to contain the situation psychologically to prevent secondary trauma occurring. Nurses need to quickly be able to establish a therapeutic relationship, so the survivor feels safe, and comfortable enough to answer direct questions about the reason they are seeking medical treatment.

Survivors need to feel safe so that they will confide in the nurse who is treating them and be able to take them into their confidence. As Participant E2 went on to say "*"I really feel that what that survivor needs at that moment is to feel safe. That is the most vital thing, is like*

when you actually receive this survivor, please treat them with respect"

Patient's rights need to be respected and their rights to self-determination respected. Nurses might feel compelled to tell a survivor to leave their situation, but that decision is not theirs to make. Participant E4 concurred by saying *"I think clients, they should not like, maybe not tell clients what to do. They should give them choice, to choose. Choice on what they want and what they do not want"*

Nurses need to be trained in asking screening questions, because as Participant E5 explained *"the first port of call would be screening, because in most cases people don't present as SGBV, they will present as a clinical condition like a fracture, a bruise, or headache, depression, so those are the presentations. And at the moment we do treat whatever they present with, but we don't screen, and that is where we drop the ball"*

The nurses interviewed agreed that nurses have a vital role in empowering the survivors, advising them of the choices they have.

The experts interviewed highlighted the importance of documenting every detail that a patient presents with, because, often a survivor will come in on multiple occasions, having been exposed to violence once again, and the records will be painting a picture of that abuse, a chronological order of events that would assist the survivor should that case ever go to court. As Participant E5 said *"It doesn't paint an accurate picture that can really defend yourself like, but, for example, people get strangled and there's no bruises, then they pass out. A lot of times because things are not documented, you will just come in, its like painful, no fracture, discharged. But the fact that you were strangled and passed out, which is a very serious assault, it is not documented. And that will paint a better picture when the Court says look, this person was almost killed herself, four or five times previously…..these are the notes, you can see the pattern and the severity".*

Some nurses interviewed expressed anxiety at having to deal with survivors of SGBV and in fact some recognized the fact that they were in denial at recognizing it in a survivor or pretended it didn't exist as they felt ill-equipped to deal with the situation. As Participant L4 stated *"it was not highlighted in my training. It was not even a factor I thought of. And in fact there is a little bit of an attitude of looking down on people that come in with bruises etc. Maybe it's our ignorance on what to do with them. They're probably locked into a SGBV cycle – you know with a boyfriend and don't know how to get out of it".*

Nurses need to be aware of how to contain trauma, when they deal with a survivor caught in this cycle of abuse/violence. They need to be sympathetic and have an educated understanding of where these people are coming from and be able to manage them in a non-judgmental way, regardless of their sexual orientation or gender.

As one of the Participant nurses (N1) said, *"It takes thirty-three times for a person to come and report it. So I have to beat you thirty-three times for you to come and report. So it's very hard. It's very hard to pick up, I mean, the signs of abuse to some individuals because they know how to hide it, you know?*

As some of the nurses interviewed discussed the difficult issues facing survivors of economic abuse, one Participant N1 said *" ..when you ask them, you are being assaulted for a second time, for a third time, why? The person will say I don't have shelter, I don't have food, I don't have money to pay rent, so I'm going to have to be put in that home or in his flat. I can't do anything you know".*

Nurses were concerned as to how they should or could maintain confidentiality and remain in ethically acceptable parameters. L2 said "*not knowing what the legal framework we can work around is..what can we disclose to her..what can we disclose to him?...we weren't all familiar with how to manage that confidentiality agreement".* L3 mentioned that it can be very scary for a first-year nurse to have to report suspected child abuse.

Some of the nurses and educators interviewed (L4, L5, N3 and L6) also felt it would be helpful to teach nurses about the role of a forensic nurse and the possibility of being trained in that area themselves.

4.1.1.4 Support Systems

The support systems referred to are legal support systems that could assist the survivor and the nurse and systems of referral to other professionals that nurses need to be aware of. Participants believe that nurses should be taught what legal resources survivors of SGBV have as a recourse of help and should be aware of what the various Acts in South Africa state about protecting woman's rights and dignity. Nurses also have a legal responsibility toward children that come in for medical attention, where possible abuse is suspected.

As one of the experts (E1) stated " *So I would just say they just need to make it really explicit what the opportunities are and, if someone does present and say I need help, then they should have the information available to advise them as best they can".*

It was suggested (E3) that training on the very important document that survivors can obtain against their abusers, namely a Protection Order, should be given. It would be very helpful if nurses could advise survivors as to how they should go about obtaining one, to enforce distance between themselves and the perpetrator. E3 stated "*..when you discuss the rights to them, you educate them, there's also a little bit of justice...I think when you find yourself in a situation like this in the emotional abuse, it is very good for a person to go and do the Protection Order.."*

All the nurses interviewed concurred that they had some basic idea of the law but very little understanding of what pertained to gender-based violence and how to assist survivors in this regard. They also did not know what their legal obligations were, for example, the process to be followed should they suspect child abuse.

As L2 said "*…and then what is the legal parameters…to protect yourself as well as the hospital/clinic where you're working…as well as the patient"*

L3 went on to say *" so explaining briefly the Domestic Act and the Child Act and all those things. Just to put in perspective-and this could be introduced between third and fourth year"*

Systems of referral refer to other medical professionals and organisations that survivors can be referred to through nurses, to receive counselling, medical treatment and longer-term care. Nurses need to be aware of which organisations fulfil specific roles so that they will not feel alone in their quest to assist survivors of SGBV.

As one of the experts (E2) mentioned "*And if I work with a client and I see but ah-ah, I think that he needs more a specialized services like a, maybe a medical doctor or a psychiatrist or a psychologist, then I can refer the client …."*

Participant E4 concurred saying about nurses *"whether its emotional or sexual or whatever, and they have an inability to deal with it because of lack of training, that traumatizes them. Or as I've said, nurses don't need to become social workers, they just need to be very good referral systems".*

The referral of these survivors is extremely important in empowering them, even if they do not make a choice to leave the situation initially. At least they will be made aware of possible options should the need arise.

4.1.2 Theme 2: Teaching and learning

Teaching and learning in this theme refer to all the elements required to make it possible for a person to gain knowledge, attitudes, and skills, and is therefore divided into the curriculum which refers to the structure issues required, and process. which refers to what must be done to realize the curriculum. Although the focus is to develop a CPD (Continuing Professional Development) programme, many participants interviewed (E4, E5, E6,L2) felt it would be beneficial to integrate SGBV training into the four-year undergraduate degree in a layered format, from describing the basic definitions of the different forms of SGBV, to the identification and management of these survivors.

4.1.2.1 Curriculum

In this sub-theme the ideas of the participants that related to types of curricula are included. During the discussion it was made clear that the curriculum would need to cater for nurses working full-time in the primary health care clinics, but many participants believed that at least some contact learning would be required due to the nature of the programme and the profile of the participants.

Remote learning

As a result, there was some support for remote learning but most of the discussion centered around the reasons for using remote learning, being mainly time constraints, rather than how a remote curriculum would be structured or implemented. One of the educators (L1) who supported the implementation of a remote curriculum did so on the assumption that Covid would continue to influence the way we teach and learn for some time.

When the educators spoke of remote learning, they referred to online learning, where educators and students can remain engaged and connected though online content. This content is delivered through various webinars, online programmes, live internet teaching and other methods of e-learning. The student can then work from home.

One of the concerns raised by Participants E3 was of existing time constraints to train nurses and existing staff. *…" I don't know how we can reach them because they're always busy at work…*"

Participant L3 concurred saying "*we don't have time for a whole week so it will be about how you structure it so that it's the most meaningful for the practitioner as well".*

Contact learning refers to face to face learning between the student and the educator in the same room in an educational facility. The educators gave advice as to how this type of learning could be structured and implemented including the need for pre-reading as expressed by participant L3 who felt that possible pre-reading before a short formal lecture could be beneficial in stimulating a student to think more thoroughly about the subject before the lecture.

Another participant (L1) felt that the programme should be presented as a face-to-face learning experience due to the sensitivity of the topic. This was due to the belief that face-to-face contact would encourage more interaction and feedback.

This idea had support from participant L3 who felt that interactive face-to-face meetings would be really beneficial, in smaller groups, where a video could perhaps be played, and they could identify the "red flags", and then to talk about their own feelings when they see these things, *"cos that's one way of dealing with their own problems and then also saying how they will manage that..".* L3 also suggested that the use of real-life case studies, where

possible, would be beneficial for students to discuss in small groups, as it creates an in-depth learning experience.

Two participants gave advice about the presentation of face-to-face learning saying, "it is important to keep the formal lecture short and to the point, to allow student participation around the issues to be addressed (L3 said *"if you do have a formal kind it must be very short. Not more than a few minutes and the rest must be interaction around the issues you want to address"),* and " a *comprehensive way to teach SGBV would be to have it taught over the whole year, which would create more impact and importance to the subject, as one could then approach the subject far more comprehensively."*(L2).

Blended learning

There was general support for the use of blended learning for this programme. This refers to a teaching style which incorporates face-to-face and online teaching. The reasons given for this related to the need to introduce various types of learning experiences that could not be offered on-line.

Participants L2 and L3 both suggested this format, with participant L2 stating *"ja it's a mixture. We are literally depending on what is the topic or what is the need or how it's been presented. So some might be online, some might be in the workplace, some in the classroom, some in the dem room-so it would be a combination".* L3 concurred saying *"...I will do it both ways, because virtual is accessible".*

The benefit of using standardized patients that have been well prepared was discussed by participant L2, as well as the possible use of movie clips that could perhaps come from a popular television series, for the students to analyse what type of abuse they thought they were seeing. L2 said "*or test their ability to read, recognizing signs/interacting with people/knowing what questions to ask..and practice that in a safe environment..so having a standardised patient that has been prepared".*

Participant L1 and L2 felt it was critical to allow students to practice "counselling" standardized patients, developing their confidence in identifying and managing survivors of SGBV. As L2 mentioned *"Having a module, and you can definitely use simulation to illustrate that or test their ability to read/recognize signs/interacting with with people/knowing what questions to ask...and practice that in a safe environment. So having a standardized patient that has been prepared".*

Participant L4 raised an important point that students need to be taught an integrated approach when dealing with patients. She explained "…*I think we need to get away from the perception that we are dealing exclusively with a "rape survivor"-no, no, no…you're dealing with someone that's come to you mostly with a medical problem..so it's an integrated health*

care approach. They're coming to you for an ante-natal check-up and they have an unusual bruise or fracture or something and what do you do about that? And we're not talking about someone standing in front of you and saying outright "I am a survivor". I know I'm sounding simplistic, but you know what I'm saying. We need to realise it's actually part and parcel of our dealing with patients"

Media

The use of all types of media was also suggested as a teaching method. Participant L4 stated that there is value in using social media as nurses belong to social media groups and they could be used to educate and teach. L4 went on to say "*it gives them a social platform in which they say help".* It was felt that perhaps nurses could even use these platforms to anonymously reach out for help themselves, either personally or with work situations. As L4 *mentioned "..you could have a primary healthcare midwife in a small Primary Healthcare Clinic in Kwazulu-Natal..who can't leave the clinic cos' there isn't someone to take over, and she can't travel cos' she doesn't have the financial resources".*

Participant L4 went on to say that it would also be very useful to have a hands-on manual for nurses to refer to. For example "*..like with maternal mental health…I'm not sure how to approach this woman who has clearly got post-natal depression so let me look at this manual and use some of the very usable tools that are in it".*

Participant L3 felt that many more articles should be published in nursing journals about the subject to educate educators, and to disseminate information. She said, *"A Professional Nurse today is a free journal that's sent to many organisations' paid up members and in there is lots of articles that educators use"*. She went on to say that it would be helpful to have posters at nursing stations with the relevant contact numbers for patient referral e.g., the SGBV Gauteng Hotline number.

Participant L6 expanded on this a little further and felt that it would be useful for nurses to carry "business cards" on them that give a list of possible resources in your area, to hand out to survivors. The size of the cards would make it easy for survivors to hide in a safe, unobtrusive place should they need it.

4.1.2.2 Process

The issues raised under this sub-theme related to concerns that the participants had which may impact on the successful implementation of the programme as well as some positive remarks about the idea of implementing a CPD programme.

There were concerns raised by participant L3 as to the suitability of educator's experience in teaching about this subject. L3 said "*if you have too young educators with not enough experience they will miss the whole drama that's taking place under their noses*". She felt that should the educator not be experienced enough, the gravity of the pandemic in our country might be overlooked, and the nurses would not be adequately trained to discern the "red flags" or other signs and symptoms. Participant L3 went on to say that they felt the educator should at least have 5 years of clinical experience in a clinical area to teach others. There was concern raised about the availability of nurses to access training due to time constraints (E3) and their long working hours, and that is why a CPD programme would be more effective if online material were to be made available.

CPD programmes would also be able to keep abreast of current trends and offer up to date methods of handling situations and relevant advice. It would be essential to include material on ethics and legalities, that would influence the nurse's interaction with the survivors (E4). "*And then CPD is good – to give value-cos people lose interest after a while – so to separate this into various CPD sessions tackling the different kinds. Obviously starting with the more regular types/kinds. It's also important to cover topics/cases/types you don't always see….those that come in silently-the children that come in that's been taken away from parents by the social worker-the nurse doesn't understand the exact background where the baby comes from? So its also recognizing…making the effort to observe…" (L3)*. Four of the participants (E4, E5,E6,L2) recommended integrating training on SGBV from their first year of training.

4.2 DISCUSSION

The discussion of the findings relates to the contributions of the three groups of stakeholders and assist to inform the programme which was developed according to the ADDIE model and is described in the following chapter.

4.2.1. The content of the programme

All three groups made important suggestions regarding the content of the programme.

The experts contributed valuable information based on their experience of managing survivors of SGBV, what should be included in a programme to support nurses and how it should be taught. The emphasis from their point of view should be on providing a holistic service, teaching nurses to screen potential survivors of SGBV and the importance and difficulties related to social and psychological support of the survivors. There was agreement

among the experts that nurses have an important role to play in the management of survivors of SGBV.

The idea of having a comprehensive approach close to the community from where the survivors come, has been successfully trialed in Nepal where they introduced a “one stop crisis management” approach at district hospitals. Here they learned that there is a need to use a specific mental health approach to prevent survivors from committing suicide (Dangal, B., Khadka, M.B., Moktan, S., et al., 2021).

Colucci supported the idea of having a holistic programme that is multi-disciplinary in nature and included training on the identification of cases (Colucci, A., Luzi, A.M., Belasio, E.F., et al., 2019). The experts also proposed that nurses should be aware of the roles of the members of the multi-disciplinary team who provide support for the survivor, and who can assist nurses in the management of survivors.

Cannon supports the opinion of the experts that nurses have an important role to play as they are in a position to improve the care that traumatized patients receive (Cannon, L.M., Coolidge, E.M. LeGierse, J., et al., 2020). To do this, nurses need to be adequately prepared through the education programs they are taught especially with regards to trauma management.

Slutkin, Ransfors and Zvetina, (Slutkin, G., Ransford, M.P.P and Zvetina, D., 2018) further emphasized the need for health professionals to rise up and advocate effective care with new intervention and detection methods in relation to violence in society.

Most of the contributions from the health professionals related to the content they believed should be included based on their perception that, except those who were forensically trained they were ill-equipped to deal with survivors of SGBV, and unable to recognize relevant signs and symptoms. One nurse mentioned that even if she suspected abuse, she would ignore it as she did not know how to handle it. They were unaware of the legal issues surrounding SGBV and said they would not know if survivors were hiding signs of abuse.

In a study done in 2018, which evaluated how prepared and ready newly registered nurses were able to screen patients for domestic violence, it was found that there was a lack of education across all four years of study, rendering qualified nursing staff incompetent at recognizing and managing survivors of SGBV (Wyatt et al., 2019).

The importance of training for nurses was emphasized by Briones-Vozmediano, (Briones-

Vozmediano, E., Maquibar, A., Vives-Cases, C., et al., 2018) who recommended training to increase the frequency of screening, self-efficacy and detection of SGBV.

In another study done, it was reported that nurses do feel there are obstacles to effectively recognizing signs of SGBV, and that definite curriculum changes are needed to address the knowledge gaps (Jack, S., Kimber, M., Davidov, D., et al., 2021). All nurses felt they needed training on trauma containment and how to understand the psychological side of handling survivors to avoid secondary traumatization. They felt ill- equipped to address emotional needs.

The forensic nurses felt that registered nurses needed training in how to ask survivors questions and be able to pick up on body language or other gestures which could be indicative signs of abuse. Forensic nurses indicated a need to be regularly debriefed as the trauma they were dealing with affected them personally.

Debriefing conveys' insight into traumatic situations, it allows for recognition of possible personal biases, and more importantly provides support for nurses following their intervention in possible violent and upsetting circumstances (Drake, S.A., Godwin, K.M., et al., 2020).
All the educators felt it was very important to teach the nurses about the issue of confidentiality and ethics regarding SGBV. One of the concerns raised was that of the lack of confidence among the nursing staff to speak to a doctor and perhaps highlight their concerns of suspected abuse. Nurses need to be taught confidence during their training, and the value of asking direct core questions to the patient (developing a checklist), in their detailed history taking.

The importance of teaching about ethical issues including confidentiality is well supported in the international literature with studies from diverse countries providing evidence of this need. These include India (Suryavanshi, N., Naik, S., Waghmare, S., et al., 2018), Lebanon (Bartels, S.A., Michael, S., Vahedi, L., et al., 2019), The United States of America (Ades, V., Wu, S.X., Rabinowitz., et al., 2019), Canada (Perreault, S., 2020) and Afghanistan (Mannell, J., Ahmad, L. and Ahmad, A., 2018). Wu, S.X., Rabinowitz., et al., 2019), Canada (Perreault, S., 2020) and Afghanistan (Mannell, J., Ahmad, L. and Ahmad, A., 2018).

4.2.2. Teaching and learning

As expected, the educators contributed most to this aspect. The Educators were initially shocked about the high statistics of SGBV prevalence in South Africa, including the evidence that, with respect to women being murdered, the incidence in South Africa is five times higher than the global average (Nduna, M. and Tshona,S.O., 2021). Some Educators indicated that they themselves need training on the relevant material, so that they would feel better equipped to train the nurses, which was an issue highlighted by another educator, that those teaching the subject need to have at least five years of clinical experience.
The World Health Organisation initiated a study in Uganda in 2020, where the aim was to strengthen and impact the health system and the response to women who were survivors of violence. They completed a train the trainer programme with health professionals from three different districts, which proved to be very beneficial to the trainers.

The educators identified a need to obtain training on the subject before they would be able to teach others. This notion is supported by (Keuroghlian, A.S., Mujugira, A and Mayer, K.H., 2021) who state that in order to meet the health care needs of a community, it is critical to train healthcare workers to serve gender and sexual minority people.
Many of the educators discussed when it would be most appropriate to introduce training on SGBV into the training of undergraduate nurses. This was even though they were asked about CPD training for already qualified nurses but served to emphasize the importance of bridging this gap in knowledge before they needed it when working in the clinics.
The results of a study conducted in Spain (Maquibar, A., Hurtig, A., Vives-Cases, C., et al., 2018) indicate that training of undergraduate students is useful in that they learned to identify survivors of SGBV but that the widespread pre-existing myths about gender-based violence persisted even after training.
The value of introducing a CPD programme was well supported by all the educators, although there were concerns that it could become too theory intensive. Blended learning (as suggested by Colucci et al, 2019) was seen as an ideal method to teach this topic.
Suggestions were given about including certain approaches to ensure this programme is student- centered, interactive, and valuable, viz; pre-reading of relevant articles, video clips to analyse as to the different types of abuse being witnessed online, theoretical basics taught online then meeting in small focus groups perhaps with a simulated patient scenario, with relevant debriefing to unpack their learning experiences. Role play with other students was purported as being an excellent training tool.
However, one concern mentioned by almost all the educators, was that the nurses themselves

would possibly need counselling themselves before they could be trained to help others, should they themselves have been a survivor in their lives.
Although published in 2001, the “Practical Approach to Gender Based Violence” produced by the UNFPA (2001) deals with all the issues raised by the educators and was useful in developing the programme described in the next chapter.
All the educators felt that it would be a good idea to include information about how to become a Forensic nurse in a student nurse’s training, so that they are aware of this avenue of specialty that could be followed after they have qualified as a Registered nurse.

The nurses in the group felt that it would be critical to know the stakeholders involved in the industry that could be points of referral and help for survivors e.g., social workers, crisis clinics.
Interestingly, all nurses felt face -to- face training would be more beneficial than an online programme, due to the sensitivity of the matters being discussed. They felt that perhaps an online programme would have less interaction, although it would be of benefit, especially for those living far away from any training centre. They also agreed that role play, and simulation would be of great benefit if it could be included in a programme.

4.3 CONCLUSION

This chapter presented the findings of the research according to the themes and subthemes which resulted from the data analysis of the semi-structured and focus group discussions with the nurses, experts, and educators. The discussion findings were deliberated and supported by literature. Chapter five will explain the Development of the programme.

CHAPTER 5

DEVELOPMENT OF PROGRAMME

5.1 INTRODUCTION

In the previous chapter, the results of the study were explained and discussed. This chapter will explain the development of the programme and will provide an outline of the same. The programme was developed based on the of findings of Phase one, two and three of the study. The ADDIE model was used as a guide for the development of the programme.

This model is used as a tool for instruction and design, and helps developers create programmes that are learner-centered, which is more meaningful and valuable for the learners. There are five phases in the design model namely: Analysis, Design, Development, Implementation and Evaluation.

In the Analysis phase of this model, objectives and possible instructional problems were noted. It was important to establish the existing basis of learners' skills and knowledge, so that the correct method and depth of instruction that is needed would be established. In the Design phase the researcher needed to establish how the learning objectives will be achieved by the learners. The data collected in the Analysis phase is used to establish the most effective strategy of instruction and material that will be covered. Timeframes around activities for learning and their relative feedback mechanisms are also established. The Development phase incorporated the development of the instructional material. This includes the overall framework of learning, and the methods of delivery of such content. This can include elearning. In this dissertation, the first three phases of the ADDIE model were used (Kurt, 2017).

The last two phases of the model were outside the scope of this study. The intention is to

implement the programme and evaluate it at a later stage.

5.2 ANALYSIS

This component of the Addie model is referred to as the "goal setting stage" by Kurt (Kurt, S., 2017). The focus of this stage is the target audience, namely, the nurses working in the primary care settings who need to support survivors of SGBV. It is important that the level of intelligence and skill of each participant is matched, to avoid duplication, and to keep the focus on future education. It is vital to establish the content that is known by the target audience and what knowledge is vital for them to know once they have completed the programme, based on their needs.

This phase was used to identify the knowledge gap of nurses in identifying and managing survivors of gender-based violence. In this study, the knowledge gap was identified by interviewing nurses who dealt with survivors of gender-based violence on a regular, if not daily basis, to illicit their point of view, on what they needed to know, as well as experts in the field who had been involved with managing survivors of SGBV and had insight into the needs of nurses managing survivors. While nurse educators also gave input, theirs was geared more to how the nurses should be trained rather than the gap in their knowledge which is the focus of this phase of the ADDIE model. By identifying the nurses' knowledge gap, it became possible to identify the learning outcomes for the programme in terms of knowledge, behaviour and skills, and also create specific targeted objectives.

The outcome for this programme was therefore:

Primary health Care nurses will be able to identify and manage survivors of gender- based violence, in a knowledgeable and empathetic way.

The next step in the analysis phase was to establish the needs of the learners, which in this case was the nurses, working in Primary Health Care centres.

Primary health care is provided in both clinics and community health centres. The study was conducted in a community health centre in an urban area of Gauteng where there are ten (10) community health centers. In designing the programme, the assumption was made that the needs of the nurses in terms of providing support for survivors of SGBV would be similar in all community health centres. Community health centres are defined as "a facility that normally provides primary health care services (Kwa-Zulu Natal Department of Health, 2001), 24-hour maternity, accident and emergency services and beds where health care users can be observed for a maximum of forty-eight hours (48), and which normally has a procedure room but not an operating theatre." A wide cross section of the community utilizes the services of

the community health centres. People in the areas around each CHC represent different socio-economic, cultural, and religious groups, with most of the people using the services not having access to medical aid funding.

Nurses working in the facility are therefore required to have wide-ranging skills to manage the diversity of patients attending the centre so it was important in developing this programme that they are not specialists in the field of SGBV but need to provide immediate supportive care, rather than long-term care, and understand how, and when to refer survivors to agencies that do specialize in providing support (Kwa-Zulu Natal Department of Health, 2001).

The programme has the following learning objectives:

- To differentiate between the different forms of gender-based violence
- To identify the signs and symptoms of gender-based violence
- To recognize the possible "red flags" and subtle cues for requests for assistance
- To apply the principles of management of survivors of gender-based violence to the care of survivors.
- To refer survivors appropriately to agents supportive of survivors of SGBV.
- To explain the legal framework pertaining to the management of gender-based violence.
- To outline the role of the forensic nurse and opportunities for training in this field of specialization

5.3 DESIGN

In this phase the focus is based on content, subject matter, learning objectives, assessment instruments used, lesson planning, and the selection of media chosen. According to Petersen (Peterson, C., 2003) the researcher will be planning and doing research in this phase. Stapa and Mohammed state that this is a critical phase for strategically planning the development of the teaching and to outline the methods to achieve effective teaching (Stapa , M.A.and Mohammad, N., 2019)

In this phase decisions need to be made to include strategies that will achieve the objectives set, and to do this, the information from the analysis phase needs to be carefully considered. The best methods to deliver the programme material were considered, taking into consideration the background of the learners and the planned objectives for the programme. The best method chosen was blended learning which can be extremely effective in training healthcare professionals (Colucci, A., Luzi, A.M., Belasio, E.F., et al., 2019). Blended learning is defined as a combination of instruction via technology with face-to- face

instruction (Leidl et al., 2019). With maximizing technology i.e., the use of the internet and online programmes, one can provide another method of delivering content online (Leidl, D.M., Ritchie, L. and Moslemi, N., 2019). For the purpose of this programme the technology was used within a contact session as not all the nurses have internet connection at home, and this allows for access to on-line resources. To remain current with the development of skills, technology and knowledge is critical for nurses who need to provide consistently excellent care. Nurses face demands in their workplace on a daily basis that often influence their long-term commitment to stay within the nursing workforce and affects how they are able to deliver care.

An instructional analysis would need to be performed so that the researcher can determine the volume of instruction required to fulfil the task and the needs analysis. The nurses would need to do this programme in on-duty time or on a day when released from duty for the specific purpose of training or whenever they are able to. The educators need be well versed in the subject of gender-based violence to facilitate training effectively and meaningfully, providing ongoing support online, and in the classroom would have to be available to students who feel that studying this subject may raise uncomfortable feelings as they themselves are walking through abusive situations.

An important part of this phase is to determine how the objectives can be assessed (Peterson, C., 2003), and how they will be assessed. It is also vital that the assessments and the objectives align.

In summary, the reasons that this selection of learning method was chosen were:

- This method was an excellent way to introduce a sensitive topic with online personal assessments, and video clips to assess
- It could fit in well with the nurses' schedule, being highly adaptable as to when they could start their on-line interaction
- Smaller face-to-face groups would prove to be highly beneficial as one could choose the level of exposure to the subject before the time.
- Pre-reading could be recommended prior to the students going online or meeting

5.4 DEVELOPMENT

Once the set outcomes were established, as well as the instruction method, the next phase was to create, develop and organize the learning material which is to be used in the programme. This programme was developed by the researcher in consultation with the Supervisor. An outline of the programme was initially designed to help guide the specific material which needed to be developed. The programme was developed to run in sequence, but it can be offered over a period of time to enable better access.

5.4.1. The outline of the programme

Table 5.4.1. The outline of the programme

Objective	Planned activity
1. To differentiate between the different forms of gender-based violence	Pre-reading / watching of video online followed by Contact session 1 lasting 3 hours Includes icebreaker, didactic input and discussion groups.
2. To identify the signs and symptoms of gender-based violence	
3. To recognize the possible "red flags" and subtle cues for requests for assistance	
4. To apply the principles of management of survivors of gender-based violence to the care of survivors.	Pre-reading: Principles of management of survivors of SGBV followed by Contact session 2 lasting 4 hours 20 minutes Includes video online, role plays, didactic input, simulation with a standardized patient and discussions
5. To refer survivors appropriately to agents supportive of survivors of SGBV.	
6. To explain the legal framework pertaining to the management of gender-based violence.	Pre-reading: Legal framework and role of forensic nurse followed by Contact session 3 lasting 3 hours 15 minutes Includes didactic teaching, gaming and group discussion Visit to Thuthuzela Clinic 2 hours the following day
7. To outline the role of the forensic nurse and opportunities for training in this field of specialization	

Pre-reading is required to maximize the contact time available but may also include on-line videos to prepare the nurse for the next session. Each of the contact session includes a variety of activities to keep the nurses stimulated and involved and includes opportunities to discuss problems and issues within the safe space of the classroom.

This programme could be divided into three sessions which will be listed below. This enables the educators to plan accordingly and to allow the nurses for some thought around each sensitive topic.

5.4.2. Lesson plans for contact sessions

5.4.2.1. Lesson Plan 1

Objective/s:

- To differentiate between the different forms of gender-based violence
- To identify the signs and symptoms of gender-based violence
- To recognize the possible "red flags" and subtle cues for requests for assistance

Table 5.4.2.1. Lesson plan for first session

Duration	Activity	Rationale and resources
15 min	**Ice Breaker:** Sharing three things with another person in the room about yourself. **Instructions to participants:** You have each been given a piece of paper in front of you to write your name on. Fold it till we cannot see your name, then put the paper in the bowl in the middle of the room. When we have all done this the facilitator will mix the papers well. Each person will then come draw one name. You have five minutes to find that person, introduce yourself and learn three things about them, and vice versa that you can share with the class. (Pratama, L.D. and Setyaningrum, W., 2018)	Paper, pens, bowl Ice-breakers assist nurses to de-stress from their work environments, help them engage with one another, have fun, relax more and therefore be more open to learning.
40 min	**Slide/video presentation** The facilitator will play scenes of SGBV, stopping after each one to allow the nurses to discuss in their groups as to whether they thought gender-based violence took place, and if so, what type. After this they will be divided into groups for discussion. **Instructions to participants:** We are going to divide you into small groups. Can you discuss in your groups and then share with the class a definition of gender-based violence that you as a group have developed based on what	Video equipment, white board, and pens Videos enable nurses to witness scenes of SGBV in a safe space and therefore learn to recognize types.

	you have seen in the videos? You are asked to write the definition on the white board provided.	
45 min	**Slide presentation: signs and symptoms of the different types of abuse.** The facilitator will play the slides and explain each type, including the prevalence of SGBV. . https://video.search.yahoo.com/search/video?fr=mcafee&ei=UTF-8&p=video+showing+gender+based+violence+hand+sign+for+help&type=E211US885G0#id=1&vid=0fecbe0059bd7c1c76c49f6eb51dacc2&action=view **Instructions to participants:** Having watched the slide presentation and the videos, discuss in your group experiences you have had, either in your community or at work, when you came into contact with a survivor of SGBV. • How did it make you feel? • How did watching the slides and videos make you feel? • What assistance do you require to manage survivors of SGBV?	Video equipment Laptop Nurses from the Primary health care centres may not be aware of these red flags or possible signs and symptoms as they are often subtle. This session also gives them a chance to verbalize concerns they may have.
20 min	**Groups discussion:** The facilitator will pose a question to the groups: What is meant by the cycle of violence? **Instructions to participants**: Use the resources provided to look up information about The Cycle of violence and present your findings to the class The facilitator will summarise all the points raised and bring the discussion to a conclusion.	Laptop or Tablet This induces discussion and collaboration and keeps the training student-centered
40 min	**Fishbowl exercise**: The facilitator will provide feedback sheets and ask each participant to complete it anonymously, put it into a bowl. They will be asked to describe what they have learnt from the session if they have any comments or questions they would like answered. Facilitator then takes one out at a time, reads it and facilitates a discussion or answers questions.	The anonymity of the exercise enables participants to ask questions or make statements they would not otherwise have asked.

20 min	**Wrap up time and time of debriefing** Facilitator provides contact details of a counselor should participants need assistance. Debriefing is facilitated with participants involved Facilitator also gives out reading / instructions for session 2.	Session may have solicited stress and uncovered hidden memories of personal trauma
Total time: Three (3) hours		

Table 5.4.2.2 Lesson plan 2

Objective:

- To apply the principles of management of survivors of gender-based violence to the care of survivors

Table 5.4.2.2 Lesson plan for second session

Duration	Activity	Rationale and resources
20 min	**Icebreaker quiz:** This quiz will involve the principles of management of SGBV as well as the signs and symptoms AND "red flags" of SGBV **Instructions to participants:** We are going to divide you into two groups. I will give you the topic and then each team will give me an answer and we will go from one team and one answer to the other. The first team that hesitates will lose a member of their team. This will carry on till we have a winning team or member.	Paper and pens Nurses will often have had an opportunity to consider the previous session's input and having read the principles of management given to them will now be able to start applying that information. A quiz provides for some competition and collaboration amongst team members.
20 min	**View a video of the role of a nurse:** The different forms of SGBV, the signs and symptoms and possible "red flags". **The facilitator** will play the videos which demonstrate the role of a nurse and the critical role they play in our health care facilities. The second video will be stopped at seven minutes and 20 seconds as the last part has to do with the American Healthcare facilities. **Follow the link:** **https://youtu.be/Qc_GHITvTmI and https://youtu.be/28oed_v9p0M**	Video equipment Laptop This activity is aimed at reinforcing the important role nurses play
60 min	**Slide presentation on role of the nurse:**	Video equipment

	The facilitator will present slides on the most important components of treating a survivor/suspected survivor of gender-based violence. It will include the importance of being able to make an initial assessment of the necessity for medical treatment, for example stitches the importance of accurate history taking, to know how to ask direct questions to the survivor. It will include all the basic psychosocial training on how to listen empathetically and non-judgmentally, being able to assess the situation, how to make the survivor feel safe and ensure their safety, what important tests need to be done, for example in the case of a rape case and the timing thereof, what emergency medications need to be given to the patient and by when.	Laptop These PowerPoint slides will build on the information given in the previous session from the point of view of a professional person and ensure any misunderstandings are clarified. It aims at empowering the nurse to manage the survivor of SGBV with confidence.
15 min	Tea break	Tea/coffee/ Light refreshments
45 min	**Role play in pairs: 1 survivor and 1 nurse** The skill of asking direct questions. The facilitator will give detailed instructions on how to play each role. **Instructions to participants:** I am going to give the "nurse" a detailed case study of the survivor she is treating. You will be practicing asking direct questions (as per the handout that I give you). The roles will switch once you have completed your questions.	Paper with prepared questions for nurses This activity is aimed at building confidence in nurses as they engage in asking direct questions
60 min	**Simulation activity with a standardized patient** Rooms set up as they are in a PHC centre. A standardized patient who has been trained to be an SP will be utilized and will be specifically briefed about the role she is to play in this scenario. Debriefing will be provided for the SP and the participants. **Instructions to participants:** We are using a standardized patient for this exercise. She is playing the role of a survivor of SGBV and has been specifically briefed on her role to be as lifelike as possible. You will have to manage the patient and will need to apply all the knowledge you have been taught so far to manage her effectively.	Standardised patient This activity is aimed at giving nurses an opportunity to practice everything they have learnt so far in this session, namely, how to recognize a survivor of gender-based violence, how to spot the signs and symptoms and red flags", how to ask direct questions and interact sympathetically.

30 min	**Debriefing:** **Guidelines for debriefing will be discussed.** Debriefing of nurses after their "role play" will also be done to evaluate how they are feeling, and what they feel they could improve on and what the facilitator felt they needed to be more aware of. Ground-rules of confidentiality will be established.	This activity will allow nurses to express what they felt like when addressing survivors of violence. It is also a learning opportunity to practice their skills.
10 min	Wrap up and reminder of the next session to follow	
Total Time: Four (4) hours twenty (20) min		

Table 5.4.2.3 Lesson plan 3

Objective:

- To refer survivors appropriately to agents supportive of survivors of SGBV
- To explain the legal framework pertaining to the management of gender-based violence
- To outline the role of the forensic nurse and opportunities for training in this field of specialisation

Table 5.4.2.3 Lesson plan for third session

Duration	Activity	Rationale and resources
30 min	**Protection orders: Show video** **https://youtu.be/w0KP6f72zig** **Instructions to participants:** We are going to be watching a video first and then, based on a handout I give you, we will discuss certain factors in groups. The facilitator will then hand out the following handout. https://www.saps.gov.za/services/protection_order.php The groups will be asked to find out what a protection order is, when it can be applied and when is it necessary? When they have the answers, one group will volunteer to present the answers to the class.	Video equipment Laptop Paper Pens This activity will reinforce the importance of keeping survivors safe and one possible method of legal recourse.
30 min	**Mix and match exercise on the Acts applicable to SGBV**: (including the legal definition of rape and sexual assault), and the rights of the survivor. The following acts will be discussed, for	Paper, pens This activity is very important as nurses treating survivors

	example The Sexual Offences and Related Matters as Amended Act (SORMA), The Domestic Violence Act, the Children's Act **Instructions to participants:** It is important to know when a survivor's rights are being violated and what protection they are offered legally so that you can accurately advise them. I am going to hand out a series of mix and match information sheets where you need to match the correct Act with the correct statement. For example: Statement: This Act states that Domestic violence includes verbal abuse, stalking and intimidation. This statement would be linked to The Domestic Violence Act	need to know the information necessary to assist survivors. This information might not feel relevant to nurses but they do need to know the survivor's rights and which laws protect the survivors so they can be a source of relevant and helpful information and refer to the correct legal authority.
30 min	**A slide presentation:** Systems of referral **Instruction to participants:** This slide presentation will cover the various referral organisations/people that the nurse can call on to assist in the management and stabilization of the survivor. I will give everyone a copy of the presentation as a handout for you to keep.	Laptop Video equipment Handout This presentation will inform nurses about referral systems that can assist a survivor of SGBV
15 min	Comfort break	
60 min	**Class discussion and Questions and Answers session**: Discuss the role of Thuthuzela/Crisis Clinics in South Africa. Let participants ask the forensic nurse questions **Instructions to participants**: I have invited a Forensic Nurse here today to explain to you what her job entails and how you can be trained in this area should you feel interested in pursuing this path. She will leave plenty of time for your question.	Laptop Video equipment This activity will explain the possibility of a new area of specialization.
30 min	**Wrap up**: Prepare for the visit to a Thuthuzela Centre the following day, where possible. Instructions to participants: We will be meeting at 8am to visit a Thuthuzela centre where you will witness the role-players treating survivors of violence. There are specific ground rules which apply when visiting a centre that treat survivors of violence and we will spend a few minutes explaining them before we leave tomorrow. You will also be given a handout tomorrow to fill in the roles that you	Handouts Pens Transport to the venue

	witness each staff member performing. This will be discussed when we meet again for our next lecture. Please make a note of any questions you may have.	
Total time: Three (3) hours fifteen (15) minutes		

5.5 EVALUATION

Time will be set aside to give the nurses opportunity to provide feedback about the programme. The researcher will give each participant a handout which will ask the following:

- Write down five aspects you have learnt from this programme
- List two aspects you would like to see changed or added

As explained in Chapter Four, the scope of this study only included the first three steps of the ADDIE model, namely Analysis, design, and development. Implementation of the programme is planned to take place as a large-scale implementation whereafter the programme will be evaluated and modified as required.

5.6 CONCLUSION

This chapter presented the development of the programme which was based on the information obtained from the semi-structured interviews with the experts and the educators, as well as the focus groups with the nurses. The following chapter is the final chapter of this research report, where the summary, findings, limitations, recommendations, and conclusions will be presented.

CHAPTER 6

SUMMARY, MAIN FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

6.1 INTRODUCTION

In the previous chapter, the development of the programme and the format with which it could be presented was discussed. This chapter is the last chapter of this research report. In this chapter the summary, and most important findings from this study will be given. The limitations of this research, and the proposed recommendations for a programme in nursing training, education and research will be defined.

6.2 SUMMARY

The purpose of this study was to develop a programme for nurses to manage survivors of sexual and gender-based violence in Primary Health settings. Four objectives were established by the researcher and achieved by the study. Objective number one solicited the opinions of gender-based violence experts on content for a programme to manage survivors of SGBV. Objective number two was to solicit opinions of nurses on content and format of a programme for the primary management of SGBV survivors. Objective number three solicited the opinions of educators on content, best method of delivery, and effective presentation methods of a programme on SGBV, and the last objective was to develop the outline of a programme for nurses on the recognition and management of SGBV.
In this study, one focus group of eight people and fourteen (14) semi-structured interviews were conducted with nurses, educators, and experts in the field of SGBV. The interviews were all directed by interview guides. From these interviews, two themes and six sub-themes emerged. The two main themes that were derived from the study are Content of programme and Teaching and Learning. The main findings will be discussed below.

6.3 MAIN FINDINGS

There is agreement on the part of the Educators, Experts and Nurses that nurses are under - prepared to deal with SGBV. Specific issues that were identified were:

- Nurses not being trained adequately especially related to confidentiality, attitudes, and other ethical issues
- Poor holistic management of SGBV
- Undertrained and underprepared nurses that are unable to recognize SGBV in patients

- Nurses being more equipped to deal with medical issues that emotional situations
- Nurses being unaware of referral systems available for survivors
- Nurses being unaware of the Legal system, the laws that govern SGBV, and the possible protection it could offer
- Nurses being unaware that SGBV is not a stand- alone condition but intertwined in other presenting conditions e.g., a pregnant woman

This study revealed that the educators felt that, in view of the world-wide prevalence and statistics of SGBV in the world and our country, SGBV training should be included and integrated into the undergraduate programme. This training programme should start at undergraduate level and continue through to a CPD programme for nurses employed in the service.

The educators also felt it would be useful if the nurses themselves could go through some form of self-assessment programme and possibly some psychosocial counselling, as they have possibly been exposed to SGBV in their own lives, which could trigger their sense of trauma.

Nurses in the field feel unsupported specifically related to day-to-day issues, new information and debriefing of the staff.

The findings led to the development of the programme which was designed to meet the needs as identified in the study. The ADDIE model proved to be appropriate for designing the programme.

6.4 LIMITATIONS

6.4.1 Methodological limitations

- The sample size was small and confined to a large Primary Healthcare Centre in a metropolitan area in Gauteng. Until this programme is rolled out more widely it is not possible to say whether this programme will be relevant to all Primary Health Care Clinics in all areas of the country

- While the original intention was to hold focus groups, due to Covid, some of the participants had to be interviewed individually online which may have precluded in-depth discussion between participants

- While there are many programs available on the theory of SGBV, practical participative programs with active participation of nurses are limited. It was therefore not possible to compare this study with other studies

- While the educators came from one Academic Institution, the experts, had national and far-reaching experience

- Due to the focus group being attended by nurses of several different ranks, there may have been an element of social desirability bias

6.4.2 Researcher limitations

- Access to some nurses was limited as they had been transferred out of the research setting and redeployed due to the Covid pandemic

6.5 RECOMMENDATIONS

6.5.1 Recommendations for nursing education

Nursing education institutions need to adequately equip nurses with the skills and knowledge they need to manage survivors of SGBV once they have completed their qualification. The researcher suggests that nurses could be better prepared to identify and manage survivors of SGBV by exposing them to the subject from their first year of their undergraduate training continuing into in-service education as trained staff.

- Educators need to integrate practical experience including role plays and use of standardized patients into undergraduate training

- All nurses working in PHC clinics need to attend a programme on the recognition and management of SGBV survivors.

- Nurse educators need to be up skilled in relation to the recognition and management of survivors of SGBV.

6.5.2 Recommendations for research

- A quantitative study should be conducted to determine the baseline knowledge, skills and attitudes of PHC staff in relation to recognizing and managing survivors of

SGBV.

This programme needs to be piloted on a wide scale to a larger number of Primary Health Care Clinics and evaluated and modified according to the findings of that evaluation.

- Further studies need to be established in developing a CPD programme to train an existing workforce who feel ill-prepared in recognizing and managing these survivors. The best methods need to be further researched and established to ensure active participation and involvement of nurses.

6.5.3 Recommendations for practice

- A forensically trained nurse should be employed at every PHC clinic, to manage referrals of nurses as forensic nurses can act as a consultant to PHC staff on a regular basis to assist them to identify, manage and problem-solve issues
- Posters indicating networks of referral should be available in an easily accessible place in the PHC clinics
- Business card size information cards with referral numbers should be made available to be given to survivors to ensure they can be kept in an unobtrusive place
- It is recommended that nurses attend a crisis clinic as part of their undergraduate training for them to receive practical training in how to receive, counsel and manage survivors of SGBV.

6.6 CONCLUSION

This study explored the development of a programme for nurses to manage survivors of sexual and gender-based violence in Primary health care settings. The study highlighted the lack of readiness of nurses to identify and manage survivors of gender-based violence due to the lack of gender-based violence training in their undergraduate training. A programme to prepare nurses at undergraduate and post graduate level needs to be developed and presented in a blended learning format. This will enable nursing educators and clinical stakeholders and experts to advocate the inclusion of gender-based violence training in all aspects of undergraduate nurse training as well as the development of a CPD programme for those that are already registered. This should equip our nursing staff in Primary Health Care settings and empower them to deal with survivors effectively.

REFERENCES

Ades, V., Wu, S.X., Rabinowitz, E., Chemouni Bach, S., Goddard, B., Pearson Ayala, S., Greene, J., 2019. An Integrated, Trauma-Informed Care Model for Female Survivors of Sexual Violence: The Engage, Motivate, Protect, Organize, Self-Worth, Educate, Respect (EMPOWER) Clinic. Obstet. Gynecol. 133, 803–809. https://doi.org/10.1097/AOG.0000000000003186

Aguiar, F.A.R., Dourado, J.V.L., de Sousa, N.S., Ferreira, A.R., Vieira, L.J.E. de S., da Silva, R.M., 2021. Approach about sexual violence against women in the nursing undergraduation course. Enferm. Glob. 20, 315–329. http://dx.doi.org/10.6018/eglobal.460031

Alhalal, E., 2020. Nurses' knowledge, attitudes and preparedness to manage women with intimate partner violence. Int. Nurs. Rev. 67, 265–274. https://doi.org/10.1111/inr.12584

Ali, P., 2017. Gender-based violence and the role of healthcare professionals. Nurs. Open 5. https://doi.org/10.1002/nop2.120

Alshammari, K.F., McGarry, J., Higginbottom, G.M.A., 2018. Nurse education and understanding related to domestic violence and abuse against women: An integrative review of the literature. Nurs. Open 5, 237–253. https://doi.org/10.1002/nop2.133

Autiero, M., Procentese, F., Carnevale, S., Arcidiacono, C., Di Napoli, I., 2020. Combatting Intimate Partner Violence: Representations of Social and Healthcare Personnel Working with Gender-Based Violence Interventions. Int. J. Environ. Res. Public. Health 17, 5543. https://doi.org/10.3390/ijerph17155543

Bartels, S.A, Michael, S, Vahedi, L, Collier, A, 2019. SenseMaker® as a monitoring and evaluation tool to provide new insights on gender-based violence programs and services in Lebanon | Elsevier Enhanced Reader [WWW Document]. Elsevier. https://doi.org/10.1016/j.evalprogplan.2019.101715

Bradbury-Jones, C., Broadhurst, K., 2015. Are we failing to prepare nursing and midwifery students to deal with domestic abuse? Findings from a qualitative study. J. Adv. Nurs. 71, 2062–2072. https://doi.org/10.1111/jan.12666

Bradley, N.L., DiPasquale, A.M., Dillabough, K., Schneider, P.S., 2020. Health care practitioners' responsibility to address intimate partner violence related to the COVID-19 pandemic. CMAJ 192, E609–E610. https://doi.org/10.1503/cmaj.200634

Braun, V., Clarke, V., 2013. Successful Qualitative Research: A Practical Guide for Beginners. SAGE.

Brink, Hilla, van der Walt, C, 2018. Fundamentals of Research Methodology for Healthcare Professionals, 4th ed. Juta and Company, South Africa.

Briones-Vozmediano, E., Maquibar, A., Vives-Cases, C., Öhman, A., Hurtig, A.-K., Goicolea, I., 2018. Health-Sector Responses to Intimate Partner Violence: Fitting the Response Into the Biomedical Health System or Adapting the System to Meet the Response? J. Interpers. Violence 33, 1653–1678. https://doi.org/10.1177/0886260515619170

Bryant, R.A., Schafer, A., Dawson, K.S., Anjuri, D., Mulili, C., Ndogoni, L., Koyiet, P., Sijbrandij, M., Ulate, J., Harper Shehadeh, M., Hadzi-Pavlovic, D., van Ommeren, M., 2017. Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial. PLOS Med. 14, e1002371. https://doi.org/10.1371/journal.pmed.1002371

Cannon, L.M., Coolidge, E.M., LeGierse, J., Moskowitz, Y., Buckley, C., Chapin, E., Warren, M., Kuzma, E.K., 2020. Trauma-informed education: Creating and pilot

testing a nursing curriculum on trauma-informed care. Nurse Educ. Today 85, 104256. https://doi.org/10.1016/j.nedt.2019.104256
Colucci, A., Luzi, A., Emanuele, F.-B., Barbina, D., Mazzaccara, A., Farchi, S., Battilomo, S., 2019. A blended training programme for healthcare professionals aimed at strengthening territorial networks for the prevention and contrast of gender-based violence Un programma di formazione blended rivolto a professionisti della salute mirato al rafforzamento delle reti territoriali per la prevenzione e il contrasto della violenza di genere. Epidemiol. Prev. 43, 177–184. https://doi.org/10.19191/EP19.2-3.P177.057
Craver, G.A., 2014. Not Just for Beginners - A Review of Successful Qualitative Research: A Practical Guide for Beginners. Qual. Rep. 19, 1–4.
Crombie, N., Hooker, L., Reisenhofer, S., 2017. Nurse and midwifery education and intimate partner violence: a scoping review. J. Clin. Nurs. 26, 2100–2125. https://doi.org/10.1111/jocn.13376
Dangal, B., Khadka, M.B., Moktan, S., Khadka, S., Ghimire, R., Dahal, R., Tamang, D.D., Kayastha, S., Jirel, S., Bajagain, G., 2021. Addressing Gender Based Violence (GBV) in rural Nepal with One Stop Crisis Management (OCMC) approach. J. Gen. Pract. Emerg. Med. Nepal 8, 1–5.
Dardis, C.M., Dixon, K.J., Edwards, K.M., Turchik, J.A., 2015. An Examination of the Factors Related to Dating Violence Perpetration Among Young Men and Women and Associated Theoretical Explanations: A Review of the Literature. Trauma Violence Abuse 16, 136–152. https://doi.org/10.1177/1524838013517559
Doran, F., Hutchinson, M., 2017. Student nurses' knowledge and attitudes towards domestic violence: results of survey highlight need for continued attention to undergraduate curriculum. J. Clin. Nurs. 26, 2286–2296. https://doi.org/10.1111/jocn.13325
Doran, F., Hutchinson, M., Brown, J., East, L., Irwin, P., Mainey, L., Mather, C., Miller, A., van de Mortel, T., Sweet, L., Yates, K., 2019. Australian nursing and midwifery student beliefs and attitudes about domestic violence: A multi-site, cross-sectional study. Nurse Educ. Pract. 40, 102613. https://doi.org/10.1016/j.nepr.2019.08.007
Drake, S.A., Godwin, K.M., Wolf, D.A., Gallagher, M., 2020. Evaluation of Fundamental Forensic Knowledge and Perceived Ability in Emergency Nurse Practitioner Education via Forensic Simulation. J. Forensic. Nurs. 16, 22–28. https://doi.org/10.1097/JFN.0000000000000277
Du Plooy-Cilliers F, Davis C, Bezuidenhout, 2014. Research Matters. Retail Mark. Rev. 10, 57. https://doi.org/10.10520/EJC165713
García-Moreno, C., Hegarty, K., d'Oliveira, A.F.L., Koziol-McLain, J., Colombini, M., Feder, G., 2015. The health-systems response to violence against women. The Lancet 385, 1567–1579. https://doi.org/10.1016/S0140-6736(14)61837-7
Ghoshal, R., 2020. Twin public health emergencies: Covid-19 and domestic violence. Indian J. Med. Ethics 01–05. https://doi.org/10.20529/IJME.2020.056
Gordon, C., 2016. Intimate partner violence is everyone's problem, but how should we approach it in a clinical setting? S. Afr. Med. J. 106, 962–965. https://doi.org/10.7196/SAMJ.2016.v106i10.11408
Government, S.A., 2011. National Straetgic Plan concept. Available at: file:///C:/Users/adeleg/Downloads/National-Strategic-Development-Plan-Concept-Note-201213-%E2%80%93-201617.pdf
Idriss, M.M., 2018. Key agent and survivor recommendations for intervention in honour-based violence in the UK. Int. J. Comp. Appl. Crim. Justice 42, 321–339. https://doi.org/10.1080/01924036.2017.1295394
Jack, S.M., Kimber, M., Davidov, D., Ford-Gilboe, M., Wathen, C.N., McKee, C., Tanaka, M., Boyle, M., Johnston, C., Coben, J., Gasbarro, M., McNaughton, D., O'Brien, R., Olds, D.L., Scribano, P., MacMillan, H.L., 2021. Nurse-Family Partnership nurses'

attitudes and confidence in identifying and responding to intimate partner violence: An explanatory sequential mixed methods evaluation. J. Adv. Nurs. 77, 3894–3910. https://doi.org/10.1111/jan.14979

Kafonek, K., Richards, T.N., 2017. An Examination of Strategies for the Prevention of Gender-Based Violence at Four-Year Institutions of Higher Education. J. Sch. Violence 16, 271–285. https://doi.org/10.1080/15388220.2017.1318576

Karnitschnig, L, Bowker, S, Flagstaff, AZ, 2020. Intimate Partner Violence Screening in the Emergency Department: A Quality Improvement Project. J. Emerg. Nurs. JEN 46, 345–353. http://dx.doi.org/10.1016/j.jen.2020.02.008

Kaufman, M.R., Williams, A.M., Grilo, G., Marea, C.X., Fentaye, F.W., Gebretsadik, L.A., Yedenekal, S.A., 2019. "We are responsible for the violence, and prevention is up to us": a qualitative study of perceived risk factors for gender-based violence among Ethiopian university students. BMC Womens Health 19, 131. https://doi.org/10.1186/s12905-019-0824-0

Keuroghlian, A.S., Mujugira, A., Mayer, K.H., 2021. Healthcare worker training to improve quality of care for sexual and gender minority people in sub-Saharan Africa: learning from efforts in Uganda. J. Int. AIDS Soc. 24, e25728. https://doi.org/10.1002/jia2.25728

Kurt, S., 2017. Definitions of The Addie Model. Educ. Technol. URL https://educationaltechnology.net/definitions-addie-model/ (accessed 3.11.22).

Kwa-Zulu Natal Department of Health, 2001. Definitions of Health Facilities [WWW Document]. URL http://www.kznhealth.gov.za/definitions.htm (accessed 2.13.22).

Lanham, M., Ridgeway, K., Dayton, R., Castillo, B.M., Brennan, C., Davis, D.A., Emmanuel, D., Morales, G.J., Cheririser, C., Rodriguez, B., Cooke, J., Santi, K., Evens, E., 2019. "We're Going to Leave You for Last, Because of How You Are": Transgender Women's Experiences of Gender-Based Violence in Healthcare, Education, and Police Encounters in Latin America and the Caribbean. Violence Gend. 6, 37–46. https://doi.org/10.1089/vio.2018.0015

Leidl, D.M. (first), Lauren Ritchie, Neda Moslemi, 2019. Blended Learning in undergraduate nursing education-A scoping review. Elsevier Ltd 10. https://doi.org/doi.

Leslie, E., Wilson, R., 2020. Sheltering in place and domestic violence: Evidence from calls for service during COVID-19. J. Public Econ. 189, 104241. https://doi.org/10.1016/j.jpubeco.2020.104241

Lovi, R., Hurley, J., Hutchinson, M., 2018. Qualitative findings from an Australian study of inter-partner violence content within undergraduate health curriculum. Nurse Educ. Today 70, 1–7. https://doi.org/10.1016/j.nedt.2018.07.012

Lutge, E., Moodley, N., Tefera, A., Sartorius, B., Hardcastle, T., Clarke, D., 2016. A hospital based surveillance system to assess the burden of trauma in KwaZulu-Natal Province South Africa. Injury 47, 135–140. https://doi.org/10.1016/j.injury.2015.08.020

Machisa, M.T., Christofides, N., Jewkes, R., 2017. Mental ill health in structural pathways to women's experiences of intimate partner violence. PLOS ONE 12, e0175240. https://doi.org/10.1371/journal.pone.0175240

Mannell, J., Ahmad, L., Ahmad, A., 2018. Narrative storytelling as mental health support for women experiencing gender-based violence in Afghanistan. Soc. Sci. Med. 214, 91–98. https://doi.org/10.1016/j.socscimed.2018.08.011

Maquibar, A., Estalella, I., Vives-Cases, C., Hurtig, A.-K., Goicolea, I., 2019. Analysing training in gender-based violence for undergraduate nursing students in Spain: A mixed-methods study. Nurse Educ. Today 77, 71–76. https://doi.org/10.1016/j.nedt.2019.01.017

Maquibar, A., Hurtig, A., Vives-Cases, C., Estalella, I., Goicolea, I., 2017. Mapping training about Gender Based Violence in nurse education programmes in Spain: Amaia Maquibar. Eur. J. Public Health 27, ckx187.714.

https://doi.org/10.1093/eurpub/ckx187.714
Maquibar, A., Hurtig, A.-K., Vives-Cases, C., Estalella, I., Goicolea, I., 2018. Nursing students' discourses on gender-based violence and their training for a comprehensive healthcare response : A qualitative study. Nurse Educ. Today 68, 208–212.
McLindon, E., Fiolet, R., Hegarty, K., 2021. Is Gender-Based Violence a Neglected Area of Education and Training? An Analysis of Current Developments and Future Directions, in: Bradbury-Jones, C., Isham, L. (Eds.), Understanding Gender-Based Violence: An Essential Textbook for Nurses, Healthcare Professionals and Social Workers. Springer International Publishing, Cham, pp. 15–30. https://doi.org/10.1007/978-3-030-65006-3_2
Mgopa, L.R., Rosser, B.R.S., Ross, M.W., Mohammed, I., Lukumay, G.G., Massae, A.F., Mushy, S.E., Mwakawanga, D.L., Mkonyi, E., Trent, M., Bonilla, Z.E., Wadley, J., Leshabari, S., 2021. Clinical Care of Victims of Interpersonal Violence and Rape in Tanzania: A Qualitative Investigation. Int. J. Womens Health 13, 727–741. https://doi.org/10.2147/IJWH.S301804
Morrow, S.L., 20050404. Quality and trustworthiness in qualitative research in counseling psychology. J. Couns. Psychol. 52, 250. https://doi.org/10.1037/0022-0167.52.2.250
Muganyizi, P., Mpembeni, R., Darj, E., Axemo, P., 2016. Evaluation of a training program for health care workers to improve the quality of care for rape survivors: a quasi-experimental design study in Morogoro, Tanzania. Glob. Health Action 9, 31735. https://doi.org/10.3402/gha.v9.31735
Nduna, M., Tshona, S.O., 2021. Domesticated Poly-Violence Against Women During the 2020 Covid-19 Lockdown in South Africa. Psychol. Stud. 66, 347–353. https://doi.org/10.1007/s12646-021-00616-9
Neetu, John, N., Casey, S.E., Carino, G., McGovern, T., 2020. Lessons Never Learned: Crisis and gender-based violence. Dev. World Bioeth. 20, 65–68. https://doi.org/10.1111/dewb.12261
Perreault, S., 2020. Gender-based violence: Unwanted sexual behaviours in Canada's territories, 2018. Juristat Can. Cent. Justice Stat. 1,3-26.
Peterson, C., 2003. Bringing ADDIE to Life: Instructional Design at Its Best. J. Educ. Multimed. Hypermedia 12, 227–241.
Piquero, A.R., Jennings, W.G., Jemison, E., Kaukinen, C., Knaul, F.M., 2021. Domestic violence during the COVID-19 pandemic - Evidence from a systematic review and meta-analysis. J. Crim. Justice 74, 101806. https://doi.org/10.1016/j.jcrimjus.2021.101806
Polit, D.F., Beck, C.T., 2008. Nursing Research: Generating and Assessing Evidence for Nursing Practice, Eighth. ed. Lippincott Williams & Wilkins.
Poreddi, V., Reddy, S.S.N., Gandhi, S., P, M., BadaMath, S., Poreddi, V., Reddy, S.S.N., Gandhi, S., P, M., BadaMath, S., 2021. 'Unheard voices': Perceptions of women with mental illness on nurses screening routinely for domestic violence: A qualitative analysis. Investig. Educ. En Enferm. 39. https://doi.org/10.17533/udea.iee.v39n3e03
Potter, L.C., Feder, G., 2018. Domestic violence teaching in UK medical schools: a cross-sectional study. Clin. Teach. 15, 382–386. https://doi.org/10.1111/tct.12706
Pratama, L.D., Setyaningrum, W., 2018. Game-Based Learning: The effects on student cognitive and affective aspects. J. Phys. Conf. Ser. 1097, 012123. https://doi.org/10.1088/1742-6596/1097/1/012123
Randa, Mokoena, 2019. The role of nurses regarding the care and support provided to victims of gender-based violence | Gender and Behaviour. Afr. J. 17, 13664–13672.
Rees, K., Zweigenthal, V., Joyner, K., 2014. Health sector responses to intiate partner violence: A literature review. Afr. J. Prim. Health Care Fam. Med. 6. https://doi.org/10.4102/phcfm.v6i1.712

Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, Burroughs H, Jinks C. Saturation in qualitative research: exploring its conceptualization and operationalization. Qual Quant. 2018;52(4):1893-1907. doi: 10.1007/s11135-017-0574-8. Epub 2017 Sep 14. PMID: 29937585; PMCID: PMC5993836.

Scannell, M, MacDonald, A.E, Berger, A, Boyer, N, 2018. Journal of Forensic Nursing — Vol. 14 Issue 2 — University of Witwatersrand (WITS) — BrowZine [WWWDocument].URL https://browzine.com/libraries/3004/journals/1611/issues/152384562 (accessed 3.12.22).

Sigsworth, R., Vetten, L., Jewkes, R., Christofides, N., n.d. Policing rape in South Africa 13.

Slutkin, G., Ransford, C., Zvetina, D., 2018. How the Health Sector Can Reduce Violence by Treating It as a Contagion. AMA J. Ethics 20, 47–55. https://doi.org/10.1001/journalofethics.2018.20.1.nlit1-1801

Society, A., 2021. Action Society-Funding Proposal. Available at file:///C:/Users/adeleg/Downloads/Action%20Society%20-%20Funding%20Proposal%20-%20January%202021.pdf [Accessed August 21, 2022].

South Africa, South Africa, Department of Justice and Constitutional Development, 2015. The Constitution of the Republic of South Africa, 1996: as adopted on 8 May 1996 and amended on 11 October 1996 by the Constituent Assembly.

Sprague, C., Hatcher, A.M., Woollett, N., Black, V., 2017. How Nurses in Johannesburg Address Intimate Partner Violence in Female Patients: Understanding IPV Responses in Low- and Middle-Income Country Health Systems. J. Interpers. Violence 32, 1591–1619. https://doi.org/10.1177/0886260515589929

Stapa, M.A., Mohammad, N., 2019. The Use of Addie Model for Designing Blended Learning Application at Vocational Colleges in Malaysia. Asia-Pac. J. Inf. Technol. Multimed. 08, 49–62. https://doi.org/10.17576/apjitm-2019-0801-05

Stewart, D.E., Aviles, R., Guedes, A., Riazantseva, E., MacMillan, H., 2015. Latin American and Caribbean countries' baseline clinical and policy guidelines for responding to intimate partner violence and sexual violence against women. BMC Public Health 15, 665. https://doi.org/10.1186/s12889-015-1994-9

Suryavanshi, N., Naik, S., Waghmare, S., Gupte, N., Khan, S., Mave, V., Deluca, A., Gupta, A., Golub, J., Bollinger, R.C., Shankar, A., 2018. Gender-based violence screening methods preferred by women visiting a public hospital in Pune, India. BMC Womens Health 18, 19. https://doi.org/10.1186/s12905-018-0515-2

Temmerman, M., Ogbe, E., Manguro, G., Khandwalla, I., Thiongo, M., Mandaliya, K.N., Dierick, L., MacGill, M., Gichangi, P., 2019. The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. PLOS Med. 16, e1002886. https://doi.org/10.1371/journal.pmed.1002886

The South African Nursing Council, n.d. Code of Ethics for Nursing Practitioners in South Africa [WWW Document]. URL https://www.readkong.com/page/code-of-ethics-for-nursing-practitioners-in-south-africa-1412254 (accessed 3.11.22).

Tsapalas, D., Parker, M., Ferrer, L., Bernales, M., 2021. Gender-Based Violence, Perspectives in Latin America and the Caribbean. Hisp. Health Care Int. 19, 23–37. https://doi.org/10.1177/1540415320924768

UN Women, 2021. Women leaders examine how to end 'invisible emergency' of gender-based violence [WWW Document]. UN Women. URL https://www.unwomen.org/en/news-stories/news/2021/12/women-leaders-examine-how-to-end-invisible-emergency-of-gender-based-violence (accessed 1.15.22).

van der Wath, A., van Wyk, N., Janse van Rensburg, E., 2016. Emergency nurses' ways of coping influence their ability to empower women to move beyond the oppression of intimate partner violence. Afr. J. Prim. Health Care Amp Fam. Med. 8, 1–7. https://doi.org/10.4102/phcfm.v8i2.957

van Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., Oertelt-Prigione, S., 2020. COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. EClinicalMedicine 21, 100348. https://doi.org/10.1016/j.eclinm.2020.100348

World Health Organisation, 2021a. Devastatingly pervasive: 1 in 3 women globally experience violence [WWW Document]. URL https://www.who.int/news/item/09-03-2021-devastatingly-pervasive-1-in-3-women-globally-experience-violence (accessed 3.15.21).

World Health Organisation, 2021b. Violence against women [WWW Document]. URL https://www.who.int/news-room/fact-sheets/detail/violence-against-women (accessed 12.16.21).

World Health Organisation, 2020. Strengthening the health system response to violence against women in Uganda.

World Health Organisation, 2018. WHO: Addressing Violence Against Women [WWW Document]. URL https://apps.who.int/iris/bitstream/handle/10665/275982/WHO-RHR-18.18-eng.pdf

World Health Organisation, 2016. Global Plan of Action to strengthen the role of the health system with a national multisectoral response to address interpersonal violence against women and girls. and against children.

World Health Organisation, 2013. Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines. World Health Organization.

Wyatt, T., McClelland, M.L., Spangaro, J., 2019. Readiness of newly licensed associated degree registered nurses to screen for domestic violence. Nurse Educ. Pract. 35, 75–82. https://doi.org/10.1016/j.nepr.2018.12.010

Yilmaz, E.B., Yüksel, A., 2020. Factors affecting nursing students' attitudes towards violence against women: a cross-sectional study. Cent. Eur. J. Nurs. Midwifery 11, 85–93. https://doi.org/10.15452/cejnm.2020.11.0013

ANNEXURE 1

INFORMATION LETTER FOR INTERVIEWS FOR SEMI-STRUCTURED INTERVIEWS

Development of a programme for nurses to manage survivors of sexual and gender-based violence in Primary healthcare settings

Hello

My name is Adele Greasley; I am a student at the University of the Witwatersrand, studying for a Master Degree in Nursing Education. As part of the course requirements, I am expected to conduct research under supervision.

The purpose of this research aims to develop a programme which will benefit nurses at Primary health care levels, with regards to their management of gender-based violence survivors.

I am extending an invitation to you to take part in this research study.

What is involved in this study: You will be invited to attend a Zoom interview. It is estimated that the interview will take approximately 45 minutes and will be recorded digitally with your consent. You will be asked to discuss what your opinion is on the content of a programme for nurses should be, including the best method of delivery and effective presentation methods of such a programme.

Risks involved in the study: choice of participation in this study is voluntary, and no risks will be attached to participation or not.

Benefits of being in the study: there will be no financial benefits if choosing to participate in this study, however, participants will have access to findings of the study upon completion.

Participation is voluntary: participation in this study will be entirely voluntary, and withdrawal from the study can be done at any time if the participant wished to do so, without the participant being charged or penalized in any way.

Confidentiality and Anonymity: The Researcher will ensure confidentiality within each interview by ensuring that no discussion will be discussed outside the interview, however absolute confidentiality cannot be guaranteed. If a direct quote is made of anything a participant says in the report, this will be done so anonymously, whereby there will be no mention of names.

Approval and permission to do the study will be obtained from the Human Research Ethics Committee, and from the Post Graduate Research Committee of the University of the Witwatersrand.

Human Research Ethics Committee administrator and Chairperson, Professor Clement Penny, may be contacted on this number (011)717-2301 to report any complaints/problems related to the study, or if you would like to understand anything relating to your safety while participating in the study. You may also email on Clement.Penny@waits.ac.za. The telephone number for the Committee secretariat are (011) 717 2700/1234 and the email addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za.

Name and contact numbers:

Researcher: Adele Greasley	(083 957 3241)
Supervisor: Dr. Sue Armstrong	(011 488 3094)

ANNEXURE 2

PARTICIPANT CONSENT SHEET

Development of a programme for nurses to manage survivors of sexual and gender-based violence in Primary healthcare settings

1. I have been given a Participant Information sheet which explains the nature and processes involved in this study, which is attached hereto;
2. I was given time to read it, or had it read to me, in the language I best understand;
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment;
6. I understand that participation will not cost me anything but my time;
7. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purpose of the study would immediately be destroyed, unless I give consent for it to be retained;

Researcher: Adele Greasley (083 957 3241)

Supervisor: Dr. Sue Armstrong (011 488 4272)

Name

Participant:_____

Date:_____

Place:_____

Signature :

_____

ANNEXURE 3

CONSENT FOR DIGITAL RECORDING

I would like to request your permission to digital recording of the interview that will be conducted with you. Your real name will not be used in the interview and these records will not be given to anyone else other than those involved in the study. I will destroy these records once they are no longer required to be used in the study.

Thank you

A.Greasley

MSc. Nursing Education

Department of Nursing Education

University of Witwatersrand

CONSENT TO DIGITAL RECORDING

I....., consent to be interviewed and I understand that this interview will be recorded for the sake of accuracy and reliability. I understand that this consent is voluntary and that once these records are completed its use towards research, they will be destroyed.

Participant signature:…….Date:……..

ANNEXURE 4

INTERVIEW GUIDE FOR SEMI-STRUCTURED INTERVIEWS

Interview questions for experts:

1. Based on your experience of dealing with survivors of sexual and gender-based survivors, could you give me a description of the topics that should be covered in a programme which would assist nurses when dealing with survivors of SGBV?

    Probes:

    - Could you elaborate on that idea?
    - Can you explain why that would be important?

2. In your opinion, what would be the best way to reach more nurses with a view to training them on the management of SGBV survivors?

    Probes:

    - Could you explain this?
    - In your view, how would training nurses effectively assist the level of care in your organisation?

3. What is, or should be, the role of primary health nurses and emergency room nurses in improving the management of these survivors?

    Probes:

    - Tell me more

4. What other recommendations could you advise one to be mindful of when training nurses in a programme?

    Probes:

    - Can you explain why that is important?
    - Tell me more

ANNEXURE 5

INFORMATION LETTER FOR FOCUS GROUPS (PHC nurses and educators)

Development of a programme for nurses to manage survivors of sexual and gender-based violence in Primary healthcare settings

Hello

My name is Adele Greasley; I am a student at the University of the Witwatersrand, studying for a Master Degree in Nursing Education. As part of the course requirements, I am expected to conduct research under supervision.

The purpose of this research aims to develop a programme which will benefit nurses at Primary health care levels, with regards to their management of gender-based violence survivors.

I am extending an invitation to you to take part in this research study.

What is involved in this study: You will be invited to attend a join a focus group interview. It means that you will be interviewed as a group of nurses or educators. The focus group will consist of five (5) people per group, every participant's view will be considered very important, and will not be used against the participant. It is estimated that the focus group will take approximately 45 minutes and will be recorded digitally with your consent. There will be be a co-facilitator who will assist with note taking.

Member of the focus group will be asked to discuss which skills/knowledge they feel would benefit nurses when dealing with survivors of SGBV.

Risks involved in the study: choice of participation in this study is voluntary, and no risks will be attached to participation or not.

Benefits of being in the study: there will be no financial benefits if choosing to participate in this study, however, participants will have access to findings of the study upon completion.

Participation is voluntary: participation in this study will be entirely voluntary, and withdrawal from the study can be done at any time if the participant wished to do so, without the participant being charged or penalized in any way.

Confidentiality and Anonymity: The Researcher will ensure confidentiality within each interview by ensuring that no discussion will be discussed outside the interview, however absolute confidentiality cannot be guaranteed. If a direct quote is made of anything a participant says in the report, this will be done so anonymously, whereby there will be no mention of names.

Approval and permission to do the study will be obtained from the Human Research Ethics Committee, and from the Post Graduate Research Committee of the University of the Witwatersrand.

Human Research Ethics Committee administrator and Chairperson, Professor Clement Penny, may be contacted on this number (011)717-2301 to report any complaints/problems related to the study, or if you would like to understand anything relating to your safety while participating in the study. You may also email on Clement.Penny@waits.ac.za. The telephone number for the Committee secretariat are (011) 717 2700/1234 and the email addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za.

Name and contact numbers:

Researcher: Adele Greasley	(083 957 3241)
Ms Agnes Huiskamp	(011) 488 4272
Supervisor: Dr. Sue Armstrong	(011 488 3094)

ANNEXURE 6

INTERVIEW GUIDE FOR FOCUS GROUPS WITH NURSES

Interview questions for nurses:

1. What do you understand by the term sexual and gender-based violence (SGBV)?

   Probes:

   - Could you elaborate a little more?

2. How well able do you feel to assist survivors of SGBV?

   Probes:

   - In terms of their physical needs?
   - In terms of their psychological needs?
   - In terms of their social needs?
   - In terms of their legal rights?

3. If we were to offer a programme to help you manage survivors of SGBV, what would you like to see included?

   Probes:

   - Could you tell me why this would be important to you?

4. What method of delivery would you prefer for such a programme?

   Probes:

   - On-line?
   - A workbook?
   - A workshop at the workplace?
   - Any other method
     - Can you tell me why you have made these choices?

5. What support would help you in dealing with SGBV survivors?

   Probes:

   - Can you tell me why you have made these choices?
   - Could you elaborate on that point?
   - What support would help you in dealing with SGBV survivors?
   - Tell me more
   - Explain what you mean by that?

ANNEXURE 7

INTERVIEW GUIDE FOR SEMI-STRUCTURED INTERVIEWS WITH EDUCATORS

Interview questions for Educators:

1. What is your opinion on the subject material that should be covered in a programme for nurses on the management of SGBV?

   Probes:

   - Legal matters?
   - Referral systems?
   - How to manage survivors: Psychologically, socially, physically?
   - Counselling skills?

2. Do you foresee any problems with developing a programme of this nature?

   Probes:

   - Can you elaborate on this?
   - How can this best be avoided?

3. What would be the best method of offering a CPD programme on the management of SGBV for nurses?

   Probes:

   - Can you explain what you mean by that?
   - Do you foresee any problems using this method?
   - What would the advantages be?

4. Do you have any other ideas on keeping nurses' training up to date in this regard, for the foreseeable future?

   Probes:

   - Can you elaborate on your idea?
   - Do you have any other suggestions?

ANNEXURE 8: PART OF TRANSCRIBED DATA[SA1]

Transcript of Semi-structured interview held over Zoom on 19 July 2021. Interviewer is the researcher and participant is referred to as E6

Transcript	Analysis	Participant
PARTICIPANT: Yes. And what you are sharing is quite very important. In fact, as we are busy talking about how nurses might have felt less equipped to deal with rape victims, I am thinking of an almost similar situation where victims report their cases to the police. And it is the same situation where, the police are only interested in just taking the statement about whatever might have happened, it is not about what the person is going through at that particular moment, which is very, very important. Because it is very important as to how you deal with the person the first time when the person decides to engage a specific office. Because if, for whatever reason, the intervention, the initial intervention, has not been properly managed, chances are you have made this person to even lose hope on getting the necessary professional intervention. In fact, even when there was a need for this person to either engage a social worker or engage a psychologist, the person might decide to terminate whatever professional intervention that might have been available to this person. So, so, it will be important, especially when we are dealing with nurses because unlike, sometimes you will feel sorry for the police, because well, they are trained for other, you know, things which have to do with police matters. But when it comes to a nurse, I strongly believe that other than medical attention, it is very, very important to also have an idea of how to tap into the human side of this person. So that, even when that person is finally referred, at least the person will have an understanding as to why is there a need for further professional intervention. Because if a person had a terrible experience the first time the person engage with a nurse, chances are that person might not even be willing to be engaged in further interaction with another professional, irrespective of whether that professional is a nurse or any other professional. So, and nurses are even in a privileged position because even before the person might decide to even engage a social worker or a psychologist, the person might want to receive medical intervention, first and foremost before any other intervention. So, I regard nurses as being in a privileged	Nurses don't feel equipped Identifying SGBV survivors Management of survivor and importance of effective management Teach nurses how to help survivors emotionally Referral systems	E6

position to be the first point of reference before all the cases gets to be referred to different professionals. INTERVIEWER: Yes. I totally hear you and I hundred and fifty percent agree with you. And I think that is why it is so important to develop this programme, or to suggest changes in curricula to say how can we best teach them, for example, how do you recognise obvious signs and symptoms of emotional abuse? How do you recognise symptoms of sexual abuse? What is the behaviour in a child or adult?	Nurses are first point of reference	

ANNEXURE 9: PERMISSION FROM GAUTENG PROVINCE, RESEARCH COMMITTEE OF JOHANNESBURG HEALTH DISTRICT

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Research Committee of Johannesburg Health District

Joburg
a world class African city

Dear: Mrs Adele Greasley

Enquiries: Ms. Busisiwe Sikhosana
Tel: Oli 694 3909
Email
:Busisiwe.Sikhosana@gauteng.gov.za
Hillbrow CHC: Administration Building,
Cnr Smith Str. & Rein Street Private
Bag X21 Johannesburg,
South Africa, 2017

8 Sherwood Village, Amplifier Road
Radiokop,
Gauteng
1724

Email: adelelgreasley@gmail.com

8th December 2020

TITLE: Development of a programme for nurses to manage survivors of sexual and genderbased violence in Primary health and emergency care settings
DRC Ref: 2020-08-007

NHRD Ref no: GP 202008 059

OFFICIAL APPROVAL

The Johannesburg Health District Research Committee (DRC) has reviewed your application. This letter serves as approval to access the Districts Health facilities (mentioned below) for the above research.

The following conditions must be observed:

- The facilities in which the research will be conducted are: [redacted]
- These facilities will be visited from: 08/12/2020 to 08/12/2021
- Participants' rights and confidentiality will be maintained all the time.
- No resources (Financial, material and human resources) from the above facilities will be used for the study. Neither the District nor the facility will incur any additional cost for this study.

- The study will comply with Publicly Financed Research and Development Act, 2008 (Act 51 of 2008) and its related Regulations.
- You will submit a copy (electronic and hard copy) of your final report. In addition, you will submit an annual progress report to the District Research Committee.
- Your supervisor and the University of Witwatersrand will ensure that these reports are being submitted timeously to the District Research Committee.
- The District must be acknowledged in all the reports/publications generated from the research and a copy of these reports/publications must be submitted to the District Research Committee.
- You will liaise with the manager/s before initiating the study.

Contact	Sub District	Sub District Manager/ Area Manager	Contact No,	Cell phone
X	ABCEF	Ms Lombuso Matlala	011 440 1259	082 307 0267
		Ms Maria Mazibuko	011 674 1200	082 781 9919
		Mr Peter Mathole	011 213 9603	072 483 6839
	CoJ A	Ms Nelly Shongwe	011 237 8010	082 467 9276
	Col B	Ms Zanozul<0 Mbane	011 718 9656	082 551 5804
		Mr Tebogo Motsepe	011 761 0200	084 655 5420
	CoJ D	Ms Busi Phiri	011 986 0164	082 467 9316
		Mr Vusi Mazibuko	011 582 1504	082 464 9547
		Mr M Monyamane	011 681 8130	082 467 9423
		Ms Olga l<ruger	011 211 8936	083 286 0388

We reserve our right to withdraw our approval, if you breach any of the conditions mentioned above. Please feel free to contact us, if you have any further queries.

On behalf of the District Research Committee, we would lil<e to thank you for choosing our District to conduct such an important study.

Regards,

Prof S. Moosa

Chairperson: District Research Committee
Johannesburg Health District
Date: 8th December 2020

Mrs M.L Morewane
Chief Director
Johannesburg Health District
Date: 08/12/2020

ANNEXURE 10: PERMISSION FROM SCHOOL OF THERAPEUTIC SCIENCES

School of Therapeutic Sciences

Faculty of Health Sciences · Private Bag 3, Wits, 2050,
Tel: +27 11 717· Fax : 27 11 717/086 55·3 -E mail irene.jansevannoord·wyk@wits www.wits.ac.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

18August 2020

Mrs A Greasley
Department: Nursing Education
School of Therapeutic Sciences
Student No: 1960926

Dear Mrs Greasley

PERMISSION GRANTED

[redacted], Head of the School [redacted], hereby grant permission to [redacted] to conduct and distribute an electronic based survey for her Masters entitled *Develop[redacted] Programme for Nurses to Manage Survivors of Sexual and Gender-Bas-ed Violence in Primary Health and Emergency Care Settings* " to interview purposively selected lecturers in the School of [redacted].

Kind regards

[redacted]
Head
[redacted]

THERAPEUTIC Sciences

ANNEXURE 11: PERMISSION FROM HUMAN RESEARCH ETHICS COMMITTEE, CLEARANCE NO. M200636

R 14/49 MS AGreasle

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M200636

NAME: (Principal Investigator)	Ms A Greasley
DEPARTMENT:	School of Therapeutic Sciences Department of Nursing Education Medical School University
PROJECT TITLE:	Development of a programme for nurses to manage survivors of sexual and gender-based violence in primary health and emergency care settings
DATE CONSIDERED:	26 June 2020
DECISION:	Approved unconditionally
CONDITIONS:	This approval applies only to the study sites listed in Annex 1 attached Further sites may be added on presentation of evidence of management approval to the HREC (Med)
SUPERVISOR:	Dr S Armstrong
APPROVED BY:	CB Penny Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	1 December 2020

This clearance certificate is valid for 5 years from the date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and ONE COPY returned to the Research Office Secretary on the 3rd Floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to submit details to the Committee. I agree to submit a yearly progress report. When a funder requires annual recertification, the application date will be one year after the date when the study was initially reviewed In this case, the study was initially reviewed in June and will therefore reports and re-certification will be due early in the month of June each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

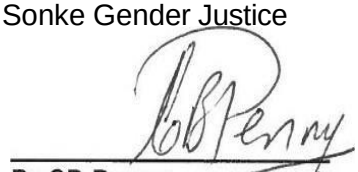
Principal Investigator Signature Date

Annex 1

Protocol No. M200636

Study sites approved under this Clearance Certificate

Study site	Date of HREC (Med) Approval
Centre for Gender-based Violence, Pretoria	2021/04/29
Charlotte Maxeke Johannesburg Academic Hospital	2020/12/01
Hillbrow Community Health Centre	2020/12/01
FAMSA Knysna	2021/04/09
Mamelodi Thuthuzela	2021/04/21
People Opposing Women Abuse (POWA)	2021/07/09
Sonke Gender Justice	2021/07/09



Dr CB Penny
Chair: HREC (Medical)

University of the Witwatersrand, Johannesburg
Date:2021/07/09