EXPERIENCES OF CASUALTY DOCTORS REGARDING THEIR ROLE IN THE MANAGEMENT OF GENDER-BASED VIOLENCE VICTIMS AT THE INTERMEDIATE HOSPITAL, OSHAKATI

BY

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submitted in partial fulfillment of the requirements for the degree of

Magister Artium (MA) in Health and Welfare Management

in the Faculty of Health Sciences at the

Nelson Mandela Metropolitan University

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JANUARY 2011
DEDICATION

This work is dedicated to all cadres of professionals who contribute in diverse ways to the prevention, treatment and/or rehabilitation of gender-based violence victims globally.
ACKNOWLEDGEMENTS

Undertaking a research project entails the cooperation and assistance of several people. It is obviously impossible to list all the people who contributed to the success of this study and indeed my entire M.A (Health and Welfare Management) programme; however mention must be made of a few.

My wife Enoo, and my precious kids, Elo and Ese, who were recurrently denied of valuable ‘family time’ to meet up with the rigours of this programme. Thanks for your understanding. My parents, Mr and Mrs Richard .O. Tachere, siblings and other family members who over the years have made several sacrifices for my upkeep, deserve a special ‘thank you’.

I earnestly appreciate the assistance of my supervisors, Dr Ricks and Mrs Williams, for their inputs from the early conception of this work till the end. I wish to also extend my appreciation to all NMMU staff members for their tutelage, especially the Programme Coordinators, Mrs Sanet Kapp (present) and Mrs Gail Klopper (erstwhile) who both share similar emulative qualities that any distance learning student can ever wish for namely, extremely supportive and prompt in responding to enquiries. Special thanks.

Numerous friends, professional colleagues and associates assisted in actualizing the dream of this post-graduate study, especially Dr A.O. Umunna (who introduced me to this course and acted as a ‘big brother’ all through) and Mrs Eva Velikoshi (Registered Nurse at the Intermediate Hospital Oshakati and Doctoral Fellow at the University of Namibia for her immense assistance). I also wish to mention my colleagues who participated in this research despite their busy schedules. To you all, I say thank you.

Most importantly to HIM, whose name is above all names, the owner and controller of the entire universe — JESUS CHRIST— for giving me life and the grace to undertake this study. To you alone, I give all the glory, praise, honour and adoration!!!
ABSTRACT

The research focused on the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital Oshakati, Namibia. A qualitative, exploratory, descriptive and contextual research design was utilized and data were collected by means of semi-structured interviews. These were audio-taped, transcribed verbatim and analyzed using the Tesch’s method of qualitative data analysis by the researcher in conjunction with an independent coder.

The research findings revealed that the study participants experienced gender-based violence as a common and recurrent public health issue. Participants indicated that the majority of the victims presented with a wide range of physical injuries as well as significant emotional trauma.

With further exploration, it emerged that participants identified alcohol abuse, low socio-economic status and several relationship problems as prevalent factors associated with gender-based violence. They also recognized that the current programme managing gender-based violence provides a measure of safety for victims by making emergency services available. In addition, these services could be accessed free of charge and victims identified as ‘high-risk’ were offered sanctuary in the ward to prevent further harm. Study participants further observed that the presence of a multi-disciplinary team of care-givers also contribute positively to the management of gender-based violence victims.

However, participants experienced several challenges that impair their role in the management of gender-based violence victims. Notable among these are high workload (arising from shortage of personnel and offering services to non-emergency cases in casualty), lack of collaboration among team members and a lack of proficiency in psychosocial intervention strategies.
Based on the study findings, it is hereby recommended that clear guidelines for the management of gender-based violence victims should be established and a better collaboration among all cadres of professionals involved in this issue should be promoted. In addition, campaigns to sensitize the community about values that can help in the prevention of gender-based violence and dangers of alcohol abuse as well as strengthening the legislative framework vis-à-vis implementing punitive measures against culprits, should be vigorously pursued.

Key Words: Gender-based violence; Casualty doctors; Experiences; Intermediate Hospital, Oshakati.
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LIST OF ABBREVIATIONS/ACRONYMS

GBV – Gender-based violence

HIV – Human Immunodeficiency Virus

IHO – Intermediate Hospital, Oshakati

MoHSS – Ministry of Health and Social Services (of the Government of Namibia)

NCIPC - National Centre for Injury Prevention and Control (in the United States of America)

NIH – National Institute of Health (in the United Kingdom)

NMMU – Nelson Mandela Metropolitan University, South Africa

UNDP – United Nations Development Programme

UNICEF – United Nations’ Children and Education Fund

UNIFEM – United Nation’s Development Fund for Women

WHO – World Health Organization
CHAPTER 1:
INTRODUCTION AND OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Gender-based violence is a major public health and human rights problem throughout the world (WHO, 2009:1). According to Heise and Garcia-Moreno (2002:89), gender-based violence occurs in all countries irrespective of social, economic, religious or cultural groups and the overwhelming burden of gender-based violence is borne by women at the hands of men. In support of this, Morrison, Luchok, Richter and Parra-Medina (2006:1495) state that partner violence is a pervasive problem that transcends culture, ethnicity and socioeconomic status.

Four types of violence have been identified; namely: physical, sexual, emotional and economic violence (Pelser, Gondwe, Mayamba, Mhango, Phiri and Burton 2005:9) and these usually occur simultaneously in any combination (WHO, 2005:32). Heise and Garcia-Moreno (2002:89) and Pelser et al. (2005:13) define physical violence as any incident in which a partner may have thrown something at the other that could harm him/her; pushed or shoved her; twisting of an arm; pulling of hair; slapping or hitting; kicking; pushing or exchange of blows; strangulation or suffocation; using sharp objects like a knife and/or the use of guns. This is the form of abuse that commonly comes to the minds of the general public as gender-based violence, probably because of its violent nature and various injuries inflicted on the victims.

Conversely, emotional abuse, according to Pelser et al. (2005:12) is any act in which a partner prevents the other from communicating with other people; limits their movement outside the house and humiliates the partner in front of other people. Emotional abuse also encompasses calling the other crazy; possessed, making threats to hurt them or
harm their children or other members of the family; threatening to damage any of their possessions; or threats to take their life, or that of their children. It is also considered to include instances in which one party might threaten to commit suicide if the partner did not do what they wanted.

Pelser et al. (2005:10-11) further state that economic abuse refers to “any act, within the confines of a marital or household relationship, in which one partner forces the other to hand them money; to ask others for money, food or clothes; preventing one partner from having access to or knowing about the family income, or earning an income themselves; or accessing any research that might enable them to get income. It also includes any situation in which one partner forced the other to be sole bread winner when that responsibility should be shared; or took the money from the other without their consent (including withdrawing of money from their partners' bank account without their partners' knowledge); refrained from paying their partner for work undertaken; forced their partner to work without being paid, or refused to pay monthly child maintenance or support”.

Finally, sexual abuse is defined as “any act in which the partner tried or succeeded in kissing, touching or feeling the respondent’s body against their will; tried or succeeded in having sex, or having any other form of sex (including penetrative, oral, anal or thigh) against their will; force the respondents to watch any of the above in a film or to watch others doing any of the above, against their will. It also includes any instances in which the partner forces the respondent to insert foreign objects into her vagina or anus against her will; forced them to behave in a sexual way with another person while they were watching; or forced the respondent to behave in a sexual way with another person for money or any other form of payment against their will. This broad definition is made to include all forms of sexual behaviour that individuals might be forced into against their will” (Heise and Garcia-Moreno, 2002:89; Pelser et al., 2005:15-16).

Globally, in terms of prevalence, the United Nations Development Fund for Women (UNIFEM, 2008:1) estimates that at least one in every three women has been beaten, coerced into sex, or otherwise abused by a man in her lifetime and more than twenty
percent (20%) of women are reported to have been abused by men with whom they live. Furthermore, results from a multi-country study on Women’s Health and Domestic Violence against Women (WHO, 2005:27; 35) revealed that between 13 and 61% of ever-partnered women have suffered physical violence by a male partner, while between 20 and 75% have suffered emotional abuse. The term ‘ever-partnered women’ as used in this WHO study refers to women who have at least once been or are currently in a relationship with a male partner. Specifically in Namibia, the above-mentioned WHO study shows that 30.6%, 16.5% and 14% of women have been victims of physical violence, sexual violence and emotional abuse respectively (WHO, 2005:28; 34-35).

In another study conducted in Windhoek, Namibia, it was found that 36% of ever-partnered women have suffered physical or sexual or both types of abuse from her intimate partner at some stage in her life (MoHSS, 2004:18). In addition, among those ever injured by an intimate partner, 46% reported that they have been injured once or twice; while 35% have been injured three to five times and 20% have suffered injuries more than five times (MoHSS, 2004:31). The Malawi National Gender-Based Violence Study (Pelser et al., 2005:9) found that physical abuse is the most common (30%) followed by economic abuse (28%); emotional abuse (25%) and sexual abuse (18%). This is similar to the WHO report (2005:27) where the most common type was identified as physical abuse, usually in combination with emotional abuse.

Numerous studies have also examined risk factors associated with gender-based violence and circumstances surrounding the occurrence of abuse. For example, it has been reported that the young age of the male or female partner is a risk factor to gender-based violence (Pelser et al., 2005:25; 29). Similarly, Dawes, Kafaar, Kropiwnicki, Pather and Richter (2004:8) from the South African National Survey on Partner Violence found that with low level of education, the risk of violence against a partner is higher. In Namibia, it has been reported that recent violence is particularly high among young partnered women (15-24 years) and lifetime physical violence shows a declining trend with increased educational level (MoHSS, 2004:22-23).
Furthermore, many studies (for example Dawes et al. 2004:8-9; Rennison and Welchans, 2007:10) have shown that lower income women have a higher rate of gender-based violence. Likewise men of lower income/economic status have higher chances of being involved in gender-based violence. In addition, Tjaden and Thoennes (2000:34) report that the rates of abuse are higher among women whose husbands had either themselves been beaten as children or had witnessed their mothers being beaten.

On the role of alcohol, it has been found that there is a strong link between gender-based violence and both “drinking in the event” and “problem drinking”. Finney (2004:2-3) explains that drinking in the event implies drinking prior to the violence while problem drinking refers to habitual or heavy drinking. Heise and Garcia-Moreno (2002:98) state that women who live with a heavy drinker are at far greater risk of physical partner violence and that those men who have been drinking inflict more serious violence at the time of an assault.

In another dimension, it has also been shown that unmarried, cohabiting couples have higher rates of gender-based violence than married couples. Marital conflict and/or instability among married couples have been identified as a consistent marker to emergence of partner violence. Constant and repeated conflict and arguments lead to physical violence and emotional abuse (Heise and Garcia-Moreno 2002:99; Dawes et al., 2004:8; 52-53 and MoHSS, 2004:24). For example, the 1998 United States of Americas’ national crime victimization survey ranked the risk of gender-based violence with marital status in the order of: divorced, never married/single, cohabiting and married (Rennison and Welchans, 2007:5).

Being unfaithful to the male partner is considered to be one of the major risk factors for gender-based violence. Results from studies conducted all over the world indicate that infidelity is the most frequent reason men give for beating their female partners. The popular belief of men and other people world over is that “an unfaithful woman should be beaten”. Indeed, a number of women do not see anything wrong if their partners beat them when they offend them (Wagman, 2003:7-8; Pelser et al., 2005:30; WHO,
A study in Namibia revealed that as much as 44% of the adult male population believes that “wife beating” is justifiable if the woman neglects the children, argues with the man of the house or refuses sex (MoHSS, 2003:40).

Studies have also shown that in most communities (including Namibia), besides the male partner being seen as the head of the household or as superior with decision making powers, males are also expected to take some disciplinary action on female partners as a way of correcting them (Pelser et al., 2005; 6-7; 30; MoHSS, 2003:40-45). This patriarchal belief has been documented in studies in Africa, Asia and America and tends to support violence against the female partner (WHO, 2005:39-41). Similarly, Rennison and Welchans (2007:7) report that women in urban areas are victims of intimate partner violence at significantly higher rates than suburban women and at somewhat higher rates than rural women.

Undoubtedly, gender-based violence has several consequences. It is well documented that repeated violence over time leads to more serious consequences on the victim than an isolated single occurrence. The United States’ National Centre for Injury Prevention and Control (NCIPC, 2006:1) asserts that the longer the abuse goes on, the more serious the effects on the victim. Most of these consequences (which affect the individual, their families, children, the entire community and indeed the country’s economy) depend on the frequency, types and severity of the abuse (WHO, 2005:55-57; 61).

It has also been documented in Namibia that with regard to women’s assessments of their general health status, women who had any history of sexual partner violence only or both sexual and physical violence, were significantly more likely to report that they had severe or many health problems (like dizziness, severe pain, discomfort, problems with concentration, poor sleep, frequent headaches and so on) than women who did not report a history of partner violence (MoHSS, 2004:27). In terms of physical violence, Tjaden and Thoennes (2000:48) in a record of the common injuries sustained by women in a national survey on violence against women in America, found the following
injuries in the decreasing order of occurrence: scratches and bruises (76.1%), fractures and dislocation (11.3%), lacerations and knife wounds (8.8%), head and spinal cord injuries (8.8%), muscle sprains and strains (6.5%), burns (1.3%) and dental injury (0.8%). Facial injuries were also reported to be the commonest in the WHO multi-country study (WHO, 2005:57-58).

Victims of gender-based violence are also exposed to various sexual and reproductive complications. Abuse during pregnancy has been shown to cause induced abortion and miscarriages (WHO, 2005:63-64). From the Central African country of Cameroon, Alio, Nana and Salihu (2009:318-324) report that women exposed to spousal violence were 50% more likely to experience at least one episode of foetal loss compared with women not exposed to abuse and indeed, recurrent foetal mortality was associated with all forms of spousal violence, with emotional violence having the strongest association. Furthermore, gender-based violence also results in several psychological and behavioural disturbances. For example, Marais, De Villiers, Moller and Stein (1999:635) found that in South Africa the prevalence of psychopathology, severe depression and attempted suicide is significantly higher among victims of gender-based violence. Similarly, mental health problems such as depression and anxiety disorders have also been documented (WHO, 2005:61-62).

More seriously, the death of victims in the hands of their partners sometimes occurs as a result of gender-based violence. Studies from the United States of America found that about 11% of murder victims were determined to have been killed by an intimate partner (Rennison and Welchans, 2007:3-4). Furthermore, Vetten (2003:14) in the review of police record in Gauteng province of South Africa also found that between 1990 and 1999 that at least one woman was killed by an intimate partner every four days. In Namibia, it is suggested that about 40-70% of all female murder victims are killed by their husbands or boyfriends (UNICEF, 2007:1).
On another note, it is important to realize that many victims of gender-based violence actually become suicidal themselves. For example, in Namibia it has been reported that over a quarter of women who have ever experienced physical or sexual partner violence have, at least once, thought of committing suicide. Among those with suicidal thoughts, women who had experienced sexual violence were slightly more likely to have attempted to commit suicide than other women (MoHSS, 2004:29).

Apart from the health impact of gender-based violence, it also places an enormous burden on the society in terms of decreased productivity (loss of man-hour) and increased use of health and welfare services. The Centers for Disease Control and Prevention in 2003 estimated that in the United States of America, the costs of intimate partner violence against women exceed $5.8 billion annually. These costs include nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (NCIPC, 2003:32).

Furthermore, studies have shown that gender-based violence has a negative impact on children who often witness the abuse of their mother. In the United States of America, it was recorded that between 1993-1998 children under the age of 12 resided in 43% of the household where violence occurred (Rennison and Welchans, 2007:8). Children present during such violence have a higher risk of developing a wide range of psychological, emotional and behavioural disorders and could grow up to be perpetrators of violence of any sort including gender-based violence. Indeed in Namibia, it has been reported that women who have experienced physical violence from a partner are more likely to report that their children have nightmares, suck their thumbs, wet their beds, are timid and aggressive, shoplift and have had to repeat a year at school, compared to women who have never experienced partner violence (MoHSS, 2004:35).

One significant point that needs to be mentioned is the help-seeking behaviour of victimized partners which has been noted to vary from place to place, according to the culture of the people. Unfortunately, it is reported that a substantial proportion of
women in violent relationships do not tell others about the violence they are experiencing nor do they seek help (WHO, 2005:79). This finding is similar to the Malawi National study mentioned previously which revealed that many abused women do not report the incidents to anybody as long as the injury is minor; however, some report to the members of the extended family, to the church’s priest, marriage counsellors, traditional leaders, friends of their partner, traditional healers while others report to medical personnel, in order to receive treatment, if the abuse leaves severe physical injury (Pelser et al., 2005:38-42). It has been reported that 21% of victims of gender-based violence in Namibia had never told anybody; while own parents (35%), friends (33%) and siblings (26%) were mentioned as the people to whom they reported the incidents. Professional categories were mentioned much less and range between police (10%); health staff (4%); religious leader or counsellor (1%) each (MoHSS, 2004:36).

The World Health Organization issued guidelines for the management of gender-based violence. These guidelines on the medico-legal care of victims of sexual violence stipulate that they require comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The types of services that are needed include testing and/or prophylaxis for sexually transmitted infections, treatment of injuries and psychosocial counselling. In addition to providing immediate health care, the health sector can act as an important referral point for other services that the victim may later need, for example, social welfare and legal aid (WHO, 2003:2).

The study reported in this document was conducted at the Intermediate Hospital Oshakati, Namibia — a 750-bedded government-owned facility headed by a Medical Superintendent with a complement of professionals in many medical and allied medical fields. It serves Oshakati District in Oshana Region with a catchment of approximately 180,208 people. It also serves as a referral hospital for Omusati, Ohangwena, Oshana, Oshikoto and Kunene Regions in the northern part of Namibia (MoHSS, 2008:3). Its
professional and clinical services are under the auspices of two Chief Medical Officers and the hospital is organized into several departments/units, including the emergency/casualty unit.

The casualty unit operates on a 24-hour basis daily and offers emergency medical services all day in addition to routine medical care after hours, weekends and on public holidays. At the time of conducting this study, eleven (11) casualty doctors (who are full time medical officers or principal medical officers in other departments like Surgery, Paediatrics and Internal Medicine) are assigned to manage the unit on a rotational basis.

The services presently available in this hospital for victims of gender-based violence are coordinated by the Women and Children Protection Unit (WCPU) which is staffed by two social workers and police officers. The Mental Health Department of the hospital (comprising several nurses, one psychiatrist, one medical officer and an occupational therapist with a visiting clinical psychologist) also renders additional services.

However, as alluded to above, many victims of gender-based violence also seek emergency medical services. Indeed, a study in Namibia reports that among the ever injured women, 63% were so badly injured that they needed emergency health care, with as much as 32% of them spending at least one night in the hospital (MoHSS, 2004:31).

As Muellaman, Lenaghan and Pakieser (1998:128) have rightly suggested, future episodes of gender-based violence can be prevented if appropriate identification and referral occurs from the emergency department. Thus, the staff of the casualty department of any hospital can play a tremendous role in the management of gender-based violence victims.
1.2 PROBLEM STATEMENT

From the above discussion, there is no gainsaying the fact that gender-based violence is an enormous problem in Namibia, as in most parts of the world. Namibia is a middle-income developing country in Southern Africa with a population of about 2.1 million people (World Factbook, updated 14/05/2009; at https://www.cia.gov/library/publications/the-world-factbook/geos/wa.html; accessed on 19/05/2009).

Records available at the casualty department of the Intermediate Hospital, Oshakati, Namibia suggest that on a monthly basis, over twenty women (out of the hospital’s catchment of about 180,208 people) are treated for acts of gender-based violence, with the majority of cases presenting during the week-ends (Friday and Saturday nights).

However, from the experience of the researcher (who is a casualty doctor at the above hospital), besides a high prevalence of gender-based violence, there is also a high frequency of recurrence among victims of gender-based violence presenting to the casualty unit of the hospital. A look through the health book of many of the victims actually concur with the findings from the Windhoek study mentioned above that there is a high rate of recurrence of these violent acts. This is the key area that informed the conduct of this study as it is a pointer to an apparent ineffective utilization of available services for gender-based violence victims. Put succinctly, it seems that presently there is lack of effective and holistic collaborative care being rendered to these victims as there is a high rate of recurrence among victims of gender-based violence presenting to the casualty unit of the hospital.

Given that the majority of the victims of gender-based violence at one time or another received emergency medical services; it becomes reasonable that the casualty unit can be effectively used as an entry point of holistic care for these victims. Irrefutably, therefore, casualty doctors being the managers in charge of this unit are in a vantage position to initiate this process in their routine contact with the victims of gender-based violence. Thus, the justification for this study which attempts to explore and describe the experiences of casualty doctors at the Intermediate Hospital, Oshakati regarding
their role in the management of gender-based violence victims, derives from this rationale.

1.3 RESEARCH QUESTIONS

To embark on this study, the following research questions were formulated:

- How do casualty doctors experience their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati, Namibia?
- What measures should be taken to address the ensuing research findings?

1.4 RESEARCH PURPOSE

The purpose of this study is to explore and describe the experiences of casualty doctors with regards to their role in the management of the victims of gender-based violence presenting at the Intermediate Hospital, Oshakati, Namibia. It is intended that findings from this study will be used in making recommendations to hospital managers that will contribute to the management of gender-based violence victims in Namibia.

1.5 RESEARCH OBJECTIVES

This study is aimed at achieving the following objectives:

- To explore and describe the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital Oshakati, Namibia.

- To make recommendations to hospital managers that will address the emergent research findings pertaining to the management of gender-based violence victims in Namibia.
1.6 CLARIFICATION OF CONCEPTS

To ensure that there is uniformity of understanding, the following concepts referred to in this study will be clarified further.

▪ Gender-based violence

The United Nations Declaration on “Violence against Women” defines this concept as: "violence involving men and women, in which the female is usually the victim; and which is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes sexual violence, domestic violence, emotional and psychological abuse, forced prostitution, trafficking for forced labour or prostitution, sexual exploitation, sexual harassment, harmful traditional practices (e.g. female genital mutilation and forced marriage), and discriminatory practices based on gender) (Available at: www.unfpa.org/intercenter/violence/intro.htm; accessed on 29/04/2009)

It is worth emphasizing that this study will focus on violence perpetrated against females by their male partners.

▪ Management of gender-based violence victims

The management of gender-based violence (GBV) requires comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event (WHO, 2003:2).

In the context of this study, management of gender-based violence victims refers to the comprehensive array of services that various care givers can offer/are offering to the victims of gender violence; for example, medical care, psycho-social care, legal services, spiritual care and so on.

▪ Role

The function or position that somebody has or is expected to perform in an organization, in society or in a relationship (Hornby, 2006:1268).
Casualty doctors

In the context of this study, casualty doctors refer to the Medical Practitioners (that is, Medical Officers and Principal Medical Officers) who, on a shift/rotational basis, are in charge of the emergency unit of the Intermediate Hospital Oshakati. They perform clinical duties (attending to patients requiring medical care) as well as management functions (including organizing, leading and controlling all activities occurring during their respective shifts). Thus casualty doctors are, middle managers in the health and welfare sector, coordinating the other cadres of staff on duty (for example, cleaners, porters, nurses and so on) and ensuring that the goals of the entire emergency unit are met. According to Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw and Oosthuizen (2004:10-11), middle managers “receive broad, general strategies and policies from top managers and translate them into specific goals and plans...by coordinating schedules and resources with other managers”.

Experience

Experience is defined as the knowledge and skills that an individual has gained through doing something for a period of time (Hornby, 2006:513). Thus for this study, experiences of casualty doctors regarding their role in the management of GBV victims refer to the knowledge of this issue which they have acquired over time by performing their duties in the casualty section of the hospital.

1.7. RESEARCH DESIGN AND METHODS

This study will employ the research design and method highlighted below.

1.7.1 Research Design

The design of this research is qualitative using the exploratory, descriptive and contextual approach, details of which shall be discussed in the next chapter.
1.7.2 Research Method
The methods for this study include data collection and data analysis. Further details of how data was collected and analyzed in this study shall be discussed in Chapter Two.

1.7.3 Pilot Study
In this inquiry, the researcher will carry out a pilot study by interviewing two purposefully sampled participants following the same design and methods of the main study, as suggested by van Teijligen and Hundley (2001:2). As with the main study, consent will be sought and the emergent data will be analysed according to the analytic process to be used for the main study. The findings of the pilot study and the lessons learnt will be used to guide the methodology of the main study.

1.8 LITERATURE CONTROL
As suggested by Creswell (2003:30), in this study, literature will be used as a control by acting as the basis for comparing and contrasting findings of the study with existing knowledge once patterns, themes and categories have been identified.

1.9 TRUSTWORTHINESS
Trustworthiness is the term used to describe the criteria for judging qualitative enquiry (Morse, Barrett, Mayan, Olson and Spiers, 2002:5). For this study, the criteria that will be used are credibility, transferability, dependability and confirmability. In-depth discussion of these shall be given in the next chapter.

1.10 ETHICAL CONSIDERATIONS
An important point the researcher will conform to will be the issue of the ethics to guide the study. Ethics refers to a set of widely accepted moral principles that offer rules for, and behavioral expectations of, correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students (de Vos, Strydom, Fouche and Delport, 2004:75).
In this study, the important ethical issues that will be adhered to include, amongst others, preventing harm to or deception of participants and other stakeholders; ensuring that respondents give informed consent; and striving for competence in carrying out the study with honesty. Other measures pertain to the issues of privacy, anonymity, and confidentiality, the right of participants to take part and withdraw voluntarily if they so please. Further discussion of these issues as they affect this study will be given in the next chapter.

1.11 DISSEMINATION OF RESULTS

Dissemination of the results of the study will be as follows:

• The results of the study will be printed, bound and sent to relevant authorities including the Namibian Ministry of Health and Social Services as well as the Ministry of Gender and Equality. The final report will be written in formal style, using the guidelines of the Nelson Mandela Metropolitan University for Master’s Dissertation.

• The final report will also be available in the Nelson Mandela Metropolitan University Library, where it can be accessed by all and sundry.

• At least one article will be prepared for publication in a relevant and recognized professional journal.

• Findings of this study will be disseminated via the presentation of papers in appropriate seminars and conferences.

1.12 STUDY OUTLINE

The report of this study shall be presented in chapters as follows:

CHAPTER 1: Introduction and overview of the study.
CHAPTER 2: Research design and methods

CHAPTER 3: Discussion of results and literature control

CHAPTER 4: Limitations, Summary, Recommendations and Conclusions

1.13 SUMMARY OF CHAPTER

This chapter has introduced the inquiry, which is a qualitative research study on the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati, Namibia. It is rooted in naturalistic philosophy; therefore it will be designed in an exploratory, descriptive and contextual format, using semi-structured interviews of purposively sampled members of the target population for collecting primary data. Collected data will be analyzed and presented using qualitative data analysis methods, while strictly adhering to ethical standards stipulated by the Nelson Mandela Metropolitan University in the Guidelines on Master’s Degree research.

In the next chapter, the design and method which were used to achieve the objectives of this study shall be discussed.
CHAPTER 2:
RESEARCH DESIGN AND METHODS

2.1 INTRODUCTION
This chapter is intended to give a clear orientation and guide to the steps and processes used to fulfill the objectives of this study. Thus it will address the design of this study as well as give a clear understanding of the methods employed to ensure trustworthiness and the ethical considerations subscribed to and upheld by the researcher throughout the study.

2.2 RESEARCH DESIGN AND METHODS
The following paragraphs will address the design and methods used for this study.

2.2.1 Research Design
The research design is a guideline for a study that is followed to achieve the objectives of the research. Creswell (2003:5) asserts that a research design should address three questions which relate to the knowledge claim or theoretical perspective made by the researcher; the strategies of inquiry which will inform the procedures; and the methods of data collection and analysis.

In order to achieve the objectives stated above, this study was designed using a qualitative approach. The research design of this study was exploratory (Bless and Higson-Smith in de Vos et al., 2002:109), descriptive and contextual (Babbie and Mouton, 2001:272). These designs are premised on the assumption by the researcher that data is contained within the experiences of casualty doctors that are involved in the management of gender-based violence victims at the Intermediate Hospital, Oshakati. Therefore the researcher engaged with the casualty doctors to explore their
experiences and thereafter richly described them in the context in which they occurred; and from this, the researcher inductively explained the meaning of the data. The perspective of these designs will now be expatiated on in the next paragraphs.

2.2.1.1 Qualitative approach

According to Clissett (2008:100) qualitative research covers a wide range of approaches for the exploration of “human experience, perceptions, motivations and behaviours” and is concerned with the collection and analysis of words whether in the form of speech or writing. Grant (2008:1) explains that qualitative inquiry means to understand what others do and say or to “get grasp, hear, catch and comprehend” what something means. In essence, the goal of qualitative studies is to yield insight into human activities and opinions from the perspectives of the participants (Savenye and Robinson, 2005:65).

Thus, the qualitative approach seeks to understand people’s interpretations of their reality, being their lived experiences or perceptions of a specific issue, event or abstraction (Creswell, 2003:14). This approach seeks to give a complete picture of the issue of study; in this case, the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati.

This study utilized the qualitative approach because of the following advantages which it offers, as stated by Johnson and Onwuegbuzie (2004:20):

• Better understanding of a phenomenon and the gaining of new perspectives. In this study this is found in the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati.

• Collection and exploration of in-depth information that cannot be conveyed quantitatively. Collection of information by means of semi-structured one-on-one interviews in this study helped to make explicit intangible information that is not easily quantified.
• Provision of rich descriptions of complex phenomena.

• Exploration of sensitive topics. In this study the participants were allowed to explore their experiences through sensitive probing questions.

• Exploration of the issues of groups/ subcultures which are difficult to access.

• Tracking of unique/unexpected events. In this study examples include the unique nature of the experiences of different doctors with diverse training and cultural backgrounds regarding their role in the management of gender-based violence in Namibia.

• Illumination of experiences and interpretation by the actors.

• Giving voice to those who are rarely heard. The publication and dissemination of the findings of this study will portray the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati, to a wider audience of hospital managers and academics as well as other stakeholders.

The qualitative approach was used for this study to collect data from casualty doctors regarding their experiences in the management of gender-based violence victims at the Intermediate Hospital, Oshakati to gain an in-depth understanding of this issue by getting comprehensive information, which is presently not readily available.

2.2.1.2 Exploratory design

Exploratory studies are done to illuminate or explain a relatively unknown phenomenon, subject or issue, with the researcher wanting to gain insight into the issue (Bless and Higson-Smith in de Vos et al., 2002:109). This opinion is supported by Liamputtong and Ezzy (2005) cited in Dickson-Swift, James, Kippen and Liamputtong (2007:329) who
state that a qualitative research that is exploratory in nature enables researchers to gain information about an area in which little is known.

Very little information (if any) is available in the published literature about the experiences of casualty doctors in Namibia in relation to the management of gender-based violence. This study explored this knowledge through semi-structured interviews with casualty doctors on their experiences regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati.

2.2.1.3 Descriptive design

The purpose of a descriptive design is to obtain complete and accurate information about a phenomenon, issue or subject under review. The phenomenon, the research process and the findings are given in rich description that may include quotes from participants or documents related to the study, thus incorporating expressive language (Hoepfl, 1997:9). Detailed descriptions are given so that any researcher wishing to repeat the study can easily do so.

This study used a descriptive design to collect data on the experiences of casualty doctors at the Intermediate Hospital Oshakati, Namibia in relation to their role in the management of gender-based violence because the researcher intended using a thick description of the research findings in the data analysis.

2.2.1.4 Contextual design

A contextual research design refers to one in which the phenomenon, issue or subject of the study is done within the immediate setting of the phenomenon. Babbie and Mouton (2001:272) illustrate this by contending that if an event is understood against the background of the context and how this confers meaning to the events related to this context; the events can be better understood.

In this study, the context is the management of gender-based violence victims and the role of casualty doctors is the focus within this context. The experiences of casualty
doctors were obtained through semi-structured interviews. These experiences constitute the data for this study.

2.2.2 Research Method

The research method describes the techniques used to collect and analyze data and involves a description of the population who participated in the study, how the participants were chosen for the study through sampling and how data was gathered as well as the process of analyzing the data. The methods used for data collection and data analysis for this study are discussed below.

2.2.2.1 Data Collection

Under this rubric, population, sampling and method of data collection used for this study are discussed below.

2.2.2.1.1 Population

Researchers using the qualitative approach enter the world of the people they plan to study and get to know them. Dickson-Swift et al., (2007:331) contend that qualitative researchers must initiate a rapport-building process from their first encounter with a participant in order to build a research relationship that will allow the researcher access to that person’s story.

For this research, the target population is Medical Officers and Principal Medical Officers working at the Intermediate Hospital, Oshakati, more precisely, the entire complement of eleven (11) casualty doctors who work in the emergency unit of the hospital.

2.2.2.1.2 Sampling

A sample is the element of the population considered for actual inclusion in a study. Sampling is used in qualitative research although less strictly applied or structured than in quantitative research. In qualitative investigations non-probability sampling is used
almost without exception (Strydom and Delport in de Vos et al., 2004:333). These authors assert that the reason why there is flexibility in sampling in qualitative research relates to the methods of qualitative data collection. A good illustration of this is the explanation by Marshall (1996:523) who observed that “choosing someone at random to answer a qualitative question would be analogous to randomly asking a passer-by how to repair a broken-down car, rather than asking a garage mechanic - the former might have a good stab, but asking the latter is likely to be more productive”. The aforementioned author further explains that some informants are 'richer' and are more likely to provide insight and understanding for the researcher than others.

Savenye and Robinson (2005:68) emphasize further that because in qualitative research multiple voices of participants are described and compared, research participants are not selected randomly but purposively in an effort to carefully represent these many voices. Supporting this viewpoint, Groenewald (2004:5) contends that purposive sampling is the most important kind of non-probability sampling method to identify primary participants.

For this research, purposive sampling was used to select casualty doctors who were considered as knowledgeable by virtue of their experiences in managing the casualty department of the hospital and who met all the criteria specified for inclusion in this study. The purposive sampling method was used for this study because it was consistent with the objectives of the study, which were to explore the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati. It was not initially possible to determine the exact number of participants however strict criteria were used to determine the eligibility of participants.

The criteria for inclusion in this study were that participants:

• must be medical officers/principal medical officers who undertake rotations as casualty doctors in the emergency unit of the Intermediate Hospital, Oshakati;
• must have been working in the casualty unit and been involved in managing gender-based violence victims for at least six months prior to involvement in this study.

Given (2008:687-688) argues that sampling should be seen as a series of strategic choices about ‘with whom’, ‘where’ and ‘how’ research should be done. She explains further that this has to be tied to the study objectives and that an appropriate sample size for a qualitative study is dependent on the research question(s).

Two strategies are often used to determine sample size in qualitative research. One approach is based on range or sufficiency, namely, the number of interviews, observations and so on required to capture a representative view of the phenomenon under study. The second approach depends on data saturation or redundancy, namely, the number of people who need to be interviewed or observed before no new data emerges (de Vos et al., 2004:300). In this study, the data saturation criterion was chosen, but data was eventually collected from all potential participants that voluntarily consented to take part as new data kept emerging as the interviews progressed.

2.2.2.1.3 Data gathering

This refers to the gathering of information required to address the research problem. Qualitative research utilizes many methods of data collection but the semi-structured interview method was the primary data collection method used in this study because of the amount of detail it provides from each interviewee (Pope, van Rooyen and Baker, 2002:148).

Participants were asked to respond to the same questions (with appropriate probing where deemed necessary), namely:

• Tell me, how do you experience your role in the management of gender-based violence patients?
What are the strengths of the current management approaches to gender-based violence in this hospital?

What in your view are the weaknesses of the current management approaches to gender-based violence in this hospital?

Tell me, what do you think will improve the management of gender-based violence patients presenting at the casualty department?

The language used for the interviews was English as all the participants are fluent in the language. An audiotape was used to record the interviews, after participants had given permission and this was augmented with field notes. Before the interviews the recording equipment was checked to guard against equipment failure. Back-up equipment was kept on standby in case of such failures and a long-playing digital recorder was used to avoid stoppages. Although it was not possible to get a similar setting for all the interviewees, efforts were made through prior explanations to all the participants, to get a place and time that was devoid of noise and distractions and was convenient for each participant as suggested by de Vos et al. (2004:300-305).

**Preparation for the interviews**

The study was conducted at the Intermediate Hospital, Oshakati within the Ministry of Health and Social Services in Namibia. The setting for the interview with each participant was made as convenient and private as possible so as to yield the best result for the study and not be disruptive to the work routine of the participants.

Planning for the interviews involved the following steps: access was negotiated with the participants through authorization from relevant authorities (see appendices for letter of study approval/authorization); the participants were prepared for the interview by giving them prior explanation verbally of what the research was about and by a written summary of the research proposal including explanations regarding voluntary
participation, confidentiality and privacy. Furthermore, the participants were given an interview schedule with an explanation of their role during the interview and how the interview would proceed; this was done prior to the interviews.

**Before the interview**

The time and place of the interview was arranged. Follow-up was done via electronic mail and confirmed closer to the date by phone calls. It was ensured that the setting for the interview was a quiet environment with privacy, which was not threatening to the interviewee and free of interruptions and a comfortable seating arrangement that encouraged involvement and interaction was made available - a sitting position that allowed eye contact.

**At the beginning of the interview**

Introductory pleasantries were engaged in and again the general purpose of the research was confirmed, the role that the interview played in the research was explained and the approximate time it would take. It was also pointed out that the interview would be treated with confidentiality and details given by one participant would not be shared with any other participant. Furthermore, the manner in which the interview would be recorded was explained and the participant’s permission was obtained for the recording. Finally the signing of the voluntary consent form was formalized and the participant was reminded that he or she could withdraw at that or any other point if he/she wished to.

**During the interview**

Rapport was established by attentive listening, and by showing interest and respect for what the participant was saying; the interview was started with the key research questions and further questions were derived from the answers given to the main questions as listed above. Participants were allowed to express their views and ideas about particular issues freely, clearly, and elaborately within the focus of the subject. The interviews were kept to a maximum of one hour over several occasions where practicable, instead of conducting a very long single interview.
At the end of the interview

There was a gradual recourse to an explanation of the questions asked through a summary of the main points to avoid an abrupt end. The participants were asked if they had any questions or anything more to add. The participants were asked to contact the researcher by phone or e-mail whichever was more convenient for them in case they needed any further clarification. Participants were then thanked for their availability and participation. Afterwards the transcribed interview was given to the particular participant to check for corrections, additions and to ensure that the researcher had correctly transmitted the information the participant was trying to convey.

The transcribed data was augmented with field-notes which were taken during the interviews and some aspects were jotted down, while immediately after each interview a written account was made of what the researcher had heard, seen, experienced and thought about during the course of each interview.

2.2.2.1.4 Field Notes

Field notes were used to complement data from the audio-taped semi-structured interviews. Field notes are the observations made by the researcher regarding the participants during the interviews including gestures, facial expressions and comments (Polit and Hungler, 1995:642). They also include everything the researcher sees, hears and observes before, during and after the interviews.

Four types of field-notes were taken to augment the audio-taped interviews, namely, observational notes (ON), theoretical notes (TN), methodological notes (MN) and analytical notes (AN). Lofland and Lofland (1999:5) maintain that field notes should be written within twenty four hours. This was done for this study. An explanation is given below of the various types of field notes taken for this study.

Observational Notes

These are notes of observed incidences and occurrences in the study site that the researcher considered important in the course of the study. Groenewald (2004:6)
emphasizes that in observation during a qualitative study all senses should be used. For example, in this study the researcher observed and noted the work environment of participants and noted areas that corroborated descriptions by participants such as human resources and facility limitations.

**Theoretical Notes**

Theoretical notes were taken by the researcher in an attempt to derive meaning from reflection or thoughts on participants' descriptions of their experiences with regards to their role in the management of gender-based violence victims.

**Methodological Notes**

These were “reminders, instructions or critique” which the researcher noted down regarding the processes used during the study.

**Analytical Notes**

These were end-of-field-day summaries, an attempt by the researcher to review the progress of the study at the end of each day in the field. The practical techniques for taking field notes suggested by Mack, Woodsong, MacQueen, Guest and Namey (2005:44) were used as a guide in this study, as follows:

Each entry in the field note for each interview was started with the date, time, place, and the type of data collection event; for specific entries a space was left for expanding the notes later on. The notes taken during the data collection were strategic and only brief notes were written, along with key words and phrases that were easy to recall without writing in detail. Shorthand that could be understood later facilitated this. Key words, body language, moods or attitudes and the general environment were also noted.

During the interviews, questions were also jotted down as follow-up or probes to issues brought up by the participants. After the interviews, the notes were expanded within twenty-four hours. The notes that were written in shorthand, the key words and the personal observations of the researcher were then expanded into full sentences and
composed into a descriptive narrative. The expanded notes were reviewed and final comments were added accordingly.

The data transcribed from each interview was made available to each participant after each interview to verify the accuracy of the transcript. The transcribed interview was analyzed using preliminary coding and a clean copy of the transcripts was then presented to an experienced independent coder in preparation for final data analysis.

2.2.2.2. Data Analysis

Qualitative data analysis is the range of processes and procedures through which the researcher moves from the collection of data to the explanation, understanding or interpretation of the people, issue or situation that is being studied (Lewin, Taylor and Gibbs, 2005:1). Qualitative data analysis attempts to preserve the textual form of the data gathered and to generate analytical categories and explanations (Pope et al., 2002:149). Furthering the same viewpoint, de Vos et al. (2004:339) state that qualitative data analysis is a search for general statements about relationships among categories of data.

Thus the objective of analyzing qualitative data, as Basit (2003:1) points out, is to determine categories, relationships and assumptions that inform the respondent’s view, or experience of the issue being studied.

Furthermore, Creswell (2003:190) describes the process of data analysis as preparing the data for analysis, conducting different analyses, moving deeper and deeper into an understanding of the data, representing the data and making an interpretation of the larger meaning of the data.

Lewins et al. (2005:1) posit that for data to be derived from an interview the researcher may want to identify any or all of the following: people’s interpretation of the world; why they have that point of view; how they came to that view; what they have been doing; how they convey their view of their situation and how they identify or classify themselves and others in what they say.
One common aspect of the techniques for qualitative data analysis is the process of clustering of units of meaning to form themes. This is also referred to as ‘coding’. Tesch (cited in Creswell, 2003:192 and James, 2002:37) proffers the following step-by-step process of how coding may be done:

• Get a sense of the whole.

• Pick one document (one interview). Go through it not thinking about the substance of the information but rather of its underlying meaning.

• Cluster together similar topics and form them into columns that may be arrayed as major topics, unique topics and leftovers.

• Abbreviate the topics as codes and write the codes next to the appropriate segments of the text to see if new categories and codes emerge.

• Find the most descriptive wording for your topics and turn them into categories. Look for ways to reduce your total list by grouping topics that relate to one another.

• Make a final decision on the abbreviation for each category and arrange these codes in alphabetical order.

• Assemble the data material belonging to each category in one place and perform a preliminary analysis.

• If necessary recode the existing data.

This theoretical technique was used in analyzing the data for this study. A protocol was developed based on this technique. After the analysis, the independent coder and the researcher jointly reached a consensus on the themes and categories which constitute the findings of this study (as discussed in chapter three).
2.2.2.3. Pilot Study

A pilot study was carried out in the same manner as the main study using two participants from the same population as the main study. This was a trial run of the main study and was done to ensure that the design of the study was feasible, that problems encountered were eliminated in the main study relating to developing questions following the participants’ response to the open-ended research questions, and to assist the researcher in developing a meaningful procedure for analyzing the collected data as suggested by van Teijlingen and Hundley (2001:2). These were included in the data analysis of the main study.

2.2.2.4. Literature Control

Creswell (2003:119) asserts that existing literature plays different roles in qualitative research than it does in quantitative studies. In qualitative research existing literature on a subject may be used to make the researcher focus on aspects of the study. The often exploratory nature of qualitative research means that sometimes literature to support the initial aspects of study may be very limited.

However, as data is collected and categories and themes emerge from the collected data, existing literature on related studies becomes very important in qualitative studies. This helps to make sense of the emergent findings and their interpretations or to distinguish the uniqueness of findings by their anomaly or lack of corroboration with what is currently in the existing literature. The specific pattern in which literature was used as control for this study will be further explained under reporting of the study findings in the next chapter.

2.3 TRUSTWORTHINESS

The criteria for judging the quality of a study requires that the researcher ensure that the study is worthy of being taken into account. In qualitative research the concept of trustworthiness is used to address this necessity. This study draws the strength of its
quality primarily from the congruency between the research question and the 
epistemological orientation of the research strategy. This congruency justifies the 
methods of data collection and analysis.

The specific issues of trustworthiness relating to the credibility, transferability, 
dependability and confirmability are addressed by specific strategies, which are stated 
as they relate to different aspects and processes of this study as explained below. 
However, before explaining these specific strategies, it is necessary for the researcher 
to elaborate on why these criteria have been given prominence because qualitative 
research in general involves many strategies depending on the purpose of the study. 
The variety of strategies has necessitated a variety of approaches for judging the quality 
of each study.

In their analysis of the criteria for judging the rigor of qualitative research in two 
separate articles, Morse et al. (2002:6) and Finlay (2006:5) maintain that several criteria 
have been suggested for judging the quality of qualitative studies because they became 
necessary for various reasons. In explaining the reasons, Finlay (2006:5) points out 
that the traditional criteria for judging the rigor of research has some implications for 
qualitative studies, for example, validity which refers to “the degree to which research 
truly measures what it was meant to measure”. This criterion rests upon the 
assumption that the phenomenon being investigated possesses ‘reality’ in an 
undisputed, objective sense. Qualitative researchers in general view this as 
inappropriate. Given the diversity of the social world, they argue, it is erroneous to 
assume the existence of one unequivocal reality to which all findings must respond. 
Instead, they are concerned to show that findings can be transferred and may have 
meaning or relevance if applied to other individuals, contexts and situations (Finlay, 
2006:5-6)

Such contentions resulted in the suggested criteria for judging qualitative research, 
which includes trustworthiness, proposed by Guba and Lincoln (1981, 1982 and 1985 
cited in Finlay, 2006:4-6). Trustworthiness includes credibility, dependability,
transferability and confirmability strategies which are audit trail, member checks when coding, categorizing or confirming results with participants, peer debriefing, negative case analysis, structural corroboration and referential material adequacy (Morse et al., 2002:6; and Finlay (2004:6).

Morse et al. (2002:16) propose that such criteria should be used proactively throughout the study to manage the research rather than as a judge of the outcome. For this study, the strategies that were used to ensure trustworthiness and how they were applied are summarized in the table below.

Table 2.1: Strategies to ensure the trustworthiness of this study*

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Actions</th>
<th>Application Criteria</th>
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<tbody>
<tr>
<td>Credibility</td>
<td>• Prolonged and varied field experience</td>
<td>• Contact was made with the participants prior to the interviews to build rapport with them.</td>
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<td></td>
<td></td>
<td>• The researcher had gained insight into the context in which the participants experience the management of GBV victims.</td>
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<tr>
<td>Reflexivity</td>
<td>• For purposes of reflection, the researcher made use of a journal and a diary in conducting the interviews.</td>
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<td></td>
<td></td>
<td>• The researcher used this diary to check for biases.</td>
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<tr>
<td>Triangulation</td>
<td>• Data were verified by literature control (Theoretical triangulation).</td>
<td></td>
</tr>
<tr>
<td>The researcher jointly analyzed the data with an independent coder who is experienced in qualitative research (Triangulation of investigators).</td>
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<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Interviewing technique</strong></td>
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</tbody>
</table>
| • All participants were asked the same research questions to determine whether a logical rationale was present.  
• Semi-structured interviews were conducted using open-ended questions.  
• Verbal and non-verbal skills were used to encourage participants to talk freely. |
| **Structural coherence** |
| • The researcher ensured that there were no inconsistencies between the data and its interpretation.  
• The participants’ experiences of managing victims of GBV were the main focus of the study. |
| **Transferability** |
| • Nominated sample |
| • A purposive, criterion-based sample was selected from the available participants  
• A dense description was given of the results with supporting, direct quotations from the interviews with the participants. |
2.4 ETHICAL CONSIDERATIONS

Babbie and Mouton (2003:520) assert that in order to conduct social research, a researcher must be aware of the general agreements among researchers about what is proper and improper in the conduct of a scientific enquiry. These agreements constitute the ethical foundations of research; and the prevailing expectations of these agreements on a researcher include the following aspects:

• Voluntary participation: participants in a study should give their consent and be informed of the purpose of the study. Only consenting participants took part in this study after providing them with details of the study.

• No harm to participants: this study did not cause any harm to the participants physically, socially (societal embarrassment, prejudice and so on) or psychologically (emotional or mental distress arising from issues in the study).
• Anonymity, privacy and confidentiality: although it was not possible to make this study anonymous because of the method of data collection, the researcher carefully ensured that the participants’ names and other data that could make them identifiable were either omitted or deliberately presented in pseudonyms. In addition, no unauthorized person was allowed access to the collected primary data (interview audiotape recording and transcripts), which was stored confidentially.

• Prevention of deception of participants: study participants should be made aware of the study details without any form of dishonesty. This was adhered to in this study by giving the participants a written summary of the problem statement, the research objectives and the research methodology in addition to the verbal explanations given before each session of data collection.

Specifically for ethical issues relating to qualitative studies in health services, Richards and Schwartz (2002:135) provide a clear picture of the ethical issues affecting qualitative research in health services, summarizing their study into five key messages, two being pertinent to mention in this study.

The above-mentioned authors posit that risks which are particularly relevant to participants in qualitative health services research include anxiety and distress, confusion of the research process with a therapeutic encounter, coercion and identification of need for further help as well as misrepresentation. These risks may be minimized by researchers being clear about the boundaries of their research; by treating informed consent as a process rather than a once-off affair; by being explicit about and reflexive toward their professional background; and by ensuring that they are adequately trained and supervised.

In tandem with these expectations, Creswell (2003:63) maintains that ethical issues primarily arise in specifying the research problem, identifying a purpose statement and research question, and in collecting, analyzing and writing up the results of data. Thus for this study the following measures were taken to ensure that these aspects of the study were carried out ethically.
2.4.1 Avoidance of marginalization and disempowerment

The articulation of a subject such as the management of gender-based violence victims through research will bring the issues affecting the participants (casualty doctors at the Intermediate Hospital, Oshakati) into a clearer focus. Some of these have the potential of leading to victimization and possible disempowerment of the casualty doctors, especially when an issue like poor hospital management strategy arises with respect to the care given to the victims of gender-based victims.

The researcher carefully avoided this possibility by ensuring that none of the research participants’ identity is obvious and none can be inferred from the report of this study.

The ethical issues arising in the purpose statement and research question relate to the avoidance of deception as explained below.

2.4.2 Avoidance of deception

In order to avoid deception of participants and relevant authorities regarding this study, the researcher ensured that the purpose and question underpinning this study was clearly conveyed. Authorization was received from the appropriate authorities of the Nelson Mandela Metropolitan University and the Namibian Ministry of Health and Social Services through a written proposal, which was approved (see attached approval letters in appendices). The participants were also given a written summary of the problem statement, the research objectives and the research methodology in addition to the verbal explanations given before each session of data collection. The researcher ensured that the stated purpose was the executed actions of the study.

The ethical issues arising in data collection are in relation to voluntary participation, consent, anonymity and confidentiality as well as the respect for the context in which the data is collected.

2.4.3 Voluntary participation and informed consent

After approval was obtained from the Namibian Ministry of Health and Social Services and the permission of the hospital authorities sought to carry out the study, the
researcher ensured that the participants who took part in the study did so voluntarily without any inducement or coercion, after having been informed of the purpose of the study and its methods. Participants were also clearly informed that they were at liberty to withdraw at any point of the study if they so desired.

Their right to ask questions regarding the study, the benefits of the possible outcome of the study to their work, and the respect of the researcher for their privacy were also clearly explained.

2.4.4 Anonymity and confidentiality

Complete anonymity of respondents to the researcher was not feasible in this study as the data collection involved face-to-face interviews but the confidentiality of the information proffered in the interview was ensured by making sure that the participants’ names, work location/department and person-specific titles and events which made them easily identifiable were either omitted or deliberately presented in pseudonyms.

In addition, no unauthorized person was allowed access to the collected primary data (interview audiotape recording and transcripts), which was stored confidentially.

2.5 SUMMARY OF CHAPTER

This chapter focused on the designs and methods of the study relating to the experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati using a qualitative approach.

In this chapter, the theoretical basis for using this design and method were discussed, as well as the techniques for data collection and analysis. In addition, the need for congruency between the design and method with the research question and objectives in order that the quality of the study could stand up for verification and how this was achieved, were explained. Measures were presented that ensured that the study was done ethically. The next chapter will present details of the study findings and further discussions regarding this study
CHAPTER 3:

DISCUSSION OF RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

This chapter will describe the results of the study based on the analysis of the collected data. The results of the data analysis will be discussed along with direct quotations from the raw data to support the emergent themes, sub-themes and categories. The aforementioned findings will be verified with existing literature, to confirm, contradict or present a new dimension to the phenomenon being studied.

3.2 PRESENTATION OF RESULTS

In this study, data was collected from all participants who voluntarily consented to take part. Six semi-structured interviews were conducted, while written textual data was collected from the seventh participant (due to logistical problems experienced at the time of the study with this participant).

The demographics of the study participants were as follows:

- Five of the casualty doctors who participated in this study were males while two were females;

- Two of them were over 40 years old while the remaining five were in their 30s;

- All had over five years of experience in medical practice (mostly elsewhere outside Namibia) but the duration they had worked at the casualty department of the hospital where the study was conducted varied between one and thirteen years;

- All except one of the study participants were married.
Participants were asked to respond to the same questions, with further probing as deemed necessary. The basic questions asked were:

- Tell me, how do you experience your role in the management of gender-based violence patients?

- What are the strengths of the current management approaches to gender-based violence in this hospital?

- What in your view are the weaknesses of the current management approaches to gender-based violence in this hospital?

- Tell me, what do you think will improve the management of gender-based violence patients presenting at the casualty department?

Basit (2003:2) describes the outcome of qualitative analysis as the *condensation* or *distillation* of data through interpretation and organization. The aforementioned author asserts that when categories (or themes) are devised, the researcher is making decisions about how to organize the data in ways that are useful for analysis. This author further describes categories or codes as links between locations in the data and sets of concepts or ideas. In this study, these links between ideas in the data were organized into two main themes, five sub-themes and several categories.

In the following paragraphs, the analyzed data will be presented first in a summarized tabular form and then by a narrative description that follows a sequence of introduction of the emergent themes, sub-themes and categories.
Table 3.1: Main themes, sub-themes and categories relating to the experiences of casualty doctors in the management of gender-based violence victims

<table>
<thead>
<tr>
<th>MAIN THEMES</th>
<th>SUB-THEMES AND CATEGORIES</th>
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| **Theme 1:** Casualty doctors had both challenging and positive experiences in the management of gender-based violence victims. | **Sub-Theme 1.1:** Casualty doctors had challenging experiences when managing gender-based violence victims. Casualty doctors experienced:  
- an increase in the number and types of injuries that gender-based violence victims present with for management at the casualty department.  
- that there are various factors predisposing to gender-based violence among the victims being managed.  
- various stumbling blocks in the management of gender-based violence victims. |
| | **Sub-Theme 1.2:** Casualty doctors had various positive experiences when managing gender-based violence victims.  
Casualty doctors experienced:  
- overnight stays as a temporary measure of protection for GBV victims;  
- the free treatment and 24-hour services offered as increasing the accessibility of the services to GBV |


Theme 2: Casualty doctors experienced a need for improving the management of gender-based violence victims.

| Sub-Theme 2.1: Casualty doctors experienced a need for a holistic approach to the management of gender-based violence victims. |
| Sub-Theme 2.2: Casualty doctors experienced a need for comprehensive training for all categories of staff involved in the management of gender-based violence victims. |
| Sub-Theme 2.3: Casualty doctors experienced a need for improved interventions and increased public awareness regarding the management of gender-based violence on a national level by various stakeholders. |

3.3 DISCUSSION OF THE MAIN THEMES AND SUB-THEMES

The main themes, sub-themes and categories will now be discussed with an incorporation of direct quotations from the collected raw data to support the description of the findings as well as using relevant literature to confirm, contradict or present a new dimension to the phenomenon of gender-based violence being studied.
3.3.1. Theme 1: Casualty doctors had both challenging and positive experiences in the management of gender-based violence victims.

Gender-based violence is a common and recurrent public health issue at the Intermediate Hospital, Oshakati. As a preamble, the Intermediate Hospital Oshakati is a 750-bedded government-owned facility that serves as a referral hospital for five regions in the northern part of Namibia. The services available in this hospital presently for victims of gender-based violence are coordinated by the Women and Children Protection Unit (WCPU) which is staffed by two social workers and police officers. The Mental Health Department of the hospital (comprising of several nurses, one psychiatrist, one medical officer and an occupational therapist with a visiting clinical psychologist) renders additional services. In addition, the casualty department of the hospital offers emergency services to the victims of gender-based violence. These various cadres of staff often work independently from one another.

The casualty doctors who took part in this study indicated that they encountered a wide range of experiences in the management of GBV victims in their daily line of duty. While some of these experiences were quite challenging and indeed acted as stumbling blocks to their ability to render quality and comprehensive services to the victims of GBV presenting at the casualty department, casualty doctors also mentioned that they had some experiences that impacted positively on the management of GBV victims.

The next section of this report will expatiate on these challenging and positive experiences as described by the study participants.

**Sub-Theme 1.1: Casualty doctors had challenging experiences when managing gender-based violence victims**

The experiences of participants in this study revealed that they are routinely confronted with several challenges in the management of gender-based violence victims. These included an increase in the number and types of injuries that gender-based violence victims present with for management at the casualty department; various factors
predisposing to gender-based violence among the victims being managed and various stumbling blocks in the management of gender-based violence victims. These categories of challenges are discussed below.

- **Casualty doctors experienced an increase in the number and types of injuries that gender-based violence victims present with for management at the casualty department**

Study participants echoed that they experienced a major challenge relating to the extent and the large number of gender-based violence victims presenting at the casualty department during their respective shifts. These findings are congruent with numerous previous studies. For example, results from a multi-country study on Women’s Health and Domestic Violence against Women (WHO, 2005:27; 35) revealed that worldwide between 13 and 61% of ever-partnered women have suffered physical violence by a male partner while between 20 and 75% have suffered emotional abuse. The United Nations Development Fund for Women (UNIFEM, 2008:1) estimates that at least one in every three women has been beaten, coerced into sex, or otherwise abused by a man in her lifetime and more than twenty percent (20%) of women are reported to have been abused by the men with whom they live.

The following quotes from the raw data of participants highlight this:

“...when it comes to gender-based violence in our society...it is a widespread thing…”

“There is a quite large number of patients who came to casualty for gender abuse. We have... em... quite a large number of victims being abused…”
“…my experience…it is a real problem; it is everyday problem in our environment…”

While the large numbers of GBV victims were identified as a real challenge by the participants in this study, they emphasized further that it is even more worrisome that, not only is there a large number of gender-based violence victims presenting to the casualty department, it is becoming more frequent than before. Some participants indicated that:

“…GBV (gender-based violence) is becoming more frequent these days…”

“Oh! Hmm, that’s a big issue. The number of these ladies is just increasing everyday…”

That GBV is a recurrent problem in the Namibian society has been reported in an earlier study conducted in Windhoek, the capital city of Namibia, where it was found that among those injured by an intimate partner, 46% reported that they have been injured once or twice; while 35% have been injured three to five times and 20% have suffered injuries more than five times (MoHSS, 2004:31).

Participants also described their experiences regarding the nature and extent of the injuries that victims of gender-based violence present with when seeking emergency care at the casualty department of the Intermediate Hospital, Oshakati. The majority of the victims were described as having a wide range of physical injuries.
“...patients usually come to casualty...they are injured and...em...injuries to the face and hands and back...”

“...the nature of injury...they used to present to casualty are beaten by objects like stick, iron rods by the husbands or by their boyfriend...em...another assault like stab wound. We have large number of stab wound here...stab wound on the back...em...and everywhere...”

“...we see gender-based violence sometimes occurring in form of physical assault...may range from a slap to...em...lacerations, stab wounds, you know...severe beating with a lot wounds...cuts all over the body...so we do see that a lot.”

“...there are all sort of injuries from...em...beaten up, laceration...em...stab wound...em...pressed against the wall or the...the ground, the floor...they get even, some get...sustained fractures, even...em...the ladies who get stab wound...”

“...I can still remember one...this lady was punched all over her body, she came with a swollen face; the lips, the eyes and in fact the whole face was swollen...”
Several researchers have documented that victims of GBV often have numerous physical injuries. In their study conducted in Malawi, Pelser et al. (2005:9) found that physical abuse is the most common (30%) pattern of presentation and in another study conducted in Windhoek, Namibia, it was found that 36% of ever-partnered women have suffered physical or sexual or both types of abuse from her intimate partner at some stage in her life (MoHSS, 2004:18). This is similar to the aforementioned WHO study (WHO, 2005:27) where the most common type was identified as physical abuse, usually in combination with emotional abuse.

In a record of the common physical injuries sustained by women in a national survey on violence against women in America, Tjaden and Thoennes (2000:48) found the following injuries in the decreasing order of occurrence: scratch and bruises (76.1%), fractures and dislocation (11.3%), laceration and knife wound (8.8%), head and spinal cord injuries (8.8%), muscle sprain and strain (6.5%), burns (1.3%) and dental injury (0.8%). Other studies in the US and Malawi, also found similar results with facial injuries being the most common (Pelser et al., 2005:8-9; WHO 2005:57-58).

In addition to these multiple physical injuries, participants also mentioned that most of the gender-based violence victims had emotional trauma. This is similar to the findings from The Malawi National Gender-Based Violence, NGBV study (Pelser et al., 2005:9) where it was found that the prevalence of emotional abuse is as high as 25%; that is, one in every four women have some sort of emotional trauma due to gender-based violence. A few quotes from participants’ raw data will illuminate this further:

“...emotional injuries are there too…”

“...the injuries…it might be in the social and the psychological part of the patient…”
“…a pregnant woman carrying one small baby on her back…imagine…beaten by her husband…she was just in tears…and you could see, oh!…she was bleeding from the heart…”

Writing on the psychological and behavioural disturbances accompanying gender-based violence, Marais, De Villiers, Moller and Stein (1999:635) maintain that in South Africa, the prevalence of psychopathology, severe depression and attempted suicide is significantly higher among victims of gender-based violence.

Similarly, mental health problems such as depression and anxiety disorders have also been documented among victims of gender-based violence (WHO, 2005:61-62). Consequent upon these depressive episodes, many GBV victims have been found to become suicidal. For instance, in Namibia, it has been reported that over a quarter of women who had ever experienced physical or sexual partner violence has, at least, once thought of committing suicide (MoHSS, 2004:29).

Costella, Chung and Carson (2005:261-2) contend that a single type of abuse does not occur in isolation but multiple forms of abuse exist at the same time. These authors further assert that psychological abuse occurs whenever any kind of aggression takes place, which is congruent with the experiences of the participants of this study.

- **Casualty doctors experienced that there are various factors predisposing to gender-based violence among the victims being managed**

Besides the increasing incidence of gender-based violence, participants in this study also highlighted that there are several factors which they have observed that are commonly associated with GBV. The identified predisposing factors which were viewed
by participants as challenges in the management of GBV victims will be expounded on below.

In the experience of the study participants, alcohol abuse is significantly associated with the prevalence of gender-based violence victims presenting at the casualty department of the Intermediate Hospital, Oshakati. Participants indicated that they experienced alcohol abuse to be an almost constant factor in all cases of gender-based violence seen at the casualty department.

It is interesting to note that the influence of alcohol on gender-based violence has been extensively reported on. Various researchers (for instance, Finney, 2004:2-3; MoHSS, 2004:22; and Caetano, Schafer and Cunradi, 2000:4) concur that alcohol is best seen as contributing to violent behaviour, rather than causing it. Research has also shown that there is a strong link between gender-based violence and both “drinking in the event” and “problem drinking”. Finney (2004:3) explains that drinking in the event implies drinking prior to the violence while problem drinking refers to habitual or heavy drinking.

The following statements made by participants accentuate this viewpoint:

“…alcohol abuse stands out… I don’t need to think to tell you that…”

“…almost every case… alcohol in one or another way is involved…”

“…alcohol factor is the major factor because most of them are drinking…”
However contrary to the experiences of the study participants, Klevens (2007:114) reports that alcohol drinking patterns and their subsequent consequences may have less explanatory value for the occurrence of intimate partner violence in Latinos compared to other groups.

Furthermore, it was the participants’ experience that while in some cases both partners are actually intoxicated with alcohol, it is more often the male partner’s alcohol abuse that triggers the violent acts of abuse on their female partners. This is congruent with the study of Heise and Garcia-Moreno (2002:98) who identified that women who live with a heavy drinker are at far greater risk of physical partner violence and that those men who have been drinking inflict more serious violence at the time of an assault.

The following verbatim quotes from participants depict this view:

“…people that are usually involved…some of them are drunk, either on the partner’s side or…I am talking about the male partner or even both of them are drunk…”

“…it is the alcohol that triggers their aggressive behaviour; in their normal state of…you know…composure, they don’t really go for such aggression but when they are drunk, they can do anything…”

“…that’s quite common…most of these guys assault these ladies when they have taken alcohol and lost their minds…”

Another factor that the study participants experienced as predisposing to gender-based violence is low socioeconomic status.
At the Intermediate Hospital Oshakati, casualty doctors who participated in this study experienced that the majority of the victims of gender-based violence presenting at the hospital casualty were from the lower socioeconomic strata of the society. Poverty, unemployment and low level of education were some factors identified as associated with gender-based violence in the context of this study, as the following statements from participants reveal:

“…I think it is still more in the poor people. Maybe…em…I think lack of education…I would rather say low level of education also contributes…”

“…the more lower the socioeconomic status and the more lower the…em…educational background and then the more the gender abuse…”

“…they used to tell me, like, they don’t have money and the husband is not employed…”

“Em…I have also noticed that…that it is common among people of low socioeconomic status…”

While this finding could however be attributed to a higher percentage of the population from the lower socioeconomic class using this public hospital, it is worth emphasizing that available literature suggests that with low levels of education, the risk of violence against a partner is higher. Studies from the United States of America and the United
Kingdom reveal that a lower educational level of women predisposes them to abuse (Rennison and Welchans, 2007:10). Dawes, Kafaar, Kropiwnicki, Pather and Richter (2004:8) also found a similar trend in a South African National Survey on partner violence.

Furthermore, Kishor and Johnson (2004:31) report that in India, the more education a woman has, the less likely she is to report having experienced violence. This is also the viewpoint of Simister and Makowiec (2008:510) who assert that education seems to reduce not only violence, but also the acceptance of it.

Of interest, however, is that the converse of the above finding does not hold true; stated explicitly, high levels of education does not rule out violence; it only appears to be protective as women with more education tend to have more educated men as partners and they are also more able to negotiate greater autonomy and control of resources within the marriage (WHO, 2005:33-34).

In addition, low income in both partners has been identified as a risk factor related to gender-based violence. Many studies (for example Dawes et al., 2004:8; Rennison and Welchans, 2007:9-10; Pelser et al., 2005:27-28) have shown that lower income women have a higher rate of gender-based violence than higher income women. Likewise men of lower income/economic status have higher chances of being involved in this menace than higher income men.

Participants in this study strongly contend that several relationship problems are often associated with the prevalence of gender-based violence among those presenting at the casualty department of the hospital. These relationship problems which act as predisposing factors also pose a great challenge in the management of GBV victims, as discussed below.

Based on their experiences, casualty doctors at the Intermediate Hospital, Oshakati, who participated in this study, indicated that several relationship problems are fundamentally associated with the prevalence of gender-based violence. Principal among these relationship problems are jealousy (arising from unfaithfulness and/or its
suspicion among partners), HIV-related problems (where one partner accuses the other of having infected him/her) and cohabiting unions (that is, unmarried people living together).

Wagman (2003:7-8) reports that unfaithfulness to the male partner is one of the most common of the major risk factors for gender-based violence. This is similar to the experiences of the participants in this study. Furthermore, results from the international study on GBV conducted by the World Health Organization (WHO 2005:39-40) indicate that infidelity is the most frequent reason men give for beating their female partners.

The following quotes from participants’ raw data give credence to this point:

“…Yeah, jealousy, you know, most of the patients…maybe…yeah…like the lady may have another boyfriend or the man may have another girlfriend, so they are…em…the man is thinking that his woman has another boyfriend…so he start beating her…”

“…maybe…I will say jealousy. Jealousy also sometime…in fact…not sometimes, a majority of time…may be…the partner hears that the wife…the female partner is sleeping with another person, the male partner can, you know, can…you know…without asking what actually happened or verifying the authenticity of what he has heard…he starts beating the woman up…”

“…another thing is…the woman is suspecting or the woman know that he has another girlfriend…so she is asking the man and the man started getting angry and then, you know, he start beating her…like that…”
While the participants in this study experienced a higher prevalence of GBV being associated with jealousy, it was similarly mentioned that gender-based violence also tends to occur more commonly when there is a suspicion of a partner having infected the other with the human immune-deficiency virus (HIV), as the following participant puts it:

“…the husband stab her because the husband think she is the one that gave him HIV…”

This is not particularly surprising given that researchers have found a higher risk of HIV infection among victims of gender-based violence. For example, from a study among pregnant women attending ante-natal care in the Soweto suburb of Johannesburg, South Africa, Dunkle, Jewkes, Brown, Grag, McIntyre and Harlow (2003:1417-1419) reported that those who experienced violence from intimate partners had a 50% higher risk of being infected with HIV.

Furthermore, cohabiting relationships were suggested as contributing to the prevalence of gender-based violence. In fact, one participant explains that:

“…but I have noticed some things…the fact that it’s more common among unmarried couples...(who live together)…”

The experiences of the study participants that the aforementioned relationship problems are associated with an increased prevalence of GBV have also been reported by
various researchers. For example, it has been shown that unmarried, cohabiting couples have higher rates of gender-based violence than do married couples (Heise and Garcia-Moreno 2002:99 and MoHSS, 2004:24).

According to Dawes et al., (2004:8; 52-53) marital conflict and/or instability among married couples have been identified as a consistent marker to emergence of partner violence. Constant and repeated conflict and arguments lead to physical violence and emotional abuse. On a similar note, the 1998 US national crime victimization survey ranked the risk of gender-based violence with marital status in the order of: divorced, never married/single, cohabiting and married (Rennison and Welchans, 2007:5).

Also, it has been shown that gender-based violence is more common in families where power is concentrated in the hands of the husband or male partner and the husband makes most of the decisions regarding family finances and strictly controls when and where his wife or female partner goes. In such cases the male partner may resort to showering abusive words on his female partner (emotional abuse) and even physically assault her (Pelser et al., 2005:6-7).

It is apt to highlight, at this juncture, that the predisposing factors discussed in the foregoing paragraphs relating to the prevalence of GBV as seen at the Intermediate Hospital, Oshakati, acted as challenges to the study participants because a comprehensive and an effective management of GBV victims depends largely on positively ameliorating these factors.

- **Casualty doctors experienced various stumbling blocks in the management of gender-based violence victims**

In addition to the two categories of challenges discussed above, several other stumbling blocks were identified in the management of GBV victims by the study participants.

Based on their experiences, casualty doctors taking part in this study indicated that they are faced with several stumbling blocks. These include a high workload, lack of team
work and lack of adequate skills which act as major challenges with regards to the management of GBV patients.

Boy and Kulczycki (2008:63) rightly note that the medical system could play an important role in identifying and helping victims of intimate partner violence. However, the issues of lack of time and inadequate skills by doctors act as stumbling blocks, as the study participants highlighted. This finding was reported by Ahmed, Abdella, Yousif and Elmardi (2003:1078) who mentioned that reported barriers to caring for gender-based violence victims among Sudanese doctors included lack of knowledge of the topic and insufficient time to intervene.

A high work load was mentioned by the study participants as one of the major challenges that affect their role in the management of GBV victims when they present at the casualty department. It is important to note that a high work load was attributed by participants to a combination of factors, notably inadequacy of manpower and the large number of non-emergency cases treated at the casualty unit of the hospital, leaving casualty doctors little or no time to properly attend to the victims of GBV, especially for meeting their emotional needs.

On the inadequacy of manpower, participants aired their experiences as follows:

“…the staff strength is weak; we don’t have enough hands to really look into this problem… I will say the manpower is not really there…”

“…only one doctor on duty in casualty is not enough…”

“…because we are very busy in casualty as we are working alone… as only one medical officer in casualty…”
Participants also experienced that the large number of non-emergency cases being attended to in casualty contributes to the high workload, as the following participants put it:

“...you know...so many cold cases come around also…”

“...most of the patients who came to casualty, they used to come, even sometimes, they even don’t have any injury…”

“...the queue of those cold cases that should really wait for OPD (out-patient department) the following day, will be so long…”

A combination of the above two factors (that is inadequacy of staff and too many non-emergency cases) contribute to casualty doctors not having sufficient time to render proper emotional care to victims of GBV in casualty. This challenging and apparently de-motivating experience of excessive workload in casualty is echoed by several participants as follows:

“...the pressure of work we have in casualty...we have too many patients and...only one doctor on duty…”
“…our weakness is we are too busy in casualty…”

“…the workload is too much…”

“There is really hardly any quiet time in casualty. You work and work until you are completely fagged out…”

The lack of adequate numbers of health personnel especially in developing countries (like Namibia where this study was conducted) is a well-documented predicament facing the health system. In the emergency setting specifically, from their study in South Africa on the experiences of health care providers managing sexual assault, Skhosana and Peu (2009:2) reported that increased workload and time constraints among others, were the major challenges facing health care workers managing assault victims in the emergency unit.

Another significant challenge in the opinion of the casualty doctors who participated in this study was that caregivers have limited knowledge about the role of other team members. While they agree that there is a framework on the ground which is multi-disciplinary in nature to care for victims of GBV, study participants indicated that, at present, there is no team work among them:

“…one of the weaknesses is that we are not working together, I mean, as a team…”
“…we are doing things differently and independently…”

“…everybody is doing what he thinks is right…”

“…no cooperation…for example, in casualty, we treat that’s all. Some come to the gender unit straight away to see the police people…from there, are they referred to social workers?”

Another concern expressed by the participants is the issue of preventing future occurrences by adequate follow-up of patients as well as conducting home visits with the aim of helping to identify triggering factors of GBV that can be ameliorated.

This critical aspect of managing victims of gender-based violence was also identified by the casualty doctors as a great challenge. The following verbatim statements from participants buttress this opinion:

“We don’t…well… let me not say we, I don’t even follow up on patients I refer there...(to social workers)…”

“…we even don’t know whether social worker is going to their…(the victim’s)... house to find out what exactly is the cause of this assault and...we manage on the spot, and then we give treatment and we even didn’t follow it up…what happen after that…”
“...we don’t know what will happen afterwards...after seeing them, that’s all; we don’t really follow-up, as in, to know what really caused the problem, how we can prevent it in future...”

On another note, it also emerged that besides the issues of high workload and lack of team work which were perceived by the participants as great challenges hindering their role in the management of GBV victims, casualty doctors’ lack of adequate skills in counselling and other psychosocial intervention strategies was another major predicament. Speaking on this, one participant emphasized that:

“...some of us don’t have the special training to manage...em...this kind of cases...in the social and the psychological part of the patient...”

A similar finding was recently reported in South Africa by Skhosana and Peu (2009:1-2). They noted that in a district hospital at the Mpumalanga Province where they conducted their study, lack of trained personnel was a major challenge facing health care workers managing sexual assault victims in the emergency unit of the hospital, in addition to the increased workload, time constraints, and poor communication between team members.

This sub-section described the challenging experiences of the study participants relating to their role in the management of gender-based violence victims presenting at the casualty department. The focus in the next section of this report will shift to the experiences of the casualty doctors that impact positively in the management of GBV victims. These positive experiences will be organized and discussed under a different sub-theme.
Sub-Theme 1.2: Casualty doctors had various positive experiences when managing gender-based violence victims.

In the experience of the casualty doctors that participated in this study, the programme that manages the victims of GBV has some aspects that positively impact on the outcome of the overall management rendered to victims of gender-based violence. These positive experiences are discussed in the following categories below:

- Casualty doctors experienced overnight stays as a temporary measure of protection for GBV victims

Study participants have the viewpoint that one of the positive aspects of the programme is that it provides a measure of safety for victims of GBV because victims at high risk are promptly admitted to hospital.

“Sometimes we even lodge some of them in the ward…who come alone and who are not able to go back home…at least, by morning, the man would be out of the alcohol...I think this is a good way we help patients of gender violence…”

The relevance of providing a sanctuary for victims of gender-based violence as experienced by the study participants as a positive aspect of the programme at the Intermediate Hospital, Oshakati, has also been highlighted by other researchers. For example, in their study with women receiving help for gender-based violence, Postmus, Severson, Berry and Yoo (2009:861) report that the victims view tangible supports like food and housing as the most helpful interventions for them.
• **Casualty doctors experienced the free treatment and 24-hour services offered as increasing the accessibility of the services to GBV victims;**

In this regard, they indicate that access to free treatment at the casualty department and the fact that it operates round the clock everyday are measures that assure that victims receive prompt emergency care without financial hindrances.

> “…the free treatment they get is a major strength. At least, we don’t send anybody away because of money; we treat all of them, even do all the lab tests and admit them, without saying they must pay fees. This is really good from the government…”

> “…the fact that we operate 24/7 (twenty four hours per day seven days a week) in the casualty is another big strength; I mean, most of these ladies come at very odd hours, very late into the night most times. If we are not covering the whole night, then they will really have problem with the basic first aid and the treatment which we give them…”

An earlier study in Namibia reports that among the ever injured women, 63% were so badly injured that they needed emergency health care, with as many as 32% of them spending at least one night in the hospital (MoHSS, 2004:31). Thus the experiences of the study participants that the availability of round-the-clock services is a positive aspect of the programme, is in tandem with this previous study.

• **Casualty doctors experienced the availability of the multidisciplinary team as conducive to a holistic approach.**

The participants who took part in this study experienced that the presence of a multi-disciplinary team (including doctors, nurses, social workers, psychiatrists and so on)
within the hospital is another positive aspect in the comprehensive management of GBV victims. This viewpoint is resonated by the following participants’ quotes:

“…another strength is the presence of everybody within the hospital, I mean, social workers, psychiatrists, counsellors and even the police people. Also the woman/child abuse unit is inside the hospital; that is very good too…”

“…the structure that we have on ground is a good plus…I mean the framework of the structure…”

Despite the positive aspects discussed above, the study participants also experienced the need to improve the overall management of GBV victims, given that there are several identified predicaments that impede on their role in the management of gender-based violence patients. These will be discussed in the following section of this report.

3.3.2. Theme 2: Casualty doctors experienced a need for improving the management of gender-based violence victims.

The participants experienced that the current status quo of the management given to gender-based violence victims by the various cadres of care-givers at the Intermediate Hospital, Oshakati, should be improved. Study participants described numerous measures that can contribute to achieving this. These will be discussed under the following sub-themes.
Sub-Theme 2.1: Casualty doctors experienced a need for a holistic approach to the management of gender-based violence victims.

The participants in this study expressed a need for all care-givers involved in the management of gender-based violence victims to work with one accord. Presently, care-givers do not appear to be approaching the problem as a team. Working as a team, in the opinion of participants, will improve the quality of management given to GBV victims. The following quotes from participants clearly portray this viewpoint:

“I would say the main thing is…em…collaboration. I think that is the right word...collaboration…”

“…working together to help these patients…”

Expatiating further on the envisaged holistic approach indicated by the casualty doctors in this study, one participant stated that:

“All gender-based violence victims must receive sensitive social support… possibly financial help as well…”

This array of holistic services is highlighted further by another participant who indicated that:
“...some very necessary steps to be done...compulsory psycho-emotional support; appropriate medical service...primary legislative protection...”

The need for a holistic approach to the management of gender-based violence victims, as mentioned by the study participants, is highlighted by Krug, Dahlberg, Mercy, Zwi and Lozano (2002:3). These authors assert that the aetiology of violence against women is extremely complex resulting from a variety of forces that operate on several levels including that of the individual, the family, the community and the society. Based on this fact, Martin, Coyne-Beasley, Hoehn, Mathew, Runyan, Orton and Royster (2009:45) contend that no single simple intervention is sufficient for the prevention of such violence. Rather, as Briere and Jordan (2004:1263) put it, clinical intervention is likely to be most effective if it is to some extent multimodal. Expanding further on the need for holistic care, the latter authors add that, because every victim of violence differs in her relative need for such interventions, the clinician must be prepared to provide a range of services and to refer the client to other helpers when indicated (Briere and Jordan, 2004:1268).

Study participants, as the above quotes illustrate, clearly emphasized the significance of a multi-disciplinary team working together in the management of gender-based violence victims at the Intermediate Hospital, Oshakati. In addition, they also adduced several measures that can help to achieve this, for example, one participant suggests that:

“…setting up a special committee (on GBV) in this hospital will be very helpful...comprising of some casualty doctors and nurses, the social workers and counsellors, psychiatric people and these admin guys...”
“…the police officers need to be involved too…”

Study participants suggested that the GBV committee should be responsible for coordinating all issues relating to the management of gender-based violence victims presenting at the hospital with a view of encouraging more holistic approaches and indeed improving the current management strategies.

More specifically, with regards to the proposed GBV committee, some participants stated that the committee should:

“…come up with a set of guidelines for everybody to follow…”

“…audit these departments to find out the problems, analyze the problems… see how we can get deeply involved in solving…these…problems…”

Participants also experienced the need to make a daily effort to follow up on the advocated holistic approach to the management of gender-based violence victims and realizing that,

“…this problem (GBV) is more complex…at the same time (it) is getting worse…”
Participants indicated that:

“…we can actually have a separate notebook in casualty to enter all GBV patients and their contact details; then the social worker can actually make a turn in casualty every morning to copy the names and trace them…and their husbands…and take it up from there…”

“…empower the police to follow some of these cases to the end…”

In support of a more holistic approach to managing GBV victims, Michau (2007:2-3) argues that “comprehensive community mobilization is essential if we are to see meaningful, sustained change on the issue of violence against women. Community mobilization can provide a viable alternative to ad hoc programming.” The aforementioned author further explains that “community mobilization adds up individual interventions, sequences them into a logical progression, strives to build on what is achieved, and has an overview on how various activities will slowly come together to change the social climate. It is responsive, participatory, and based on a holistic analysis of the root cause of violence against women.”

Similarly on the management of gender-based violence, the WHO guidelines for medico-legal care of victims of sexual violence stipulate that they require comprehensive, gender-sensitive health services to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The types of services that are needed include testing and/or prophylaxis for sexually transmitted infections, treatment of injuries and psychosocial counselling. In addition to providing immediate health care, the health sector can act as an important referral point for other services that the victim may later need, for example, social welfare and legal aid (WHO, 2003:2).
Besides adopting a holistic approach, study participants believe that comprehensive training of staff is essential for improving the overall management of GBV victims. This is discussed under the following sub-theme.

**Sub-Theme 2.2: Casualty doctors experienced a need for comprehensive training for all categories of staff involved in the management of gender-based violence victims.**

There is no gainsaying the fact that efficient delivery of services in any sphere of human endeavour depends greatly on the competence of the caregivers.

In this study, participants experienced a need for further training for all cadres of workers that deal with GBV victims. They maintain that all professionals involved in the management of gender-based violence victims should be given tailored training especially in psychosocial intervention strategies of relevance to this category of patients.

The following quotes from participants substantiate this sub-theme.

“...there should be adequate training for all cadres of staff on how to handle such issues…”

“...key resource persons among them (various groups of professionals)...should be trained and adequately equipped…”
A few participants went further to explain what the training should encompass by stating that:

“…because the doctors and the nurses are the first point of call when the patient comes in, they need some level of training in counselling…”

“…all the doctors who are…involved in…in handling patients in casualty may go for training…such a training should be specific about gender problems…”

On how this can be achieved, study participants suggest that the required training can be accomplished by in-house seminars and workshops as well as by outsourcing it to professional consultants, as the following quotes clearly reveal:

“…I think the training can be through the workshop organized by the Ministry…em…in the national level and also can be workshop organized by the hospital …em…the management of the hospital…”

“…and we (casualty doctors) may also be involved in the training with the social workers just to personally get involved in the psychological and social treatment or approach to the problem…”
The relevance of training and development of employees, according to Grobler, Warnich, Carrel, Elbert and Hatfield (2006:302-303) includes, *inter alia*, improved performance and updating of employees’ skills. Indeed, given the enormity of the problem of gender-based violence at the Intermediate Hospital, Oshakati, the significance of a more comprehensive training for all cadres of staff involved in the management of gender-based violence victims, as mentioned by the study participants, cannot be over-emphasized.

In their extensive review of the literature on health-care based interventions for women who have experienced sexual violence, Martin, Young, Billings and Bross (2007:3-18) concluded that clinicians often need training in the provision of sexual assault care and that not all emergency departments have sexual assault care protocols. They thus advocate that training in this area is encouraged for all health-care based providers, given that clinicians trained in sexual assault counselling provide better quality care for women who have been sexually assaulted.

In addition to the above measures that can improve the management of GBV victims, study participants also experienced a need for improved interventions at a national level. These form the content of the next section of this report.

**Sub-Theme 2.3: Casualty doctors experienced a need for improved interventions and increased public awareness relating to the management of gender-based violence on a national level by various stakeholders.**

The need to improve the present management of gender-based violence victims was clearly identified by casualty doctors who participated in this study. Beyond measures that can be implemented at the hospital level, study participants are of the opinion that several key interventions should be executed by various stakeholders at the national level since the issue of GBV cuts across the entire nation. In fact, one participant declares thus:
“…It is not just in our community here in Oshakati. It’s also all across the country…we read about it in the newspaper everyday…so we should look at it holistically as a nation and see what we can do…”

Hence, to ensure that the programme managing the issue of gender-based violence gets maximum impact, study participants contend that it is essential that there is a strong backing in terms of appropriate legislation. They thus propose that at the national level, laws should be enacted and a framework for their implementation be put in place that will further support the hospital-based approaches; for example, implementing punitive measures against offenders will not only correct their behaviour but also act as a deterrent to potential offenders.

On this issue, the following participant has this to say:

“…set up enabling laws and policies within the framework of this society that will progress…you know…the course of this fight against gender-based violence…”

This participant clarifies further that:

“…they need to come up with very good laws that will help the people…”

In addition, study participants argue that to improve the management of gender-based violence victims, it is vital that the entire community should be adequately sensitized about the issue of gender-based violence to ensure that culprits can be shamed by their fellow community members, and victims helped accordingly.

Thus they suggest that campaigns should be arranged at all levels across all communities in Namibia to increase the awareness of all and sundry about the menace
of gender-based violence. In addition, societal values that can help in the prevention of gender-based violence like stable single relationships should be encouraged. This is echoed in the following statements made by study participants:

“…and also make it public in the radio and the TV through these open forums and we educate…the population…about this problem…”

“… we can have…em…topical debate involving the whole society…right from the mass media to within our little districts…you know…all across …cutting across these things…we need to sensitize ourselves about it…”

Indeed, the position of the study participants on involving the entire community in this battle against GBV is congruent with the opinions of other researchers because, as Macy, Nurius, Kernic and Holt (2005:138) assert, abused women often seek help from many informal and formal networks. Thus, Michau (2007:2-3) contends that “comprehensive community mobilization is essential if we are to see meaningful, sustained change on the issue of violence against women”. Expatiating further, this author explains that community mobilization adds up individual interventions, sequences them into a logical progression, strives to build on what is achieved, and has an overview on how various activities will slowly come together to change the social climate. It is responsive, participatory, and based on a holistic analysis of the root cause of violence against women.

Furthering their views on the need for improved interventions relating to the management of gender-based violence on a national level by various stakeholders, casualty doctors that participated in this study assert that the educational system of Namibia should be more empowered to teach learners about the consequences of
gender-based violence, which will no doubt significantly contribute to ameliorating this quagmire. Thus they suggest that, beginning from the early stages of education at the primary level right through tertiary levels, the school curricula should be broadened to incorporate the issues of gender-based violence as well as better ways of convivial communal living. This will help to inculcate good interpersonal relationship ideals into people at an early stage and beyond.

One participant illuminates this viewpoint by clearly stating that:

“...If we can design our curriculum in such a way that we can introduce some of the elements of gender-based violence...how man to woman should interrelate...you know...this is going to help...”

In another dimension, given that gender-based violence is significantly associated with the prevalence of alcohol abuse in the community, study participants advocated that better strategies to curb the abuse of alcohol in the Namibian society should be put in place. For example, they suggest that measures to control the sale of alcohol and the operating hours of ‘shebeens’ (taverns) should be tightly regulated. Furthermore, health education on the dangers of alcohol abuse should be given priority by relevant authorities (like the mass media, mental health programme of the Ministry of Health and Social Services and so on).

Speaking on this issue, one participant declares that:

“...I think health education will be a better approach...”

And another clarifies that:
“…we can give more health education via the mass media system…to give more health education about this substance abuse and what is going to happen…if you are taking alcohol and…”

Because many of the perpetrators of gender-based violence are already actually addicted to alcohol, one participant suggests that, there is a:

“…need to set-up something supportive within the society…that will help them rehabilitate into a normal life style…to overcome that their dependency on alcohol…”

The study participants’ call for a wider community involvement in curbing the issue of gender-based violence is congruent with the view of other researchers. For instance, Briere and Jordan (2004:1268) state that prevention efforts are ultimately the only true answer to violence against women. To this end, Muftic and Bouffard (2007:47) suggest that the primary goal of society’s response to domestic violence is the protection of the victim from further abuse.

It is interesting to note that in a study with victims of gender-based violence to assess the helpfulness of the various agencies rendering care, participants described service delivery practices that are essential (regardless of the type of domestic violence or sexual assault service being delivered). These services should include the provision of information to survivors and the importance of collaboration with other legal, health, and human service providers in their communities (Zweig and Burt, 2007:1149-1178). This is in tandem with the experiences of casualty doctors that participated in this study.

On the other hand, the role of poverty and unemployment in perpetuating gender-based violence is highly acknowledged across all communities worldwide. This is because they not only lead to frustration and anger, they also make people more easily short-tempered thus increasing the propensity for numerous violent acts. Thus to tackle the
peril of gender-based violence effectively, study participants strongly recommend that the government at the national level along with other development partners should make more efforts in increasing the socioeconomic levels of people across the country by creating more jobs and enhancing more self-developing skills that can make people more self-reliant.

One participant adds her voice to this crusade by stating that:

“…so I think government should…provide employment for the people…”

In summary, casualty doctors at the Intermediate Hospital, Oshakati, who took part in this study stated that measures to improve the current management standard given to victims of GBV at the hospital should include a more holistic and collaborative approach by all team members; a more comprehensive training for all cadres of staff as well as specific measures (like legislation and relevant policies) that should be taken up by the government at the national level.

3.4 SUMMARY OF CHAPTER

This chapter addressed the results of this study and expatiated on the emergent findings from the data analysis pertaining to the exploration and description of casualty doctors’ experiences regarding their role in the management of GBV victims at the Intermediate Hospital, Oshakati (which is the first objective of this study).

From the analysis of the collected data, the researcher was able to describe what the experiences of casualty doctors were in relation to their role in the management of GBV victims at the Intermediate Hospital, Oshakati.

Participants experienced gender-based violence as a common and recurrent public health issue at the Intermediate Hospital, Oshakati with a large number of gender-based violence victims presenting to the casualty department during their shifts. It was also noted that GBV is becoming more frequent than it was in the past.
Study participants also described their experiences with regards to the pattern of presentation of the victims of gender-based violence that seek emergency care at the casualty department of the Intermediate Hospital, Oshakati. The majority of the victims were described as having a wide range of physical injuries, with facial injuries predominating. In addition to these multiple physical injuries, from the participants’ experiences, most of the gender-based violence victims also have significant emotional trauma.

In the next chapter, the second objective of this study (that is, making recommendations) will be discussed in detail. The fourth chapter will also present the limitations and conclusions of the study.
CHAPTER 4:
SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The purpose of this study was to explore and describe the experiences of casualty doctors at the Intermediate Hospital, Oshakati regarding their role in the management of gender-based violence victims who present at the casualty department of the hospital. Data, which was collected by face-to-face semi-structured interviews, were audio-taped and transcribed verbatim by the researcher.

A summary of findings and conclusions will be presented in this chapter. The limitations and recommendations of the study will also be described.

4.2 SUMMARY OF FINDINGS AND CONCLUSIONS

Following an analysis of the collected data by the researcher in conjunction with an independent coder, it emerged that casualty doctors at the Intermediate Hospital, Oshakati experienced gender-based violence as a common and recurrent public health issue at the hospital, with a large number of gender-based violence victims presenting to the casualty department during their shifts. It was also noted that GBV is becoming more frequent than it used to be.

Study participants also described their experiences relating to the number and types of injuries that the victims of gender-based violence seeking emergency care at the casualty department of the Intermediate Hospital, Oshakati present with. The majority of the victims were described as having a wide range of physical injuries, with facial
injuries predominating. In addition to these multiple physical injuries, from the participants’ experiences, most of the gender-based violence victims also have significant emotional trauma.

In exploring the data further, it emerged that casualty doctors at the Intermediate Hospital, Oshakati who participated in this study experienced:

▪ Several challenges that impair their role in the management of GBV victims. Notable among these are high workload, lack of collaboration among team members and a lack of proficiency in psychosocial intervention strategies. Shortage of personnel and offering services to many non-emergency cases in casualty were seen as major contributors to the high workload that left casualty doctors with little or no time to render emotional care to GBV victims at the first contact in casualty;

▪ Alcohol abuse, low socio-economic status and several relationship problems (like jealousy among partners and cohabiting relationships) as prevalent factors associated with GBV;

▪ That the current programme provides a measure of safety for victims of GBV. In this regard, participants indicated that access to free treatment at the casualty department which operates round the clock everyday as well as the fact that victims at high risk are promptly admitted to hospital are strong measures that assure safety of GBV victims that present at the hospital;

▪ That the presence of a multi-disciplinary team of care-givers also contribute positively to the management of GBV victims;

▪ The need to improve the present situation regarding the management of GBV victims. Several suggestions were adduced including the establishment of clear guidelines for the management of GBV victims; promoting collaboration among all cadres of professionals involved in this issue; campaigns to sensitize the community about values that can help in the prevention of GBV and dangers of alcohol abuse as well as strengthening the legislative framework vis-à-vis implementing measures that will act as deterrents to potential offenders.
The aforementioned suggestions made by participants on how to improve the current programme managing the victims of gender-based violence are integrated into the next section of this report.

In view of the research findings, it can therefore be concluded that the first research objective pertaining to exploring and describing the experiences of casualty doctors with regards to their role in the management of GBV victims at the Intermediate Hospital, Oshakati, has been achieved.

4.3 LIMITATIONS OF THE STUDY
This study had the following limitations:

▪ Scheduling of appointments
  As with most qualitative studies, data collection required direct contact with participants which necessitated prior appointments. This was not easy to achieve in this study given that the participants are public hospital doctors with extremely tight schedules. Therefore, cancellations occurred in some cases and re-scheduling of appointments were done as appropriate.

▪ Subjectivity
  The researcher being an ‘insider’ had to be constantly mindful of the need for neutrality, which is not so easy to achieve in a study on shared experiences.

▪ Generalization
  As with qualitative studies at large, the question of generalizing findings is difficult because of the uniqueness of the study context. Nonetheless, the researcher instituted measures to increase transferability by providing detailed description of the context and the methodology of this study.
4.4 RECOMMENDATIONS

As mentioned in Chapter 2 above, the second objective of this study is to make recommendations with regard to the research findings.

It is anticipated that the recommendations presented here will assist in the overall management of GBV patients at the Intermediate Hospital, Oshakati in particular and in Namibia in general. These recommendations, based on the research findings, are grouped into three sections, namely: recommendations for practice, recommendations for education and recommendations for research. These are discussed below.

4.4.1 Recommendations for practice

It is hereby recommended that to ensure an improved management of GBV victims by care-givers, the following issues should be addressed by the hospital managers of the Intermediate Hospital, Oshakati together with other relevant stakeholders.

4.4.1.1 Establish clear guidelines for management of gender-based violence victims

It is hereby recommended that the hospital managers of the Intermediate Hospital Oshakati provide clear guidelines that will specify how gender-based violence victims should be managed. These guidelines should clearly state the roles of the various cadres of caregivers (like the social workers, nurses, psychiatrist, casualty doctors and others) in the holistic care of GBV victims that present to the hospital.

It is further recommended that the hospital managers set up a committee consisting of resource persons among the various cadres of care-givers to draft a copy of the guidelines. This will ensure input from all quarters and that the final document stating the guidelines should be made readily available to all staff members involved in the management of GBV victims.
4.4.1.2 Promote collaboration among all professionals

It is hereby recommended that the hospital managers promote collaboration among all cadres of professionals (such as social workers, nurses and casualty doctors) caring for GBV victims at the Intermediate Hospital, Oshakati. This will ensure that all stakeholders are able to exchange ideas, discuss challenges and chart a way forward towards enhancing the care of GBV victims.

To achieve this it is further recommended that hospital managers schedule monthly meetings of all staff members that render care to GBV victims. Given that the management of gender-based violence victims requires the input of several categories of professionals, the need for teamwork cannot be over-emphasized as this will prevent caregivers from working independently.

4.4.1.3 Keep a register for gender-based violence victims in casualty

Since the majority of gender-based violence victims seek emergency medical care at one time or the other, it is hereby recommended that a separate register be kept at the casualty department of the hospital to ensure that there is a good system of tracing GBV victims.

This will make it easier for social workers to follow up these patients and possibly make further home visits that can help to curb the growing problem of gender-based violence in the society. This can be achieved by simply assigning a notebook for this purpose and tasking the nursing staff member who initially screens patients at the casualty department to enter contact details of GBV patients appropriately.

4.4.1.4 Enhancing the legislative framework

Casualty doctors, other care-givers and indeed hospital managers should use every opportunity to lobby and network at all levels of government with key stakeholders in order to enhance the legislative framework so that GBV can be adequately dealt with and punitive measures implemented against offenders that would not only correct their behaviours but also act as deterrents to potential offenders.
4.4.1.5 Campaigns to sensitize the community

The proposed GBV committee in the hospital should liaise with various groups in the community, for example, the primary health care team, non-governmental organizations and religious groups, to have regular campaigns in all communities to sensitize them about the issue of gender-based violence. These campaigns could be jointly organized by the Ministries of Health and Social Services, Gender and Information in collaboration with the local government authorities. These should be widely publicized by using multiple mass media avenues like the local radio, television and newspapers.

The GBV campaigns should not only stress the magnitude of the problem of GBV but also highlight the various programmes which can help the victims and perpetrators. In addition, the campaigns should include messages that will help to curb the abuse of alcohol in the Namibian society.

Thus such campaigns should lead to an increase in awareness of all and sundry about the problems of GBV which will even make it easier for gender-based violence victims to seek appropriate help promptly.

4.4.2 Recommendations for education

There is no gainsaying the fact that efficient delivery of services in any sphere of human endeavour depends greatly on the competence of the care-givers.

Based on the research findings, it is hereby recommended that all cadres of workers that care for GBV victims should be given tailored training especially in psychosocial intervention strategies of relevance to managing gender-based violence. This can be achieved by in-house seminars and workshops as well as by outsourcing it to professional consultants.
4.4.3 Recommendations for research

Finally, it is recommended that further studies should be conducted to expatiate on the findings of this research that will improve the overall management of GBV victims.

For example, other studies can be derived from this research focusing on the expressed needs of victims and/or perpetrators of gender-based violence. Also, a questionnaire can be developed from the findings of this study to conduct a quantitative study on a large scale with hospital managers and the various cadres of caregivers (such as social workers, nurses and casualty doctors) to identify factors that can improve service delivery to GBV victims.

4.5 SUMMARY OF CHAPTER

This chapter described the summary and conclusions as well as the limitations and recommendations of this study.

In summary, participants experienced gender-based violence as a common and recurrent public health issue at the hospital, with alcohol abuse, low socio-economic status and relationship problems being identified as major predisposing factors.

Based on the research findings, several recommendations were made, including the establishment of clear guidelines for the management of GBV victims; promoting collaboration among all cadres of professionals involved in this issue; campaigns to sensitize the community about values that can help in the prevention of GBV and dangers of alcohol abuse as well as strengthening the legislative framework. Thus the second objective of this study was accomplished.
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ANNEXURE A

Permission from Faculty Research, Technology and Innovation Committee

Nelson Mandela Metropolitan University
Ref: 207078435

Contact Person: Ms N Ahmed

23 September 2009

Dr RO Tachere
Po Box 90038
Ongwediva
NAMIBIA
141

Dear Dr Tachere

FINAL RESEARCH PROPOSAL: MA HEALTH AND WELFARE MANAGEMENT

Please be advised that your final research proposal was approved by the Faculty Research, Technology and Innovation Committee subject to the following amendments/recommendations being made to the satisfaction of your Supervisor:

Comments

1. That the candidate rephrases “trail of facts” indicated on page 19;
2. The budget on page 22 is too extensive as items are included that is not part of the study;
3. That the candidate determines the cost for stationery and an independent coder;
4. That the writing style abbreviations used e.g.: large organisations in references is not clear;
5. Spelling mistakes e.g.: Pelser / Pesler, page numbers, internet references incorrectly reflected in the text and not reflected in the reference list;
6. Information cited under the text must be indicated in the bibliography;
7. That primary references should be used and not secondary references;
8. No ethics approval is required from REC-H for this research proposal.

Yours sincerely

MRS N AHMED
FACULTY OFFICER
FACULTY OF HEALTH SCIENCES
ANNEXURE B

Letter of Request to Namibian Health Authorities
Permission Request Letter

Intermediate Hospital,
Private Bag 5501,
Oshakati.
10th September, 2009.

The Permanent Secretary,
Ministry of Health and Social Services,
Windhoek.

Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT A STUDY AT THE INTERMEDIATE HOSPITAL, OSHAKATI.

I wish to kindly request your permission to conduct a study titled: “The experiences of casualty doctors regarding their role in the management of victims of gender-based violence at the Intermediate Hospital, Oshakati”.

I am a Medical Officer at the aforementioned hospital undertaking a distance learning programme at the Nelson Mandela Metropolitan University, South Africa. The proposed study is a part-requirement for my degree. It is intended that findings from this study will be used in making recommendations to hospital managers that will contribute to the management of gender-based violence victims in Namibia.

I shall be very grateful if my application is granted.

Thank you Sir.

Yours in service,

Dr Richardson .O. Tachere
ANNEXURE C

Permission from Namibian Health Authorities
OFFICE OF THE PERMANENT SECRETARY

Dr. O. T. Richardson
Private Bag 5501
Oshakati
Namibia

Dear Dr. Richardson,

Re: The experience of casualty doctors regarding their role in the management of victims of gender-based violence at the intermediate Hospital Oshakati.

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. Kindly be informed that approval has been granted under the following conditions:

3.1 The data collected is only to be used for academic purpose;

3.2 A quarterly progress report is to be submitted to the Ministry’s Research Unit,

3.3 Preliminary findings are to be submitted to the Ministry before the final report,

3.4 Final report to be submitted upon completion of the study;

3.5 Separate permission to be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. K. KAHUURE
PERMANENT SECRETARY

"Health for All"
ANNEXURE D

Participant’s Information Sheet and Consent Form
PARTICIPANT'S INFORMATION SHEET & CONSENT FORM

Study Title: “The experiences of casualty doctors regarding their role in the management of gender-based violence victims at the Intermediate Hospital, Oshakati.”

Introduction: Gender-based violence is a major public health and human rights problem throughout the world occurring in all countries irrespective of social, economic, religious or cultural groups. Majority of the victims of gender-based violence at one time or the other receive emergency medical services; thus it has been suggested that the casualty unit of hospitals can be effectively used as an entry point of holistic care for these victims. Therefore, casualty doctors during their respective shifts are in a vantage position to initiate this process in their routine contact with the victims of gender-based violence.

The purpose of the proposed study is to explore and describe the experiences of casualty doctors with regards to their role in the management of the victims of gender-based violence presenting at the Intermediate Hospital, Oshakati, Namibia. It is intended that findings from this study will be used in making recommendations to hospital managers that will contribute to the management of gender-based violence victims in Namibia.

Study participants will be all Medical Officers and Principal Medical Officers who work in the emergency unit of Intermediate Hospital, Oshakati, Namibia. Data will be collected by semi-structured interviews which will be audio-taped. No form of health risk is anticipated during the study which will last for about 45-60 minutes only. Participation in this research is completely voluntary and withdrawal from the study is an exclusive right of the participants at any stage of the study.

Confidentiality and anonymity are guaranteed throughout this study. Also, note that permission to conduct this study has already been obtained from the Research Ethics Committees both at the Nelson Mandela Metropolitan University, Port-Elizabeth, South Africa and the Namibian Ministry of Health and Social Services.

Should you have any further questions, feel free to contact:
1. Dr R.O. Tachere (Principal Researcher)
   Intermediate Hospital, Private Bag 5501, Oshakati, Namibia
STATEMENT OF CONSENT

I have read and I understand the information on the proposed study. I was given an opportunity to clarify areas that were not clear to me in the study. The aims and objectives of this study are sufficiently clear to me. I have voluntarily agreed to participate in this study.

I hereby give consent to participate in this research.

..........................................
Signature of participant

..........................................
Date
Permission Request Letter

Intermediate Hospital,
Private Bag 5501,
Oshakati.
10th September, 2009.

The Permanent Secretary,
Ministry of Health and Social Services,
Windhoek.
Dear Sir,

REQUEST FOR PERMISSION TO CONDUCT A STUDY AT THE INTERMEDIATE HOSPITAL, OSHAKATI.

I wish to kindly request your permission to conduct a study titled: “The experiences of casualty doctors regarding their role in the management of victims of gender-based violence at the Intermediate Hospital, Oshakati”.

I am a Medical Officer at the aforementioned hospital undertaking a distance learning programme at the Nelson Mandela Metropolitan University, South Africa. The proposed study is a part-requirement for my degree. It is intended that findings from this study will be used in making recommendations to hospital managers that will contribute to the management of gender-based violence victims in Namibia.

I shall be very grateful if my application is granted.

Thank you Sir.

Yours in service,

Dr Richardson .O. Tachere
ANNEXURE E

Confirmation Letter from Language Editor
TO WHOM IT MAY CONCERN

I hereby confirm that I have completed a professional language editing exercise on the treatise of Dr Oghoteru Richardson Tachere. The treatise is entitled:

"Experiences of casualty Doctors Regarding their Role in the Management of Gender-based Violence Victims at the Intermediate Hospital, Oshakati"

This treatise is submitted in partial fulfilment of the requirements for the degree Magister Artium in Health and Welfare Management at the Nelson Mandela Metropolitan University, Port Elizabeth.

Yours sincerely

Mrs AG Klopper
MA Health and Welfare Management
ANNEXURE F

Transcript of an Interview
TRANSCRIPT OF ONE INTERVIEW:

Researcher: Thank you very much for accepting to participate in this study. Can you please, introduce yourself?

Participant: I am a medical officer in the department of medicine and…em…I have about six years experience in the practice of clinical medicine. I joined this hospital about 2 years ago and since then I have been involved in management of patients in this hospital both at the department of internal medicine as well as…em…em…the casualty department of this hospital…that’s about it for now.

Researcher: Oh, thank you very much. Can you please describe your role as a casualty doctor in this hospital? I mean the main duties you do in casualty?

Participant: Okay...em…the role that I partake in, in casualty as a medical officer includes taking calls there; I take my shift at the department of …em…at the casualty department and I am involved in the management of medical emergencies; in fact, managing emergencies across all the different fields of medicine…including medicine, surgery, orthopaedics, and gynaecology…and…em…also we take primary care responsibility of patients outside the hospital hours, the normal working hours. So, I am involved in things like suturing…em…medical emergencies like poisoning management…em…asthma
management…a lot of emergencies that occur during…particularly after working hours, those are the things that we do.

**Researcher:** Oh, thank you very much. Now can you tell me, how do you experience your role in the management of gender-based violence victims that come to casualty during your shift?

**Participant:** Ah, experience ...em...em……I will say it varies depending on the time, from call to call, from shift to shift because it is not all the time that you see gender-based violence. But let me say that gender-based violence in Namibia is a bit more common than other places I have worked in…em…sometimes…usually…sometimes if you want me to put the average, I would say sometimes I see an average of about two to three per shift, but it may be more than that sometimes…sometimes I don’t see any. And I have also noticed that towards the end of the month you can see more. The types of abuse that we usually see…particularly on females…would range from physical abuse to sexual abuse in terms of the violence that we see. I have noticed that the age group that are normally involved are those in their twenties, thirties, some in forties and very few occasionally maybe fifties, sixties…but those are rare. It’s usually common among the younger age group…em…apart from that…em…I would say I have also noticed some patterns in the types of violence that we see…it is usually a recurrent thing and …em…the patient probably has been abused…you know…before, usually physical abuse before by the same partner and she is coming back again. Then they come up with different kinds of
stories...some don’t…for the fear of the same person that beat them, they don’t want you to…em…they don’t want to give you the full story so that...you...they are afraid that the person may repeat the same thing in the future...so they sometimes cover-up...that they fell in the gutter, but by the time you try to probe them, then you will be able to get a different story. So, like I said...em...we see gender-based violence sometimes occurring in form of physical assault and sexual assault. Physical assault such as...they range from...you know...may range from little...should we really call it little? You know...it may range from a slap to ...em...lacerations, stab wounds, you know...severe beating with a lot wounds...cuts all over the body...so we do see that a lot. And...I have noticed some things that...that go along with gender based violence...I am not saying they are responsible, but I have noticed some things, things like...the fact that it’s more common among unmarried couples...that is not to say that married couples don’t, like unmarried partners. Em...I have also noticed that...that it is common among people of low socioeconomic status...when I say low socioeconomic status, I mean things that easily provoke gender-based violence are found just...just...em...very very close to them...things like...em...because of the fact that there is no money...the wife or the partner may ask for money from the male partner for...maybe...shopping or to buy something for the kids at home or some other things...in annoyance the person returns back, you know, with a reply in form of...with a slap and little things, just argument over little things deteriorate into physical violence...by the time you try to probe, you discover that issues of money, issues of...em...of...em...that revolve around their low socioeconomic status. They likewise...em...maybe...I will say jealousy. Jealousy also sometime...in fact...not sometimes, a majority of time...may be...the partner hears that the wife...the female partner is sleeping with another person, the male partner can, you know, can...you know...don’t want to see the female partner without asking what actually
happened or verifying the authenticity of what he has heard…he starts beating the woman up…so…it ranges from presentation to presentation. There was a case that occurred recently at the mines…that’s …that’s not a gender-based violence anyway, but I am just saying that the way a man can react…he was retired from where he was working at Orangemund during this economic crises…diamond companies were laying off staff…so when he came back home, he heard that the wife who is a teacher was sleeping with another teacher in the school and he just went somewhere quietly, drank a lot of alcohol, then went to his car and drove the car inside…you know…a body of water and he died…it was published in a National Newspaper…The Namibia…but the same could have reacted differently…because he couldn’t take it…he felt he has just lost his job and also losing his wife…life is not worth living for him, that’s why he killed himself…it could have been the other way round…he could have gone home to kill the wife or go home and stab the wife seriously and result in gender-based violence. What I’m saying is that…em…information that goes around, whether verified or not verified, could produce jealousy either the male partner’s side or the female partner side to cause aggression towards the female partner…so…I think…em…those are the experiences I have heard so far.

**Researcher:** Oh, thank you very very much. Now tell me, when these patients come to casualty, what do you do for them? How do you treat them when they come to you in casualty?
**Participant:** Okay, we have a multi-faceted approach to their management, for example, myself as a doctor, the only thing I can do is to take care of the physical wounds and just provide a supportive…em…an immediate supportive management for those…for those patients. You want to probe around what happened so that you can document it properly; then we have a structure on ground that we can refer them…we have social workers that we refer them to and we have the police building within the hospital…the gender-based violence unit that we can refer them to. So that they can make a proper…em…em…a proper police report. Then apart from that, we have the counselors that get involved and counsel them, so that is what we do here in this hospital.

**Researcher:** Thank very much. Now, this approach you have mentioned…do you think there are any strengths to the management of these patients coming to the hospital with the present approach?

**Participant:** Well, I would say the structure that we have on ground is a good plus…I mean the framework of the structure because we still have to look at the structure properly, but the framework of the structure that we have…a design that is on ground that things are not done haphazardly, there is a laid-down procedure for handling such issue is a major plus for this hospital…not just handling the physical injuries that they sustain because behind every gender-based violence, apart from the physical injury that you see, there are deep emotional wounds that are involved. So, we have the gender-based violence unit in terms of the police for those that want to get proper police follow-up from there. We also have the …the counseling unit that we
can refer them to such as the social workers unit that can get involved...so I think, that is...em...an appropriate framework within the context of our own situation.

**Researcher:** Oh, thank you. Can you describe any weaknesses to the present approach to the management of these patients?

**Participant:** Weaknesses...em...I would say that in terms of weaknesses, if you look at the structure that we have on ground critically, even though it may be a right structure, how effective are they? ...In terms of producing results...we may really have to look at it and ...em...maybe see the weaknesses of that system. Em...the number of cases that we are reporting daily within our hospital...the capacity of the structure that we have on ground...how adequate are they? Those are the things that we really have to work upon...the social workers...are they being trained regularly? The councilors...are they being trained regularly? Are they even adequate in terms of staff strength? Are they making follow-ups?...(...background noise...) Do they actually make follow-ups in some of these cases? Those are the critical issues that we need to address...I think those are still the main weaknesses that we have...we have a structure on ground, but how effective the structure is, is really really very questionable. I think it is the major problem.

**Researcher:** Oh, thank you very much. Now that you mentioned and highlighted some of the weaknesses, do you think there is anything we can do to improve the management of these patients coming to our hospital?
**Participant:** Yes. Em…of course, there is always room for improvement. Like I have …have listed all the areas that we really need to work upon. First and foremost, to look at the structure that we have on ground…I think…the part of our own…em…on our part here, we need to look at…em…departments that we have highlighted…the social workers, the councilors, the police unit and really see how we can effectively get them involved, not just that they are there…I mean effectively get them involved. We need to do probably an audit of these departments to find out the problems, analyze the problems, see how we can get deeply involved in solving…these…em…problems that we have in our community and I think…em…these are some of the things that I think we can do for now…that we really need to do…except you have some other questions you want to put to me.

**Researcher:** Yeah, thank you, thank you, thank you. Now, let’s talk about what you have recommended in improving the structure…making it more effective. How do you think we should go about it? Can you describe practically what you think can be done to implement this effectiveness you have talked about?

**Participant:** Okay…em…in terms of that, then you have to look at those basic units, …like I said…alright, like in this hospital…we have a social worker, the volume of people…the traffic that you have coming in as a case of gender based violence, are they adequate enough to handle
them…in terms of staff strength? And don’t forget that the social workers are not specialized particularly for gender-based violence…they are also involved in other issues in the hospital…so, we really need to look at that; can we structure it in such a way that there will be key resource persons among them that will be trained and adequately equipped to handle some of those matter? …and probably we may even need to recruit some volunteers within the society…you know…to add to them…that’s one possibility.

The second thing is for you to empower the police to follow some of these cases to the end…because when they see that…em…offenders are being prosecuted, it will be as…it will act as a deterrent to other people that are…you know…in the future are going to be involved in such, but if somebody does it today and is not being punished for it…in the future, it encourages other people to do it either by physical encouragement or by the obvious fact that he was not punished…you know…the society will continue to harbor that kind of a behavior…will continue to harbor that kind of situation because they see it as normal

Then apart from that, I think we really also have to look at the…the state of…the …like I mentioned the other time…sometimes when people are drunk, they are…you know…have all…it also happens. When people that are usually involved……one of the situation that I have noticed is that…some of them are drunk, either on the partner’s side or…I am talking about the male partner or even both of them are drunk…such people…now we have noticed that it is the alcohol that triggers their aggressive behavior; in their normal state of…you know…composure, they don’t really go for such aggression but when they are drunk, they can do anything and so such a…need to set-up supportive something within the society that will counter
against…em…or that will help them rehabilitate into a normal life style…to overcome that their
dependency on alcohol.

Then apart from that…they have to as a matter of …em…national urgency set up enabling laws
and policies within the framework of this society that will progress…you know…the course of
this fight against gender-based violence. The legislature…must…the legislature must be
involved in this whole issue and I am glad they are doing something presently across the country.
They are trying to formulate laws and they are asking for inputs from the people and they are
doing town to town meetings…town hall meetings, all over the country in order to get further
inputs. But the main thing, they need to as a matter national urgency…because it is common…it
is not just only here…. it is all across the country….they need to come up with very good laws
that will help the people. So, I think…em…that, that, that…doing that will help us a lot in the
long way to counter the effect of this gender-based violence that is now going strong within our
society.

**Researcher:** Hmm, thank you very much. Now, you mentioned something
about staff strength…you were emphasizing on social workers, taking
local…taking volunteers and all that, on the part of doctors in casualty…the
issue of staff strength…do you think it also affects doctors in casualty, how
they handle these patients, why they are not being referred or what they do
for the patients…do you…do you think the …do you think the staff strength
issue is only for social workers and volunteers can help on that side or the
staff strength cuts across all cadres of workers handling these patients?
Participant: Of course, it cuts across all cadres of workers…we cannot just talk about those people…I am talking in terms of when we refer…what happens to them? But on the part of the doctors, when…and they have a line of almost one hundred people waiting for them and you come in as a case of gender-based violence, he literally takes you as a case of the physical injuries that they have…he is more interested in quickly suturing your wounds, dressing the wounds, writing antibiotics for you, writing…em…anti-tetanus for you and immediately just quickly document and send you to the appropriate quarters. But appropriate management is…a very realistic appropriate management of that patient…should have started from the doctor…basic counseling, encouragement…you know…trying to comfort the patient is…is important particularly at the first point of care…the person seeing the patient first most likely at the casualty is going to be the doctor. So, I…I think…em…they really need to work on that also. It should cut across…not only the social worker…but it should cut across the whole cadre of staff. There should be adequate training for all cadres of staff on how to handle such issues…you know…when a patient comes as a case of gender-based violence…right from the time she joins the queue till she is seen by the doctor, till she is seen by the social workers…usually the social workers won’t see until the following day since they don’t take calls and the police won’t be there until the following day…you know…they also won’t take calls because they are expecting gender-based violence case to come. So, the immediate treatment should have involved definitely some level of counseling from the doctor…but even if the doctor or nurse is adequately trained, even, if …if we assume that in the state they are adequately trained…because of the workload, they won’t have that time…it’s a luxury to give such a counseling at that point in time; they will rather just quickly treat the physical ailment and physical …em…injuries and
just refer; so I think…em…to help us to help the patients, they really have to look at this more holistically …from the workload of the doctors to the nurses, training on the part of the doctors and nurses and the whole health system entirely.

**Researcher:** Thank you very much. Now, I will take you back a little to what you just described…you talked about training…training for all cadres of staff. Can you throw more light on this training? What should be the content of this training? Who should give the training? And I mean…issues like that…can you explain more...how...what do you think this training should really encompass? And how should it be implemented?

**Participant:** Okay, definitely the training should be more from counseling, particularly on the side of the doctors and nurses; of course, it’s not going to be an in-depth training like the one that the counselors should have but the basic things that you need to do, the basic things that you need to say, the probing questions that you need to know…to ask…the way to encourage a person who has suffered such a big emotional hurt…you know…should be…em…em…em…should be trained or…em…should be a part of the training that these health care workers should be involved in. Like I said, their training won’t be as deep as that of the counselors, but the counselors definitely would need to be trained much more in-depthly but because the doctors and the nurses are the first point of call when the patient comes in, they need some level of training in counseling…counseling skills and…em…
Researcher: Thank you very very very much. I really thank you for participating in this study. Is there any other issue you want us to talk about with respect to gender-based violence?

Participant: Yeah…em…I think there are quite a number of issues that we may have to really look at and talk about when it comes to gender-based violence in our society. First of all, we need to know that it is not occurring in isolation. It is a widespread thing. It is not just in our community here in Oshakati. It’s also all across the country…we read about it in the newspaper everyday…so we should look at it holistically as a nation and see what we can do.

So, I will suggest also that if we can have…em…topical debate involving the whole society…right from the mass media to within our little little districts…you know…all across…cutting across these things…we need to sensitize ourselves about it…that it is an issue within our society. We should just not ignore it as if it’s just a norm or that’s the way it’s supposed to be. Just like the programme in HIV, they keep informing people during…so it’s all over the place…hardly can you go anywhere without seeing either on the television a promotion on condom or somebody wearing a T-shirt telling you that…about condom use…a car going pass with a sticker on condom use. For TB* (*tuberculosis*), you see something like that also…em…if you cough more than three weeks…you go to the hospitals, you see a sticker…you…anywhere, these are sensitizing things to the community, so they are aware of it…naturally when they come to the hospital, when they cough a little bit, they will even start
thinking it’s TB because the society has been sensitized. So we need a …to have a very good mass mobilization in sensitizing the whole community about this thing so that…em…at the end of the day we…we are ready to make…we are ready to…we are ready to project this thing as an abuse within our society…something that is not normal, something that is not part of the African Culture…so that they don’t see it as a norm rather they should see it as something that is odd and something…something that…you know…should not be…em…be harboured within…within us. That’s one thing I will mention.

Then if you want me to also…em…say another thing, may be…if they can inculcate these things into the growing children…because these are the people that eventually become adults…the people that are beating people today were also once children. If we can design our curriculum in such a way that we can introduce some of the elements of gender-based violence…how man to woman should interrelate…how, you know…this is going to help. When I was growing up, we had a course in school we call Social Studies…they taught us about our role as citizens, what we expect the government to do for us, your role as a child in the family, your role as a parent in the family…you know…it was a very comprehensive course about human inter-relationship and social interrelationship within the society…so, maybe if they have a course like that designed with some of these things, incorporated so that right from the childhood, the child knows that this thing is not right…he doesn’t see examples in the society…seeing somebody beating his wife and thinking that, yeah, that person is a man; but rather will know from education that that thing is not right. I think it will really help us a lot.

Em…maybe in addition to that, I will just say that it is also possible so that the…the…at the end of the day…anyway…although I don’t know have a clear picture of that one…anyway, we can
encourage people to marry...like I told you the other time, there have been so many cases where…it’s usually common among unmarried people. If there is anything we need to do within our society to encourage marriage relationship, then, I think we really need to focus on that. So, maybe, those are ways I would like to talk about.

**Researcher:** Oh, thank you very much. It’s been quite an interesting time with you. I will get back to you with your transcript so that you can go through and make your additions or subtractions in the next couple of days. Thank you so much for participating in this study. Thank you.

**Participant:** It’s my pleasure.

**Researcher:** Thank you. Okay. Bye.

**Participant:** Alright. Thank you.