Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
DAC	Development Assistance Committee
HIV	Human Immuno-deficiency Virus
WHO	World Health Organisation
SA	South Africa
HBM	Health Belief Model
CEDAW	Convention on the Elimination of all Discrimination Against Women
LAC	Legal Assistance Centre
NAMPOL	Namibian Police
UNICEF	United Nations Children's Fund
PTB	Pre term birth
LBW	Low birth weight
PTL	Pre term labour
CDC	Centre for Disease Control
UN	United Nations
SPSS	Scientific Package for Social Sciences
WCPU	Women and Child Protection unit
GRN	Government Republic of Namibia

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Declaration

I declare that **The views and perceptions of maternity patients on domestic violence**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledgement by means of complete references.

…… July, 2005
E.Libuku

Acknowledgement

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Abstract

Pregnancy is a period of great expectancy and excitement for most women. This is a time that they cherish, and their partners and family members also experience this feeling of excitement. They would strive to prevent any injury that may be caused either through accidents, or through indirect behavior on their side. This implies that the mother would take care to ensure that their own health is optimum for the best possible outcome during the growth and development of their unborn children, during all the phases, which include conception as well as the embryonic and fetal development phases. Unfortunately being pregnant does not exclude women from being subjected to violence.

The purpose of the study was to explore and describe the views and perceptions of maternity patients on domestic violence. Towards this purpose, the objectives were formulated, namely:

To explore and describe the views and perceptions of maternity patients on reasons for domestic violence; to explore and describe the views and perceptions of maternity patients on reasons why women do not report domestic violence; to explore and describe the views and perceptions of maternity patients on reasons why women may tend to endure domestic violence, and to explore and describe the views and perceptions of maternity patients on coping strategies they believe women use in situations of domestic violence.

For the purpose of this study the Health Belief model was used. The main components from this framework, which was deemed appropriate, were how people perceive the benefits and barriers in health seeking behaviour. (Glanz, Lewis, and Rimer, 1997:10) A quantitative, exploratory and descriptive design was utilized. The study was also contextual in design.

The target population comprised of all maternity patients admitted to the Windhoek Central Hospital for the period of April 2004 until March 2005 (Twelve months).
To obtain a representative sampling size, it was statistically determined to interview or distribute questionnaires to at least 184 maternity patients. A self-administered questionnaire consisting of open ended and closed ended questions was used in cases where no assistance was needed. In the cases where assistance was needed to complete the questionnaire, the researcher utilized the questionnaire as an interview tool.

Descriptive statistical analysis was used for describing the data and it included techniques whereby information was sorted, arranged, collected and presented in a scientific manner. (Uys & Basson, 1991:109) This was done using the Scientific Package for Social Sciences (SPSS).

As this study utilized concepts based on the *"Health Belief Model*", it was necessary to identify factors which could modify *views* and *perceptions.* This was done by implementing correlation statistics, and specifically the Pearson correlation coefficient (X^{2} / Chi- square).

It was found that some views and perceptions were influenced by biographical differences like education, age, and economic status. In some instances the views/perceptions of the maternity patients were in line with researched literature. It was recommended that during the assistance of maternity patients or during health education that consideration be given to these differences in views and perceptions.

Chapter 1

Introduction and overview of the study

1.1 Introduction and background to the problem

Pregnancy is a period of great expectancy and excitement for most women. This is a time that they cherish, and their partners and family members also experience this feeling of excitement. The expecting mother would do everything within her ability to see to it that her child is carried to term and that no harm is being done to her unborn child. She would strive to prevent any injury that may be caused either through accidents, or through indirect behavior on her side. This implies that she would take care to ensure that her own health is optimum for the best possible outcome during the growth and development of the unborn baby, during all the phases, which include conception and the embryonic and fetal development phases. Unfortunately being pregnant does not exclude women from being subjected to violence.

Most of these women opt to be admitted in a health facility when they are close to term, in order to be assisted in the birth process by health personnel, who could be medical practitioners and registered nurses, or sometimes only registered nurses. This could also be interpreted as trying to ensure that no harm befalls to their unborn children.

Once admitted at a health facility they become known as maternity patients. It is during this phase that the researcher encounters these women, now known as maternity patients. As a registered nurse and midwife, the researcher admits and cares for these patients during the period immediately before delivery, during the process of delivery itself, and during the post delivery period. This caring involves intimate contact with these maternity patients, and involves physical and emotional assessment as part of nursing interventions.

With the assessment of the maternity patients the researcher had noticed on several occasions that some of the maternity patients did not seem to be in optimum physical health. Unexplainable bruises were noticed, that could be regarded as being caused by violence, and not by accidents. These bruises also appeared to be of such a magnitude as to affect the health of the unborn child. This finding was in contrast with the general belief that women would strive to prevent any harm to their unborn children. Thus the researcher assumed that someone harmed these women. A possibility of assault within the larger frame of domestic violence was believed to be the reason for these bruises.

This assumption was further strengthened by media reports about assaults and domestic violence directed against women. According to a study being reported by a local newspaper on the incidence of domestic violence in Namibia, it was indicated that 36 per cent of the women that had been interviewed reported that they had experienced sexual or physical violence from a partner in their lifetime. In the same study as reported by the above-mentioned newspaper, it was stated that 6 per cent of these women had been beaten during pregnancy, and some of them had also been kicked in the abdomen. In most cases the

perpetrators had been the fathers of the children. (Anonymous 2003:3)

The researcher, being a registered nurse and midwife, is acutely aware of the dangers that both the mothers and the unborn children are exposed to during periods of assault and violence metered out against them. With severe assaults the possibility of pelvic fractures exists. In pregnancy the pelvic venous plexuses are engorged and rupture could lead to massive hemorrhage, should fractures be caused during an assault. Placental abruption can also occur, with fetal death, especially with kicks to the abdomen. (Greaves & Porter, 1999:501)

The women admitted to the specific health facility (State Hospital in Windhoek), appeared to be sincere, caring and intelligent. They should therefore be aware of the dangers to them and their unborn children should they be assaulted. Still they seem to endure this violence directed against them.

A need for a specific type of assistance (nursing intervention) was felt to be necessary by the researcher. Any assistance however, whether in the form of health education, emotional support, advice or referral should first of all be based on the viewpoints and perceptions of these women with regard to violence and domestic violence per se. It is these viewpoints and perceptions that let them endure and try to cope with situations that are detrimental to their health.

The implications of the above mentioned findings and assumptions will be addressed next under the formulation of the problem, research purpose, objectives and justification of the study.

1.2 Statement of the problem

Pregnancy is a high-risk period during which violence may begin or escalate, harming the fetus[1] as well as the mother. The impact of violence is not only on the unborn child but also on the mother. Women who experience domestic violence may use drugs and alcohol to conceal their shame and suffering. (Widding & Per Olof, 2000:695)

Most cases of violence against women happen at the household level. More than 1/5 (20%) of all violent cases in Namibia occur within the context of domestic relationships. As a result more than 2000 cases of domestic violence are reported to the police annually. The observation of the bruises, as made by the researcher, could therefore also be related to possible domestic violence. (Hubbard, 1999:1) Still, not all the cases of domestic violence are reported, including domestic violence directed against pregnant women This might be due to certain past experiences or belief systems that lead women and maternity patients to endure and not report incidences of domestic violence.

[1] The term fetus and unborn child will be used interchangeably. Sometimes the term “children” will also be used depending on the context of the sentence.

What was needed was an exploration and description of these viewpoints/perceptions in order to empower women and maternity patients to act and seek help. These results could also equip nursing personnel to better assist a maternity patient believed to have endured domestic violence. This might lead to a change in their belief systems.

This empowerment could be part of educational programmes. Most large institutions have continuing in-service educational programmes in place that deal with topics of interest as well as topics of "priority". An example of such a "priority" topic is HIV/AIDS. It should be regarded as a priority topic for continuous education.

The maternity section of Central Hospital in Windhoek is a large institution in it self. As such it has numerous educational programmes, not only for its own personnel, but also for the maternity patients under its care. Some of its educational programmes, which could be regarded as "high priority", are HIV/AIDS and immunization, to name but two. These educational programmes are aimed at the maternity patient.

Maternity patients need to be assisted and informed about the danger of violence during pregnancy, but also to domestic violence in general. This is necessary to ensure optimal health for mothers and their unborn children. This might lead to a better-informed female partner and to more assertive actions from them.

Information and results obtained from a study on the viewpoints and perceptions of maternity patients on domestic violence could be used as recommendations for the

compilation of an educational programme, and also to assist the registered nurse in her supporting, advising and referral role.

The problem was that the views and perceptions of maternity patients on domestic violence were not known.

In order to assist, advise and render health education, it is necessary to have a consideration of the present knowledge, attitudes, goals, perceptions, social status, power structure, cultural, traditions and other aspects of whatever the public is to be addressed. (Glanz et al, 1997:6)

Due to the sensitive nature of domestic violence, the approach to the maternity patients should be done in such a way that they would not feel as if they are being identified as victims of domestic violence. The maternity patients therefore should be informed to react to the questions about their views on domestic violence as being hypothetical, and not necessarily pertaining to them.

With the abovementioned considerations noted, the purpose and objectives of the research study are presented next.

1.3 Research purpose

The purpose of the study was to explore and describe the views and perceptions of maternity patients on domestic violence.

1.4 Objectives

- To explore and describe the views and perceptions of maternity patients on reasons for domestic violence
- To explore and describe the views and perceptions of maternity patients on reasons why women do not report domestic violence
- To explore and describe the views and perceptions of maternity of patients on reasons why women may tend to endure domestic violence.
- To explore and determine the views and perceptions of maternity patients on coping strategies they believe women use in situations of domestic violence

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1.5 The theoretical framework

For the purpose of this study the Health Belief model was used. The main components from this framework, which was deemed appropriate, were how people perceive the benefits and barriers in health seeking behaviour. (Glanz et al 1997: 10)

The selection of this framework was based on the observation made by the researcher that these maternity patients who appeared to have been assaulted, endured their ordeal and did not try to seek any help (Health seeking behaviour).

This aspect together with the main concepts will be integrated in chapter 2 as part of the literature review. The concepts that will be integrated are as follows:

- To highlight that inaction (of maternity patients) in not seeking help, could lead to serious, undesirable consequences
- To demonstrate that there are benefits to taking action
- To identify ways to deal with perceived barriers to action
- To identify the cues that might inspire action

1.6 Justification of the study

Maternity patients need to be informed about the danger of violence during pregnancy, and domestic violence in general, and this can be done through an educational programme. The results from this study might be applicable in the compilation of an educational programme. Such an educational programme could change the maternity patient's views and perceptions towards domestic violence, increase their awareness towards domestic violence and empower them with skills to deal with domestic violence if so needed. A total belief reorientation might occur. In a contextual situation, like a maternity ward, a caring

registered nurse may make a small but significant contribution in changing beliefs or viewpoints on domestic violence.

The findings of this study might also assist the registered nurse in her assessment and support of a maternity patient believed to have been exposed to bouts of domestic violence.

1.7 Definitions

For the purpose of this study, the following terminology is defined.

- **Views**

"Views" means ways of understanding or interpreting a subject, series of events and also personal opinions or attitudes, thoughts or observations that people have, hold express or oppose. (Cowie, 1994:1420)

In this study it means the way maternity patients interpret aspects of domestic violence and the attitude they demonstrate towards domestic violence.

- **Perception**

A way of seeing or understanding a situation. (Cowie, 1994:917) In this study it is how the maternity patients are seeing or understanding domestic violence.

- **Maternity section**

Refers to the department where all pregnant women deliver their babies and are admitted after delivery. (Ruth & Brown, 1989:49)

In this study it is the maternity section at the State Hospital in Windhoek.

- **Maternity services**

These are services, which are rendered to women at their childbearing age. It provides ante natal services which include examining pregnant women, providing family planning, assisting with deliveries and post natal care, which includes after delivery care and support. (Ruth & Brown, 1989:49)

- **Domestic violence**

Definitions of domestic violence and abuse vary among researchers. The WHO (1999:14) breaks down the term domestic violence into its two components:

* *Domestic and*

* *Violence*.

Each element is defined separately for a more precise clarification of the terminology being used. The term "domestic" indicates the setting in which the violence occurs. It specifically refers to a marriage or a cohabiting relationship. Violence is defined as any intentional, hostile, and aggressive physical and/or psychological act towards another individual.

In this study the violence is directed at women (pregnant and not-pregnant).

- **Abuse**

Abuse is described as the use of physical, verbal, emotional force and attacks in order to control and maintain power by frightening and intimidating someone over time. (WHO, 1996:45)

- **Empowerment**

Empowerment is the process of generating and building capacities to exercise control over one's life. (Iipinge & Williams, 2000: 6) Empowerment could be obtained through education and information.

- **Physical abuse**

Physical abuse is the intentional use of physical force with the potential for causing death, injury or harm. Physical abuse includes, but is not limited to, scratching, pushing, throwing, grabbing, biting, shaking, poking, hair-pulling, hitting, burning, the use of restraints or one's body size or strength against another person, and the use (or threat to use) of a weapon (gun, knife or object). (MOHSS: 2003:44)

- **Psychological violence**

Psychological violence includes repeated verbal abuse, harassment, confinement, and deprivation of physical, financial and personal resources. (WHO, 1997:77)

- **Violence against women**

The term "violence against women" refers to many types of harmful behaviour directed at women because of their sex. (WHO, 1999:56)

- **Educational programme**

In this study an educational programme is a structured information session based on patients' assessment and needs. The information session consists of objectives, contents, and education components. In some instances a discharge instrument might be included. (Sheehy, and Lenehan, 1997:18)

In this study it is envisaged that the findings of this study would be applicable to include in a future educational programme.

- **Pregnancy abuse**

Abuse during pregnancy can be defined as repeated physical and/or sexual assault during pregnancy within a context of coercive control. (Hayward, 2000:40.

- **Maternity patient**

A maternity patient refers to women during pregnancy and 6 weeks after childbirth. (Kindersley, 1998: 1923)

In this study it specifically refers to women admitted for the purpose of the delivery of the unborn child and the resultant post delivery care of the mother and newborn child.

1.8 Outline of the study

Chapter 1

Chapter 1 deals with the introduction and background to domestic violence, problem statement, the purpose, objectives and justification of the study.

Chapter 2

In this chapter the focus is on the literature review.

Chapter 3

This chapter describes the methodology used for the study.

Chapter 4

In chapter 4 the data is discussed and analyzed

Chapter 5

The conclusions, limitations and recommendation are addressed in this chapter.

1.9 Summary

Maternity patients were admitted with indications that some of them might have been exposed to violence. The danger to the mother and unborn child is a recognized fact, but how would it be possible to assist these women? The researcher assumed that they tend to endure abusive situations and tend not to report it. Any interventions, be they in a form of advice, support, health education or assistance depends on an exploration and description of the views/perceptions of maternity patients. Their belief system needs to be explored.

The next chapter will deal with the literature review.

Chapter 2

Literature review

2.1 Introduction

In the previous chapter the study was introduced by stating the problem, purpose and objectives. This chapter will be the literature review.

The point of departure of the literature review was to conduct the research within a framework that encapsulates the focus of the study. The researcher had noticed, as was explained under the introduction and formulation of the problem, that women with unexplainable injuries, particularly to the breast and abdomen, tend to endure and to cope. This behavioral pattern indicated an imbedded perception, a belief system that influences actions and inactions. The health belief model was therefore used to focus a great deal of the literature review. This aspect will be discussed in more detail in point 2.2

The researcher also noticed that these were generally caring women, and would not allow any action that could cause injury to them and so harm their unborn children directly or indirectly. This aspect links to their health belief system, but also on their perceptions/views of what violence, and specifically domestic violence, entails. The concept of domestic violence was therefore also analyzed through the literature reviews.

The impact of domestic violence on the mothers' health and her unborn child's health was also reviewed. Regardless of a specific belief system or perceptions/views on domestic violence, two lives are endangered. Emotional scarring is another, sometimes silent burden,

that is placed on an already taxed mother.

The first discussion point will be the *Health Belief Model.*

2.2 The Health Belief Model

When preparing the field and focusing on the problem, the researcher noticed certain trends in the views/perceptions behaviour that people verbalize or demonstrate towards domestic violence. These views/perceptions and behaviour are believed by the researcher to be influenced by how people perceive themselves as being susceptible to domestic violence and also how they perceive the severity. In addition their views/perceptions of possible barriers to cope or survive, as well as their beliefs in their own inner strength to take action, also influence their overall views on domestic violence.

Health beliefs, in particular the belief that one is susceptible, that the consequences of disease could be serious and that taking action results in greater benefit than cost, have been consistently associated with health behaviour. (Wright, 1998: 7) In this regard the Health Belief Model is a value expectancy theory. It implies that there is a desire to avoid illness or to get well, and the belief that a specific health action available to a person would prevent illness (expectancy). The expectancy can be further delineated in terms of the individual's estimate of personal susceptibility to, and severity of an illness (domestic violence), and of the likelihood of being able to reduce that threat through personal action.

(Glanz et al, 1997:46)

The Health Belief Model is explained by means of certain components. See table 2.1 These components are:

- Perceived susceptibility
- Perceived severity
- Perceived benefit
- Perceived barriers
- Cues to action

Table 2.1 an adaptation of the Health Belief Model: Components that influence women's views on domestic violence.

Individual perceptions	**Modifying factor**	**Likelihood of action**
Perceived susceptibility of being a victim of domestic violence	Age, sex, ethnicity, personality, socioeconomic, knowledge	Perceived benefits, minus perceived barriers to action against domestic violence
	Perceived threat or consequences	Likelihood of taking action against domestic violence
	Cues to action: o Education o Medical Symptoms	Likelihood of taking action against domestic violence

2.2.1 Perceived susceptibility

This is an individual's subjective perception of his or her risk of contracting a health condition (being a victim of domestic violence). There are some factors that play a role in making maternity patients susceptible to domestic violence. These factors will be discussed next.

- **Age**

It is assumed that with age comes wisdom. This assumption is based on the accumulation of experiences over time and development stages that have been reached. This acquired wisdom could have different effects when decisions have to be made on actions when being abused. Some women might decide to endure or cope while others may report violence against them and try to reach a solution. Age, however, is not really a determining factor in who is abused or not.

- **Personality**

The pervasiveness and implicit acceptability of violence in the family that is directed at women might be related to personal and individual characteristics. There is no specific personality type that can be attributed to victims of domestic violence. However, personality might influence a person's views on whether to act and report domestic violence or to cope with domestic violence. The act of domestic violence being directed at females could lead to enhancement of existing personality characteristics. As domestic violence might be regarded as a way by partners to achieve control over their victims,

women with a low self esteem or who are submissive in nature might begin to experience feelings of worthlessness. A whole new belief system might develop in the abused woman. She might feel ignorant, and that no one cares. Her thought processes might include denial, and she will become silent. Mentioning is also made of the self-defeating behavior disorder. The person may avoid pleasurable experiences, be drawn to situations in which there is suffering, or prevent others from helping her. This is however a controversial aspect, and could harm women in their quest for justice and reporting of situations of violence. (Sheehy & Lenehan 1999:575)

- **Gender Role**

Gender roles are socially given attributes of position and activities connected to being feminine and masculine in a given social grouping. Both femininity and masculinity are constructed from the role women and men are assigned and the expectations which society has of women and men, which are based on gender. While there are some similarities in what is feminine and masculine across some societies, these similarities are culturally bound or culturally specific and temporary or historically and politically determined. (Iipinge et al 2000:2) The inequalities between women and men that are common in most societies are usually also reflected in the health sector. There is a need for structural transformation for the development of an effective health-services response to women in an abusive situation. (Moreno, 2002:1511)

- **Socio-economic status**

MacEwen & Barling (1998) explained that socioeconomic status refers to a composite of demography variables that represents an individual's overall social standing and wealth. It includes educational attainment, employment status, and occupational attainment.

Economic factors and male unemployment are other repeated themes relating to domestic violence. Unemployment, poverty and alcoholism are frequent contributors. Of the perceived causes of domestic violence, none is mentioned more frequently or comes through more clearly, than the influence of alcohol on domestic violence. Women report that their husbands come back home drunk and beat or batter them to get money for more drinking. Medical personnel report treating women whose injuries were sustained during beating when the husband was drunk. Community activists identify alcohol abuse as a primary factor in domestic violence. There is no doubt that alcohol abuse is a primary factor in domestic violence. (David, 1989:34) Women who find themselves in these types of situations might also not have the financial independence to step out, and take action.

2.2.2 Perceived severity

This component addresses feelings concerning the seriousness of contracting an illness (being exposed to domestic violence) Perceived severity includes evaluation of both medical and clinical consequences, like the effects on work, family life and social relations. The combination of susceptibility and severity has been labeled the perceived threat.

(Glanz et al, 1997:47) Being pregnant tends to increased susceptibility, as will be discussed next.

- **Pregnancy – a special situation**

Although this study is focusing on domestic violence in general, domestic violence could also and in fact does occur when women are pregnant. Seeing that the population under study is a critical audience, the relationship between pregnancy and violence needs also to be reviewed.

Pregnancy is a time when friends, family and health professionals expect women's partners to be particularly concerned about and attentive to their health and well being. It is difficult to imagine that anyone, especially the father of the baby, would intentionally injure a pregnant woman, thereby jeopardize her health and the health of the foetus.

Violence during pregnancy affects more women than hypertension, gestational diabetes, or almost any other serious ante partum complication. The sequelae of abuse during pregnancy are not well elucidated, but may include miscarriage, preterm labour (PTL), preterm birth (PTB), low birth weight (LBW), fetal injury, and death. Violence during pregnancy poses a significant health risk for the woman and her fetus. (Campbell & Humphrey, 1993:156) This specific aspect of the effect of violence on the mother's health will be discussed next.

In recent reviews by the Centre for Disease Control (CDC), the rate of abuse of pregnant women was found to vary between 0,9% and 20,1%. Not enough is known about the impact of abuse during pregnancy. However, we do know that abuse can result in low weight of the infant, premature birth, and miscarriage. (Lorie, 1987:22) Violence during pregnancy is one of the most tragic and unknown aspects of gender-based violence, and has serious effects on the mental and physical health of the women involved. (Oliveira, 1997:23)

More information and data are clearly needed on the prevalence of violence among the general population, and on whether or not the pattern of violence changes during pregnancy. The studies suggest that violence against pregnant women may be a more frequent problem than pre-eclampsia, gestational diabetes and placenta praevia, for all of which women are routinely screened and evaluated. Therefore, the report suggests screening of pregnant women for violence should be incorporated into routine care and referral systems and additional training should also be provided on this problem for all relevant health-carte professionals. (WHO, 1999:9)

For assistance, health promotion and education to be effective, they should be designed with an understanding of the recipients or target audiences. This understanding entails their health and social characteristics, as well as their beliefs, attitudes, values, skills and past behaviour. (Glanz et al, 1997:11)

As the justification and motivation for this study was to assist maternity patients and recommend guidelines for a health education programme on domestic violence, as stated in the problem statement, the researcher surveyed the target population by means of a questionnaire to obtain their views/perceptions on domestic violence.

It was necessary to obtain a deeper understanding of women's views/perceptions during this special situation, especially as violence has a negative effect on the health of these women.

- **The impact of domestic violence on the health on women during pregnancy**

The violence inflicted against pregnant women affected them on many levels. Sometimes the physical signs are more visible, but the invisible psychological effects might linger longer and have more negative effects on the health of women.

The physiological impact as well as the psychological impact of domestic violence on maternity patients will be discussed next.

- **The physiological/physical impact of domestic violence on the health on women during pregnancy**

Violence against women increases their risk of poor health during pregnancy. The true extent of the consequences is difficult to ascertain, however, because medical records usually lack vital details concerning any violent causes of injury or poor health. A study of 249-court cases in Zimbabwe revealed that the intimate partner of the victim committed 59% of the homicides of women. The injuries sustained by women because of physical and sexual abuse may be extremely serious. Many assault incidents result in injuries, ranging from bruises and fractures to chronic disabilities. A high percentage of these require medical treatment. For example in Papua New Guinea, 18% of all urban married women had to seek hospital treatment following domestic violence. Recent research has identified violence during pregnancy as a risk to the health of both mothers and their unborn foetus. (WHO, 1997:33)

Violence against women in families dramatically increases their risk of poor health. Studies exploring violence and health consistently report negative and far-reaching effects, the true extent of which is difficult to ascertain because of the largely invisible nature of the crimes. An analysis's in the World Bank's World Development Report, estimating the healthy years of life lost due to different causes, concluded that between 5% and 16% of the health years of life lost to women of reproductive age can be linked to gender –based victimization, rape and domestic violence. (WHO, 1996:10)

The risk for a woman during pregnancy is high and may cost her life. This risk can be classified as trauma related. Types of disorders that might result from this "trauma" are:

- Hypovolemic shock
- Respiratory problems caused by pain inflicted during an assault
- Renal pathologies
- Coagulation abnormalities
- Disorders caused by a change in gastro-intestinal physiology
- Specific fetal problems

The above disorders are discussed next to demonstrate the physical dangers that the mother and her unborn child are exposed to during episodes of violence.

- Hypovolemic shock

The loss of circulating blood volume is a major physiologic challenge associated with trauma. In a healthy individual with a normal oxygen carrying capacity, the traditional signs of hemorrhage do not become evident until 15 – 20% (1200ml) of total blood volume has been lost. But, because pregnancy is associated with an increase in blood volume, the actual amount of blood loss that results in clinical manifestations of shock is greater in pregnant women than in non-pregnant women. (Newton, 2003:5)

Prolonged shocked could lead to a variety of consequences, namely acute renal failure, metabolic acidosis, but most importantly death. In addition, the fetus might also be deprived of oxygen, and progressive fetal acidosis may occur. (Newton, 2003:6)

Thus hypovolemic shock (due to blood loss) is detrimental to the mother and fetus.

- *Respiratory problems caused by pain inflicted during an assault*

With normal physiological changes during pregnancy (like an enlarged uterus) certain hormonal and mechanical changes occur. This leads to hyperventilation, and a subsequent increase in the minute ventilation and tidal volume by 10% and 40% respectively. The effect is hypocapnia when the $paCO_2$ is <28-32mmHg. (Newton, 2003:9)

When exposed to trauma, pain and anxiety is experienced, this may cause the pregnant woman to increase her respiratory rate. This will lead to a further significant decrease in her $paCO_2$, which could result in faintness and perioral numbness. (Newton, 2003:9)

The effect on the fetus is also significant. A 5 – minute episode of hyperventilation by the mother could decrease her $paCO_2$ by 6mmHg, but most importantly, it could drop the fetal $paCO_2$ by 3.5mmHg. (Newton, 2003:9)

- Renal pathologies

The exact pathophysiology is unknown, but pregnant women are more susceptible to symptomatic urinary tract infections. The risk may be related to increased urinary stasis, or

urinary human chorionic gonadotropin may enhance the attachment or pathologic organisms to the urinary mucosa.

Trauma during pregnancy could lead to hospitalizations. During these periods Foley's catheters may be inserted to monitor renal function. As it happens, a Foley's catheter is a risk factor for urinary tract infection. (Newton, 2003:10)

- Coagulation abnormalities/disorders

Pulmonary embolism is a major cause of maternal death, and pregnant (or immediate post-partum) women are at increased risk. The reason for this is that they contain two (2) of the three (3) risk factors associated with thrombosis, namely venous stasis and hypercoagulability.

Should they be admitted for surgery due to trauma, the risk for thrombosis and pulmonary embolism increases as the third risk factor Virchow's triad is added, namely vascular injury. Furthermore, post-operative bed rest increases the risk of stasis. (Newton, 2003:10)

- Disorders caused by a change in gastrointestinal physiology.

Certain physiological changes occur during pregnancy. The lower esophageal sphincter tone decreases during pregnancy. The circulating levels of progesterone that act as a smooth muscle relaxant cause this. In addition the large fetus, especially in the supine/lithotomic position, increases the intragastric pressure. (Newton, 2003:11)

Therefore should a pregnant woman be admitted for surgery for trauma, the risk for aspiration is high.

- Specific fetal problems

Four factors in maternal trauma or surgery predict fetal morbidity and mortality: hypoxia, infection, drug effects and preterm delivery. Fetal death can occur at any gestational age and usually results from fetal hypoxia. This hypoxia is related to maternal shock and blood loss.

If the mother is admitted for trauma/violence related reasons, and drug administration is required, it may also negatively affect the unborn child. There is for instance data, although conflicting, that anesthesia during the first trimester could lead to spontaneous abortions. (Newton, 2003:14)

The most important risk is preterm delivery. Before 23 weeks' gestation, preterm delivery uniformly results in neonatal death. The most likely cause of preterm labour in a trauma patient is abruptio placentae. (Newton, 2003:13)

It might also be necessary that the mother be immunized with the Rh globulin, should she be Rh negative. This is based on the possibility of maternal and fetal bleeding and that mixing of blood between these two may occur with a subsequent Rh antibody formation in the mother, should the fetus be Rh positive. (Lent, Morris, Rechner, 2000:3)

From the above discussion it is evident that the physiological impact of domestic violence, for example trauma, could be life threatening to both the mother and her unborn child. The woman in an abusive situation, whether she is pregnant or not might perceive some benefits to staying in the violent situation, otherwise she could have opted to act to change the situation. The aspect of perceived benefits will be discussed next.

2.2.3 Perceived benefits

This means one's opinion of the efficacy of the advised action to reduce risk. It is also the perception that a person has of the seriousness of a situation, for instance the seriousness of domestic violence. (Glanz et al, 1997:47) Women may decide to take action for their own benefit.

- **Likelihood of action**

The adapted Health Belief Model indicated the relationship between the likelihood of action, meaning to report the occurrence, or the taking of action against domestic violence, and the views/perceptions of patients of whether there are any benefits for them should they act. The perceived benefits are:

- Legal protection
- Police protection
- Religious comfort and support
-

- **Legal protection**

There is a “De Jure” protection for women when it comes to domestic violence. Violence against women and children is a violation of article 8 (2) (b) of the Namibian Constitution, which clearly states that, “No persons shall be subject to torture or to cruel, inhuman or degrading treatment or punishment”. (Constitution of the Republic of Namibia, 1990:7)

The Universal Declaration of Human Rights (1948) has formed the basis for the development of international human rights conventions. Article 3 states that everyone has the right to life, liberty and security of the person. According to article 5, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Therefore, any form of violence against a woman which is a threat to her life, liberty or security of person, or which can be interpreted as torture or cruel, inhuman or degrading treatment, violates the principles of this declaration. (WHO, 1997: 44)

This is in line with the situation in most African countries. The African States members of the Organization of African Unity, parties to the present convention entitled "African Charter on Human and Peoples' Rights", r*eaffirmed* the pledge they solemnly made in

Article 2 of the said Charter. This is to eradicate all forms of colonialism from Africa, to coordinate and intensify their cooperation and efforts to achieve a better life for the peoples of Africa and to promote international cooperation. The " better life" for the people of Africa implies its female occupants as well, and a "better life" implies not being subjugated to violence. Also according to the Universal Declaration of Human Rights, "All human beings are born free and equal in dignity and rights". They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood".

The International Bill of Human Rights includes:

- The Universal Declaration of Human Rights
- The International Covenant on Economic, Social and Cultural Rights
- The International Covenant on Civil and Political Rights and its two Optional Protocols. (WHO, 1997:41)

From these commendable statements one assumes the dignity and rights of women are also included. The international rules about torture also mentioned the following instruments:

- The Universal Declaration of Human Rights
- The International Covenant on Civil and Political Rights
- The United Nations Convention against torture and other cruel, inhuman or degrading treatment or punishment

It is especially the last instrument, namely the convention against torture, and cruelty, inhuman and degrading treatment or punishment that warrants attention. The necessary legislative frameworks are in place for a "De Facto" implementation. Namibia is a signatory to these three international instruments and in terms of our Constitution, "unless otherwise provided… international agreement binding upon under this Constitution shall form part of the law of Namibia". (Legal Assistance Centre 2003:4) The Constitution is the supreme law in Namibia. This means that no one is above the premises set out in the Constitution. In Namibia the utilization of customary law also has to be considered.

There is no comprehensive study of the treatment of domestic violence under customary law. However, it is interesting to note that there are reportedly words for domestic violence in most Namibian languages other than Oshiwambo – such as "Ondatumisire ponganda" in Otjiherero and "Upika" (making your wife or child a slave) in Rukavango. It has also been reported that headmen and chiefs are consulted about cases of repeated domestic violence in rural areas. Preliminary research on traditional attitudes about domestic violence indicates that in some communities, there is a belief that the male head of a household has the power to exert control over other family members. The most recent written collections of customary laws from the various Owambo communities do not make specific mention of physical violence within the family. The Kwaluuhdi laws of 1994 provide for fines for the husbands who beat their wives, and for children who beat their parents. A person who engages in violence can also be ordered to pay damage to the injured party. The self-stated customary law of Kwangali includes references to family disputes, such as quarrels between husbands and wives, but violence is not explicitly mentioned. (Hubbard & Wise,

1998:8)

The self-stated customary law of Fwe provides for specific fines for specific injuries resulting from domestic violence. It also contains a number of specific rules governing marital relations. Anyone who fights with his wife and breaks her hands or legs shall be fined five cattle. The customary laws of Kaoko state that if her husband subjects a wife to ill treatment, she may report this to the parents of the husband or to any member of the husband's family. In Damara culture a woman who is ill-treated by the husband should take refuge in the man's parental home rather than in her parental home. The Rehoboth Baster community provides in section 52 that any man who ill-treats his wife to the extent that it leads to the laying of a complaint shall be fined. If the ill treatment results in grievous bodily harm, it shall be treated as a criminal offence. (Hubbard & Wise, 1998:9)

It has been reported during interviews with women from the Hai//om, !Xoo and! Kung communities that San community leaders punish a husband who engages in domestic violence by allowing the wife to live with her own family until the husband promises to change his behaviour. (Hubbard & Wise, 1998:8)

Legal protection could assist also in ways other than issuing laws and regulations. In Namibia a sort of community outreach programme has been provided for. An example is the Legal Assistance Centre (LAC). The Legal Assistance Centre (LAC) is a non-profit public interest law firm with its head offices in Windhoek and advice offices in Katutura, Rundu, Ongwediva, Keetmanshoop, Mariental and Walvis Bay. The Legal Assistance

Trust supervises its work, whose trustees include legal practitioners, church leaders and other community leaders. The LAC's main objective is to protect the human rights of all Namibians. (Hubbard, 1999:8)

From the discussion it is evident that the necessary legal frameworks are in place in Namibia. From a health prospective it can be concluded that structure standards are available. The logical next point of departure is the process activation (process standards), should it be necessary to act in situations of domestic violence. The first step in this process activation is usually the involvement of the police.

- **Police protection**

In Namibia the Namibian Police (NAMPOL) is responsible for law enforcement. Domestic violence complaints can be made at any NAMPOL charge office. Still, police may not be responding, as they would do during burglaries. Historically the police have been trained to view family violence as a domestic problem, best resolved by social interventions. (Kitt and Kaiser, 1990:623) Although the attitudes of many policemen might have changed, the individual police officer that responds to calls for assistance during domestic violence may still views it as solely a domestic violence problem.

The government of Namibia established a more user-friendly imitative to bring the police in contact with abused women. It established a network of Women and Child Abuse

Centres, an initiative that is believed to be the only one of its kind in Africa. After extensive consultations between the Namibian Police, UNICEF and a range of community groups, a Women and Child Abuse Centre was established at the Katutura Hospital in Windhoek in 1993. The purpose of this centre is to provide a sensitive and integrated response to victims of rape or abuse, including domestic violence and child abuse. At the centre, victims can lay a charge with specially trained police officers, undergo a medical examination, and be referred to a social worker or to appropriate counseling groups. (CEDAW, 1993:33)

From the analysis and discussion of the Namibian situation, it appears as if police protection could be regarded as "perceived benefits". The necessary structures are in place, both from the policing side as well as from a legislative perspective. If women do perceive it as such and believe in these structures, they might utilize it.

Another perceived benefit that might prompt women to either report or endure and cope with domestic violence is their views/perceptions on the religious comfort and support they might or might not expect.

- **Religious comfort and support**

In this study the term "religious" will also be equated with spirituality. Spirituality could mean a variety of things. It includes a need for meaning and purpose of life, a need for

hope, trust, faith in self and others and a power beyond self. It also means a need for forgiveness and a need to establish and maintain a dynamic relationship with self and others and the Ultimate Other. (Malhlungula and Uys, 2004:16)

There is scientific evidence from North American and British studies that the spiritual well being of a person can influence the quality of life lived and the general response to a crisis like an illness, suffering or death (Malhlungula and Uys, 2004:16).

It implies that religious beliefs (spirituality) might influence the views and belief that women have towards domestic violence. In Africa the concept of "Ubuntu" is also regarded as one aspect of spirituality. Ubuntu is based on the value of a person as a human being. (Malhlungula and Uys, 2004:23). Women in Africa who are guided by the principle of Ubuntu will demonstrate respect for human dignity. They will also not regard it as respectful to be abused. Based on the concept of Ubuntu, it is assumed that domestic violence is not acceptable in African ethics.

In Namibia religious organisations are reaching out to abused women. Examples are the following two denominations:

- The Helping Hand Welfare Organization. This is a registered interdenominational church, which provides a range of support services for victims of domestic violence and abuse, the sick, the needy, and anyone in need of a helping hand.

- The Dutch Reformed Church Benevolence Board- Social Service Council. This organization offers the full range of professional social welfare services for any person of any religious denomination or culture.

From a religious perspective, it appears as if there are possible benefits when abused women decide to take action and report incidences of domestic violence. It depends on how their views/perceptions and belief systems have been formed by spiritual and religious encounters.

Next will be a discussion on the perceived barriers as an aspect of the Health Belief Model.

2.2.4 Perceived barriers

Here a kind of no conscious cost benefits analysis occurs, wherein the individual weights the action's expected effectiveness against the perceptions that it may be expensive, dangerous, unpleasant, inconvenient, and so forth. (Glanz et al, 1997:47)

In the case of women the possibility exists of being ostracized by family members or having to endure extended interviews by police officers should she opt to report incidences of violence. This is a sort of anti-thesis of perceived barriers, which have been discussed earlier.

The next discussion will be on *cues to action.*

2.2.5 Cues to action

The readiness to take action (perceived susceptibility and perceived benefits) could be potentate only by other factors such as media publicity. (Glanz et al, 1997:47) Reasons not to report domestic violence or endure it can be influenced by a number of factors, which will be discussed next.

- **Reasons for not reporting domestic violence**

Women are reluctant to report domestic violence because of various reasons ranging from attitudes of the police and fear of family reaction. In addition to the prevailing attitude that domestic violence is a family problem, there are other reasons why women do not report incidents of domestic violence. The police are often unwilling to intervene, partly because of a lack of remedies. In situations where police do take action, the charge is simple assault, which makes it difficult to segregate domestic violence data from other form of interpersonal violence. The current legal approach to domestic violence is inadequate, and police are frequently ineffectual. A woman who lays a charge of assault is likely to find the batterer home on bail within 48 hours. Even if the person is ultimately convicted, the penalty is unlikely to be severe. One major theme in a regional hearing dealing with

domestic violence in Northern Namibia was dissatisfaction with the way police, investigators and courts deal with cases due to prevailing gender beliefs. (Iipinge & Le Beau, 1997:79)

Thus women who are the victims of sexual abuse and violence are reluctant to report the crime to the police or even family members. In countries where a woman's virginity is associated with family honour, unmarried women who report a rape may be forced to marry their attacker. Their shamed fathers or brothers, as a way of restoring family honour, may decide on murdering a suspect person. In some countries, a woman who has been raped may be prosecuted and imprisoned for committing the "crime" of sex outside of marriage, if she cannot prove that the incident was in fact rape. (WHO 1997:44)

Women who disclose abuses are often advised to restrict their movement or adapt their clothing so as to avoid "tempting" men to attack them. This approach is inadequate because it wrongly assumes that men are unable to control their sexual impulses. It also ignores the fact that many rapes are committed in women's own homes, frequently by men whom they know.

The reason for not reporting also overlaps with the reasons for enduring domestic violence.

- **Reasons for enduring domestic violence**

It is not, as popular belief often suggests, simply a matter of walking out of the door just because the man does not have her physically imprisoned. There are children to consider, money to get, alternative housing to arrange, and personal safety to think about. So long as these dilemmas persist and her situation is not immediately life threatening, a battered woman may tend to endure violence. Thus, a woman's decision to stay appears to follow logically from power disparity and the cultural rules she has learned about marriage, the family, and a woman's role as traditionally defined. It is, after all, common cultural knowledge that women have been charged with, and have largely accepted the emotional and social work of keeping families together in domestic tranquillity. (Hoff 1993:43)

A woman who is beaten may also feel trapped in the relationship because she is emotionally and financially dependent on the man who is beating her. She may think that it will be best for the children if the family stays together. The woman may believe that the man who beats her will change his ways. (Men who beat women often say afterwards that they are sorry and promise that it will never happen again – but it usually does.) The woman may be afraid that her husband will kill her or her children if she tries to get help. She may believe that she has a duty to keep trying to make the relationship work. She may be afraid that her friends and family will think that she is the one to blame if the relationship breaks up. There are many reasons why it is not easy for a woman to leave a violent situation – but this does not mean that she wants to be beaten. (Hubbard, 1999:3) Some people believe that a marriage is very private. They think what happens inside a

family is no one else's business. An abuse woman therefore has to rely on her own "self-efficacy".

2.2.6 Self –efficacy

Self-efficacy is defined as the belief that one can successfully execute the behaviour required to produce the outcomes. In this study, the outcomes could be regarded as the ability to cope and endure. The lack of self-efficacy is a perceived barrier to take a recommended action against domestic violence. (Glanz et al, 1997:47) One has to be empowered with knowledge in order to be able to cope or to endure violence.

- **Knowledge**

The process of acquiring knowledge is a lifelong process of learning and experiencing the "self", other people and the environment. What people know is the outcome of everyday experience. (Chinn and Kramer, 1991:2)

It is therefore assumed that knowledge could influence a person's views and beliefs. Maternity patients with a tertiary education should be more knowledgeable about their rights than those patients without tertiary education. The modifying factors as they relate to domestic violence have been discussed. The more knowledge an individual has the more

she will be interested in seeing the perceived benefits of taking action against domestic violence. More knowledge is needed to remove the barriers, which prevents an individual to reach her goals in taking action. Knowledge leads to empowerment. Empowerment is the optimum goal for women. This aspect will be discussed in the concluding part of this chapter on the literature review. (WHO, 1999:33) If action is not taken immediately, and even if action is taken – some coping skills are required from women.

- **Coping strategies**

Coping could be described as "actions to manage stressors that tax an individual's resources". (Johnson & Maas, 1997:136) A more detailed description is provided by Lazarus & Folkman in Pokroy, Mayer, Stuart & Pretorius. (1999: 29) They explain the meaning of coping as "the cognitive and behavioural efforts to master, reduce, minimise or tolerate the negative consequences of internal or external demands".

Coping has two functions: The regulation of distress (emotional –focused coping), and the management of the problem that is causing the distress. Aguilera as quoted in Urden; Stacy & Lough (2002:68) states, " Coping activities encompass all the diverse behaviours that people use to meet actual or potential demands, the available coping mechanisms are those behaviours that a person draws on that have been found to be effective in the past". When a person uses the coping mechanism effectively, what she is doing goes effectively. Urden et al (2002:68) mentioned multiple appropriate coping mechanisms that help to manage a problem or stressful situation. Trust is one of the coping mechanism in which an individual

transfers the trust learned in early significant relationships onto a helper present. For example, a person who is abused must learn to trust the police to help her to deal with her abuse.

The abused maternity patient may continuously use some of these coping mechanisms also known as ego defence mechanisms. We all use these mechanisms at one time or another, but exclusive use may prevent the correct health seeking behaviour. Examples here are repression, suppression, rationalization and intellectualisation.

By means of repression the maternity patient may force certain thoughts into the unconsciousness, although they may surface from time to time in dreams or slips of the tongue. (Johnson, 1993: 13) This "slip of the tongue" is usually how the registered nurse suspects possible situations of violence.

In suppression, anxiety–producing thoughts or feelings are constantly excluded from consideration. This coping mechanism operates at an unconscious level. (Johnson, 1993: 13) This might also be the case in maternity patients who are abused, as they do not comment or tend to ignore visible signs that indicate exposure to violence.

Rationalization might be used to justify not reporting and enduring abusive behaviours. The maternity patient might argue that her partner was overworked. (Johnson, 1993: 13)

It is therefore assumed that knowledge could influence a person's views and beliefs. Maternity patients with a tertiary education should be more knowledgeable about their

rights than those patients without tertiary education, and therefore exhibits different views/perceptions and belief systems.

Domestic violence could eventually lead to psychological problems.

2.3 The psychological impact of domestic violence

The psychological health of abused women is also affected. According to Ryan and Lane, (1997) as quoted in Iipinge and Hofnie (2003: 20), "sexual abuse has short and long term effects. With short-term effects the victim may experience feelings of guilt, self-blame, sadness, worry, anger, distrustful and powerlessness". This is in line with research quoted by Wright (1998:5) where "domains" of women's views and perceptions are described after exposure to violence. One of the domains discussed was "perceived threat", or constant fear and danger that women experience. They live in fear of future harm.

Another domain described is altered identity, which reflects the abused woman's changing self concept and loss of self that follows from the negative images of herself which batterers reflect back to her.

Disconnection is also described, meaning the largely futile efforts that abusive women have to establish intimacy with their partners.

Entrapment is also identified by research, which reflects the women's loss of power. (Wright, 1998:5)

All these perceptions discussed in regard to the experience of victimization must be interpreted, accepted or rejected in relation to the victim's sense and views of the world. In order to cope with the experience, the victim develops denial, i.e. blocking the memory of the abuse, imagining it did not occur, or that it was a dream in order to protect them from being overwhelmed by the experience. Anxiety and fear may accompany the occurrence of sexually abusive behaviour. There are fears of discovery and consequences of the abuse, which also include a perception of powerlessness and confusion. (Wright, 1998:5)

With the long term impact of sexual abuse, survivors develop several dysfunctions which include somatic complaints, anxiety, depression, suicidal thoughts and suicide, substance use and abuse, eating disorders, poor interpersonal relationships, poor self image and distrust in every experience. Not every victim's perception of sexual victimization is the same, and the process of adaptation, accommodation, and coping may also be different for different individuals. Psychological effects of violence are apathy and depression, silent withdrawal, hypochondria, lack of self confidence, inhibition of sexual desire, sense of guilt and suicide or attempted suicides.

Perhaps more frequently alterations in health are indirect abuse effects, resulting from stress, substance use, suicide attempts, depression, inadequate prenatal care, and complicated obstetrical and gynecological histories. (Campbell et al 1993:170)

The way in which maternity patients perceive or view domestic violence could depend on how they define this concept. (Haber, Krainovich-Miller, Leach Mcmahon & Price – Hoskins, 1997: 784) It is therefore necessary to review the definitions as presented in the literature.

2.4 Conceptual clarification: Domestic violence

Conceptual clarification involves the definition of the key concepts, usually those referring to the key features of the phenomenon to be studied. (Mouton, 1998:66) The concept "domestic violence" will be clarified. In the literature the researcher identified fourteen (14) behaviour patterns that relate to domestic violence. These patterns were also included as fourteen sub items in the research instruments (see Appendix 2). These patterns are indicated in Table 2.2.

Physical abuse involves deliberate aggressive actions that inflict pain and or non-accidental injury that may cause temporary or permanent disfigurement or death. The definitions of physical abuse acts vary according to gender, beliefs, experience and social context. (Haber et al, 1997: 784)

The statement that definitions of physical abuse are dependent on variables like belief, etc,. was also considered in the compilation of the research instrument.

Experts also believe that slapping, pushing or spanking should be considered abusive. (Haber et al, 1997: 784)

Table 2.2 Behaviour patterns related to domestic violence.

Physical abuse	Verbal abuse	Psycho-social abuse
○ Pushing in anger ○ Forcing sex ○ Refusal to use condom	○ Shouting at partner ○ Belittling * ○ Criticizing * ○ Insulting (emotional abuse)	○ Ignoring ○ Preventing visiting friends (using isolation) ○ Taking all decision ○ Hiding food** ○ Leaving alone after an argument ○ Preventing visiting family (using isolation)
Citations (1) Batterers' Intervention program (2005: 1) (2) Haber et al, (1997: 784) (3) MOHSS, (2003:3) (4) SA Law		
• * Could also be regarded as psychological abuse • ** Could also be regarded as physical neglect		

Psychological abuse is the deliberate and willful destruction or significant impairment of a person's sense of competence and self worth. This type of abusive behaviour is less visible and more insidious than physical assault. The perpetrator inflicts psychological abuse

through behaviours that instill fear, increase dependency and damage self- esteem. (Haber et al, 1997: 784)

Abusers also use words and gestures that ridicule, harass, degrade and humiliate their victims. They may also act in a jealous manner or prevent victims from engaging in social interactions with family and friends. (Haber et al, 1997: 786.

It can thus be seen that domestic violence takes many forms, like physical abuse, psychological abuse, sexual abuse and neglect (Table 2.2). The literature also indicates that there are many more ways to abuse your loved ones than there are to respect them. The scope of types of abuse ranges from yelling and tongue slashing to rape and sodomy and to severe physical injury and death. Another kind of violence is a vicious circle that is created where the male partners who are oppressed, humiliated and exploited at the work place come home and transfer their frustration to their women and children. (CEDAW, 1993:13)

As this is a contextual study, but placed within a Namibian context, the situation in Namibia will be discussed next.

2.5 Domestic violence in Namibia

Women in Namibia do suffer from domestic violence. A daily newspaper in Namibia, has reported that 36 percent of the women that had been interviewed, reported that they had been sexually of physically abused. (Anonymous, 2003:3) The Legal Assistance Centre has added to the above statistics by stating that one-fifth of all violent crimes in Namibia occur within the context of domestic violence. (Anonymous, 2003:3)

Measuring the true extent of the prevalence of violence in Namibia today is a complex task because the available statistics from police, women and child protection units countrywide, and other formal institutions, often underestimate the levels of violence due to underreporting, or by not reporting violence committed.

The method off violence recorded may also vary between sources. For example one police officer may record all violence regardless of whether it results in bodily injury, whereas the other may record only incidents in which a physical injury occurred. Some types of violence concepts are difficult to measure. The issue of violence against women and children in Namibia has become a serious concern because they are gender discriminated against and deprived of their basic human rights. To that extent they become vulnerable members of the society. (Hancox, 2003:13)

Still violence against women undoubtedly ranks as one of Namibia's most severe human rights problems as has been stated. More exact figures in Namibia are not known as

domestic violence cases that are reported to the police are hidden within larger crime categories such as rape and assault. Hubbard continues to say, men against women perpetrate most domestic violence in Namibia. It happens among rich and poor, in every ethnic group, in both rural and urban areas, and across all levels of education. The range of physical abuse includes hitting, burning, punching, beating, and even murder. One example is the notorious 1998 Florin case in Swakopmund, in which a man killed his wife and then dismembered her body, cooking some parts and throwing others into the sea. (Hubbard and Wise, 1998:3)

Women and children also experience sexual abuse, which can include rape, sodomy and genital mutilation. Abused spouses interviewed in Luderitz, Karasburg and Keetmanshoop reported a range of sexual abuse, with 25% of those interviewed saying that they had been raped by their husbands. (CEDAW, 1993:14)

Not only are women in Namibia abused, the situation also repeats itself in Africa and internationally.

2.6 Domestic violence in Africa and internationally from a cultural perspective

The influences of culture on belief systems need to be recognized. Leininger (1991:47) refers to culture as the learned, shared and transmitted values, beliefs, norms and life ways of a particular group that guide their thinking, decisions, and actions in patterned ways.

Different cultures have different world views/perceptions (paradigms). This provides them with their value stance about life.

In some traditional African societies any form of physical, psychological or sexual imposition of one's will on another is seen as deviant behaviour. Then one might find that in some traditional African societies, 'wife beating' is considered an appropriate method of correcting a woman's behaviour. However, the act of 'wife beating' is limited so that the woman does not have clear visible signs of the incident. The use of fists and dangerous weapons such as guns and knives is not acceptable. (Iipinge et al, 1997:77)

Culture plays an important role in domestic violence. In some Tanzanian cultures, wife beating is socially acceptable, contrary to the statutory laws, which consider wife beating as a crime. In areas where a culture allows this practice, the community does not take stern measures against the culprit. The informal socialization process instills acceptance of this practice while formal institutions try to prevent wife beating. Reported cases to the police are few compared with the magnitude of the problem. (Mukangara, 1997:59)

Namibia being also an African country displays a similar pattern. Various groups in Namibia have differing beliefs about what is domestic violence and what are normal cultural practices. Some groups believe the man is the head of the house and has the right of control over family members. However, most information sources indicate that with this power must also come compassion, love and tolerance. There seems to be a fine line

between family control and family abuse. Once a man steps over the line, his behaviour is no longer acceptable in any Namibian society. (Iipinge and Le Beau, 1997:77)

A possible way to assist maternity patients should they ever befall violence is to empower them. Empowerment might change embedded paradigms (worldviews) and create different perceptions on which behaviours are acceptable or not.

2.7 Women empowerment by means of education

Empowerment refers to increasing the political, social or economical strength of individuals or groups. It often involves the empowered persons developing confidence in their own capacities. (Dictionary.LaborLawTalk.com, 2005:1) Stressing the human rights concerns raised by violence can assist in empowering women to recognize that they have a right to be free of violence. (WHO, 1999:1)

Education is a key tool for public health efforts to end violence against women. Health education is used in many fields such as discouraging the use of alcohol and tobacco and encouraging healthy practices such as breast-feeding and exercise. Public education should be coupled with service provision for women who are victims of violence**.** Public education should be in a form that is accessible to its groups, in the local dialect and in clear and simple language so that it is understandable, even for the people with low literacy. (WHO, 1996:22)

An education programme should as its central task challenge the values, attitudes and behaviours, which contribute to, or result in, violence against women. An example is a feminist re-education programme for male batterers, which could focus on the abuse of power and control in domestic violence. The safety of victims is of primary concern. (UN, 1993: 68)

Many experts see education as the key preventive toll. Education can expose the direct and underlying causes contributing to domestic violence. Education can help build an understanding of the impact and consequences of violence and promote non-violent alternatives and lifestyles. (UN, 1993:85)

A high level of female empowerment seems to be protecting against partner violence, but power can be derived from many sources such as education, income and community roles, and not all of these convey equal protection or do so in a direct manner. Education confers social empowerment via social networking, self-confidence, and an ability to use information and resources available in society. (Jewkes, 2000:1425

2.8 Summary

In this chapter the literature review was presented accordingly. The framework that guided the whole study, *The Health Belief Model*, was also described. The physiological/physical impact as well as the psychological impact was highlighted. The next chapter presents the methodology of the study.

Chapter 3

Research Methodology

In chapter 2 the literature review pertaining to viewpoints and beliefs on violence was discussed. In this chapter, the research methodology will be presented. For the purpose of clarity, the research objectives are stated below:

- To explore and describe the views and perceptions of maternity patients on reasons for domestic violence
- To explore and describe the views and perceptions of maternity patients on reasons why women do not report domestic violence
- To explore and describe the views and perceptions of maternity patients on reasons why women may tend to endure domestic violence
- To explore and describe the views and perceptions of maternity patients on coping strategies they believe women use in situations of domestic violence

3.1 Research design

A quantitative, exploratory and descriptive design was utilized. The study was also contextual in design.

- *Quantitative* implies that a study used quantification for the measuring of data. (Polit & Hungler, 1997:153) In this study the data will comprise of information obtained from closed and open-ended questions that allow for quantification.
- *Exploratory* refers to research that was conducted to provide a basic familiarity with a topic, or to explore a topic. This approach is applicable when a researcher, when the study was relatively new explores a new, interest. (Babbie & Mouton, 1998:79) As the study stated in the introduction to the problem, the views/perceptions of maternity section patients on domestic violence is an unfamiliar topic in nursing.
- *Descriptive* studies have as the main objective the accurate portrayal of the characteristics of persons, situations or groups and the frequency with which certain phenomenon occurs. (Polit and Hungler, 1997:613) In this study the views/perceptions maternity patients were described and the frequency of certain phenomena was determined by means of semantic differential scales.
- *A Contextual study* is where a phenomenon is studied because of its intrinsic and immediate contextual significance. (Mouton, 1998:133) This study was focusing only on a sub-group of respondents, namely maternity patients from a specific hospital.

3.2 Study population

The target population comprised of all maternity patients admitted to the Windhoek Central Hospital for the period of April 2004 until March 2005 (Twelve months). This period was selected due to the fact that the research proposal was approved in February 2004, and the

process of sampling could only commence at this time, especially as it involved a prospective data collection method.

The maternity patients were approached during their *"recovery"* period in the postnatal ward. The reason for approaching the population at this period of time was that they are more relaxed after the deliveries of their babies and would respond more freely and openly.

The number of patients admitted during 2003 in the postnatal ward was 3084, and the assumption was that a similar number of patients would be admitted during the period of April 2004 until March 2005. (Twelve months) The assumed size of the population for the period of study was therefore estimated to be also approaching 3000, or slightly more than 3000.

3.3 Criteria for inclusion and exclusion

All women who were willing to participate as respondents were given the instrument, a questionnaire to answer, or where necessary, they were interviewed, using the questionnaire.

3.4 Sample and sampling technique

To obtain a representative sampling size, it was statistically determined to interview or distribute questionnaires to at least 184 maternity patients. This would ensure a confidence level of 95%. A probability sampling method was used to:

- Determine the months for data collection
- Obtain a sample of patients for each day of data collection

Determining the months of data collection

By means of lottery a single month was first drawn. All the names of 12 months were put in a container and one month was drawn - April 2004.

It was discovered that one month was not enough to interview or distribute questionnaires to obtain a representative sample of 184.[1] Two additional months were therefore also drawn by means of a lottery as described above. The two additional months were February 2005 and March 2005.

Determining (sampling) which patients to interview.

Patients were only sampled on weekdays from Monday to Friday. By means of a lottery (names of patients were put in a container), three names were drawn. Patients who

[1] An initial incorrect sample size was calculated, which lead to the selection of only one month

previously had been drawn were excluded in successive samplings. Each day three patients were interviewed or completed the questionnaires. The sample size drawn per specific day was influenced by the time period it took to interview respondents, which took about 35-45 minutes per individual.

A total of 184 patients were interviewed or completed the questionnaires on their own during these three months.

3.5 The research instrument

A self-administered questionnaire consisting of open ended and closed ended questions was used. In the case when assistance was needed to complete the questionnaire, the researcher utilized the questionnaire as an interviews tool.

The questionnaire incorporates the *Semantic Differential Scale (see Appendix2)*. This scale enables the researcher to quantify abstract ideas and controversial issues. (Polit and Hungler, 1997: 330) The questions comprises of closed and open-ended questions, which were guided by the conceptual framework, namely an adaptation of the Health Belief Model.

3.6 Development of the instrument

The researcher used a questionnaire as indicated. The instrument was developed in stages, namely:

- Development of the questionnaire in line with the framework (adaptation of the Health Belief Model)
- Testing of the questionnaire

3.7 Development of the instrument in line with the framework.

The framework that was utilized was the adapted health Belief Model. The framework was discussed in Chapter 2, and in Table 3.1 an outline of the relation of the questionnaire with the framework is provided.

Table 3.1 Questions and their relation to the framework.

Framework Components	**Question components**	**Question numbers**
Modifying Factors	Biographic questions	Section 1, question 1 up to 10
Individual view/perception	○ Views on domestic violence ○ Reasons for abusing women. ○ Reasons for enduring domestic violence ○ Empowering women	○ Section 2, question 11 ○ Section 2, question 12 ○ Section 4, question 14 ○ Section 6, question 16
Likelihood of Action	○ Reasons for not reporting ○ Coping strategies	○ Section3, question 13 ○ Section 5, question 15

3.8 Testing of the instrument

Three activities were incorporated in the testing of the instrument, namely:

- Testing for validity
- Testing for reliability
- Pilot study to test for the feasibility, smooth out problems and test for certain aspects of reliability.

Validity

Validity refers to the degree to which an instrument measures what it is supposed to be measuring. (Polit and Hungler, 1997:299) The questionnaire was specifically tested for *content validity.*

Content validity is concerned with the adequacy of the content area being measured. (Polit and Hungler, 1997:300) Content validity was ensured in this study by the researcher through a thorough literature review and the utilization of expert opinion in the development of the questionnaire, which included three nursing educators. All agree on the relevance of the content.

Reliability

Reliability refers to "the degree of consistence or accuracy with which an instrument measures the attributes it is designed to measure". (Uys and Basson, 1991:75) A specific measure under reliability is stability. Stability refers to the extent to which the same results are obtained on repeated administrations of the instrument. (Polit and Hungler, 1997:387) For this study, the stability was ensured by means of:

Test retest reliability.

The same questionnaire was provided on two different occasions to five participants not included in the pilot study. The information/scores obtained were compared and on both occasions participants provided the same information.

Pilot study

A pilot study was conducted during the last week of March 2004 in the maternity section on five women who were not included in the main study. An aspect of the feasibility of the study, problem identification and the testing of reliability was implemented. Only technical changes were necessary in the questionnaire at the end of the pilot study.

3.9 Ethical issues

Permission was sought from the Ministry of Health and Social Services and also from the maternity section department to carry out the study. The purpose of study was explained to the ministry and respective departments. (See appendix 3) Respondents were assured that information will be treated confidential and anonymously.

In this study the possibility of discomfort and harm was present. The respondents had the right to be protected against discomfort and harm, and this is based on the principle of beneficence that states: "*One should do good, and above all do no harm*". (Brink, 1996:40; Burns & Grove 1997:206) In this study discomfort could have been caused if the impression was created that the respondents might have been victims of domestic violence. They therefore were specifically ensured that their participation did not imply that they were victims of domestic violence, but that their views/perceptions were regarded as important. Oral consent was obtained and no one was forced to participate in the study. (See appendix 1)

3.10 Data collection

Data collection took place during April 2004, February 2005 and March 2005. This was a prospective study in that the respondents could only be interviewed or the questionnaires could only be distributed to them during their stay in the maternity ward.

The researcher conducted the interviews or distributed the self reports (questionnaires) for those who preferred to complete it on their own. The researcher also collected all questionnaires - 184 questionnaires that were distributed.

3.11 Data analysis.

Descriptive statistical analysis was used, which means statistics are used for describing the data, and it included techniques whereby information was sorted, arranged, collected and presented in a scientific manner. (Uys and Basson, 1991:109) This was done using the Scientific Package for Social Sciences (SPSS).

As this study utilized concepts based on the *"Health Belief Model*", it was necessary to identify factors, which could modify *views/perceptions.* This was done by implementing correlation statistics, and specifically the Pearson correlation coefficient (X^{2} / Chi- square). See example below.

(X^2 =6,58

Statistics

With p=0,0037

<0,05

3.12 Summary

In this chapter the concepts and activities incorporated as research methodology have been described. These concepts and activities are the design, population, sample, instrument compilation and testing as well as the pilot study.

In chapter 4 the data analysis will be presented.

Chapter 4

Analysis and discussion of the data

4.1 Introduction

In this chapter the analysis of the data will be presented. The responses obtained from the respondents will be analyzed and discussed following the format of the instrument, which could have been independently completed by the respondents or could have been used as a structured interview tool by the researcher. This discussion focused on the views/perceptions of maternity patients with regard to domestic violence. For this analysis the researcher used descriptive statistics. This includes percentages, and where applicable, correlation determinations between variables.

4.2 The structured interviews schedule/questionnaires

The structured interview is composed in English with both closed-ended and open–ended questions (see Appendix 2). The researcher conducted the interviews personally or where deemed appropriate, the respondent completed the instrument independently.

4.3 Statistical analysis of the data

The documentation and analysis of the data will be done according to the sequence of the interview schedule/questionnaire.

4.4 Data capturing

The first step in the documentation of the data was the coding of this data. A specific numerical value was allocated to each type of response. This data of the respondent was read into the SPSS (Statistical Package for the Social Sciences) computer programme.

4.4.1 Statistical analysis

The responses of the respondents were arranged in frequency tables and figures. The discussion is presented in association with the tables and figures. Where applicable, correlations were determined between variables. Where a significant correlation had been found, it was so indicated.

4.4.2 Format of the discussion on the results

The discussion of the results is based on the outline of the research instrument. The order of the discussion will be in the following order:

- Biographical data
- Views/perceptions on domestic violence
- Reasons for not reporting domestic violence
- Reasons for enduring domestic violence
- Coping strategies
- Empowering of women

4.4.3 Biographical data

Items 1 to 10 dealt with the biographical data. The biographical data included the following aspects:

- Age
- Educational information
- Employment status
- Relationship status
- Period of relationship
- Number of children

- House ownership
- Religion
- Mother tongue (Language)

The importance of this data was to compile a profile of the respondents as well as to determine certain factors that could have influenced their views/perceptions with regard to domestic violence. This aspect was statistically addressed by means of correlation statistics, which will be referred to when applicable.

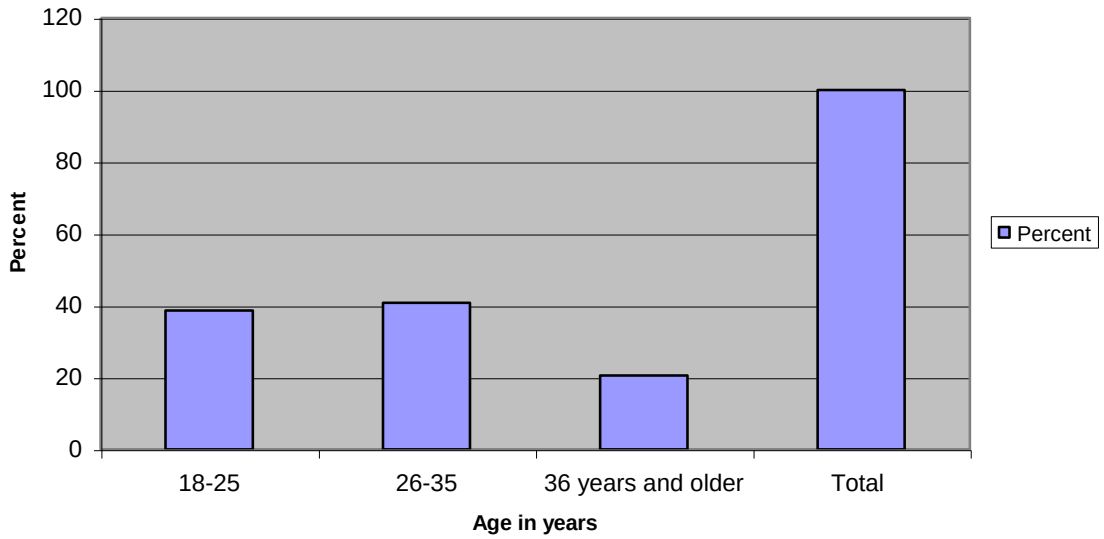
The biographical data was also situated within the adapted Health Belief Model, and more specifically the possibility for this data to act as "Modifying Factors".

4.4.3.1 Age (N=184)

In this item the age of the respondents was determined. The results are reflected in figure 4.1 The results basically indicated a normal distribution with regard to the expected age for women in labour.

A noticeable number of the respondents, namely 75 (40.8%), were between 26 and 35 years old. An assumption could be that they have more experience in family life as well as in relationships, which would allow them to respond more extensively.

Figure 4.1: Age in years (N=184)



Age was identified as a "modifying factor" in the views/perceptions on the following three items on domestic violence:

- To deny the female partner to visit her family

The age group 18-25 years did not regard it as abusive behaviour, while the age group 36 and older did regard it as abusive behaviour ($\chi^2 = 12.006$. $P = 0.017$).

- To be left alone by the male partner after an argument

The age group 18-25 years did not regard being left alone after an argument as abusive behaviour, while the age group 36 and older did regard it as abusive behaviour ($\chi^2 = 10.206$. $P = 0.037$).

- Female partner stays in an abusive relationship due to cultural beliefs

The age group (18 to 25) indicated that people do not stay in an abusive relationship due to cultural beliefs, while respondents between the ages 26 to 35 indicated that partners tend to stay in abusive relationships due to cultural beliefs ($\chi^2=13.857$. $P=0.008$).

These three (3) items will be again referred to under the applicable headings.

4.4.3.2 Educational information (N=184)

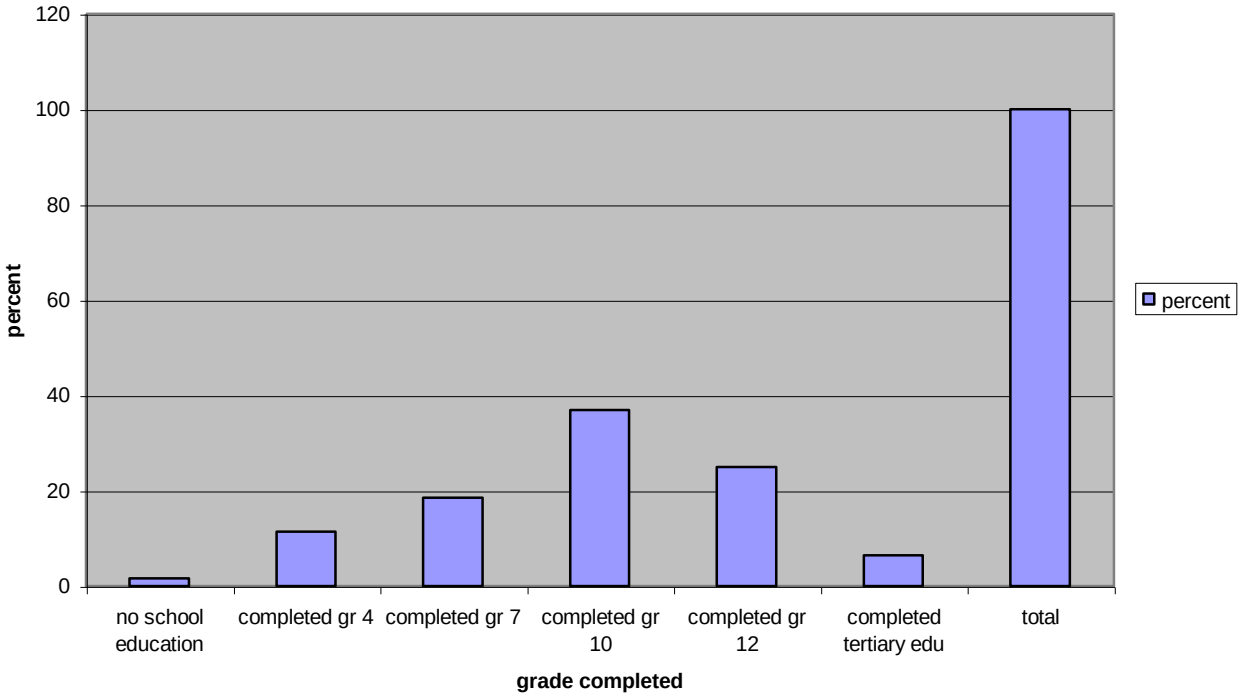
In this item the educational background of the respondents was determined. One respondent omitted to include her age. The item was necessary to establish any correlation between different viewpoints/perceptions on domestic violence and educational backgrounds of the respondents

The result, as depicted in figure 4.2, as seen below indicated that 68 (36,9%) of the respondents completed grade 10. The assumption is that this group is well read with specific viewpoints on domestic violence. An "apposite pole" exists in the sample as 34(18.5%) of the respondents had only a grade 7 or lower school qualifications. These wide differences in scholastic qualifications implied that varied viewpoints/perceptions might be expected.

A significant relationship was found between educational background and the willingness to approach a "*Women and Child Abuse Centre*" for help. Respondents with an education less than grade 12 would not prefer to approach a "*Women and Child Abuse Centre"*, while respondents with a completed grade 12 and tertiary qualifications would approach such a

centre.[2](χ^2 = 22.231. P = 0.014). Therefore in this study, the respondents with a higher education level (grade 12 and tertiary) were found to be more inclined to approach an abuse centre for help.

Figure 4.2: Educational information (N=184)



A second significant correlation was found between educational background and the respondents' views with regard to decision-making. Respondents with an education qualification of less than grade 7 did not regard it as abusive that a male partner should make all the decision for female partners,

[2] To approach a "*Women and Child Abuse Centre*" is one of the coping strategies that are discussed in section 4.4.8. The respondents had to indicate the strategy they would follow should they fall victim to domestic violence

while respondents with an educational qualification higher than grade 7 regard it as abusive not to be involved in their own choices and decision-making[3]($\chi^2 = 12.279$. $P = 0.015$).

The level of education does not exclude a person from being a victim of abuse. It happens in all walks of life, but the level of education does influence the victim's

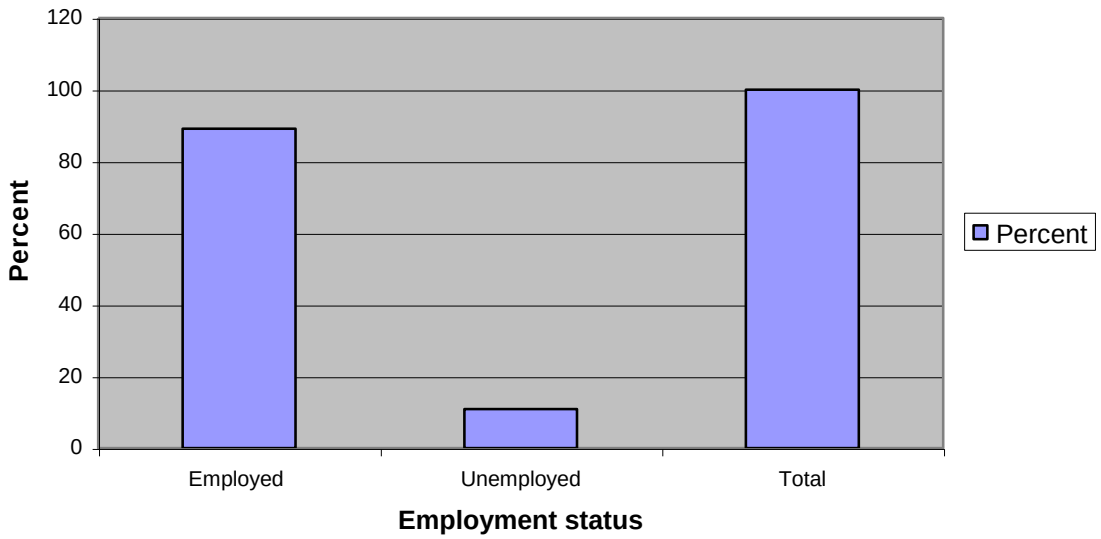
response in terms of awareness of personal human rights, motivation and assertiveness with regard to help seeking and the ability to break the financial syndrome. (Rose-Junius, Tjapepa & De Witt, 1998:84)

4.4.3.3 Employment status (N =184)

In this item the employment background of the respondents was determined. This was necessary to establish any correlation between different viewpoints on domestic violence and employment status background. The employment status of the respondents is illustrated in figure 4.3. It was noticed that the majority of the respondents were employed, namely 164 (89.1%) and 10,9% were not employed.

[3] Decision-making was one of 14 behaviours on which respondents had to comment on whether they regard it as abusive or not. See also table 4.1

Figure 4.3: Employment status (N=184)



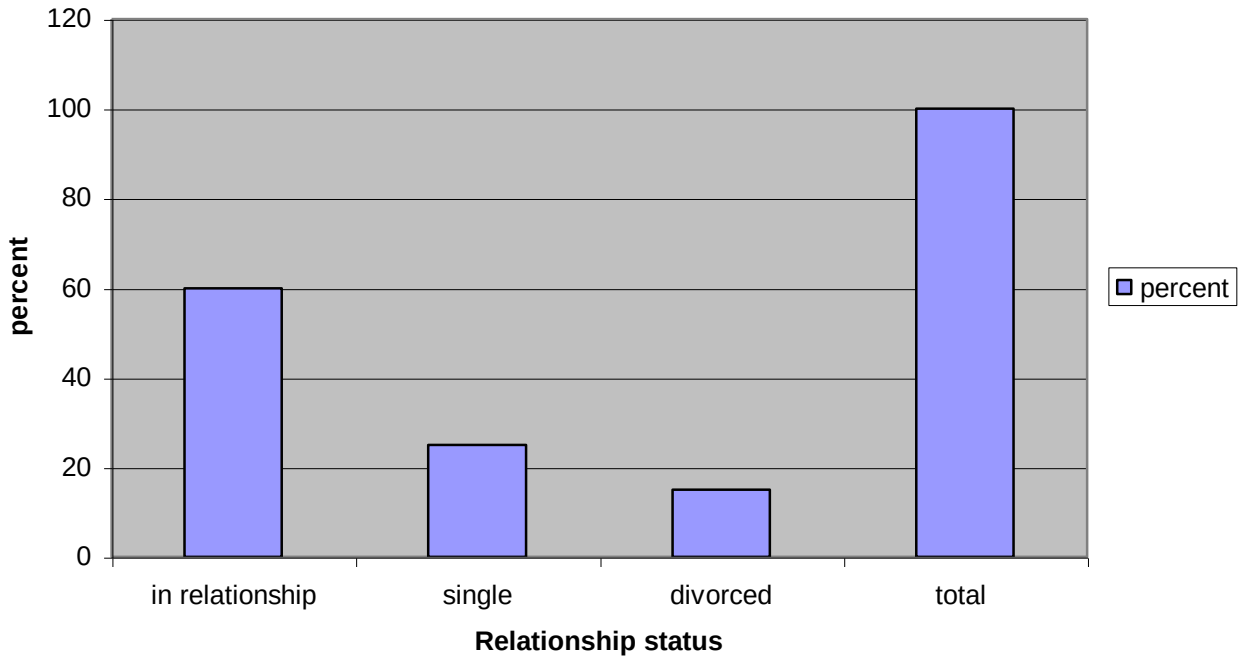
4.4.3.4 Relationship status (N=184)

In this item the relationship status was determined to establish any influence between different viewpoints on domestic violence and relationship status. The results are depicted in figure 4.4 which illustrate that 60% of the respondents were in relationships while 40%of the respondents were single or divorced. A correlation was found between the type of relationships maternity patients were in, and the views they had on whether an inadequate economics situation contributes towards domestic violence.

Single respondents indicated that an inadequate economic situation is a reason why partners might abuse women; while respondents in relationships indicated that an inadequate economic situation is not a reason why male partners abuse women ($\chi^2 = 8.949$. $P = 0.011$).

Thus in this study, relationship status (single versus in a relationship) influenced the views/perceptions of maternity patients as to whether an inadequate economic status is a reason why women are abused by their partners.

Figure 4.4:Relationship status (N=184)

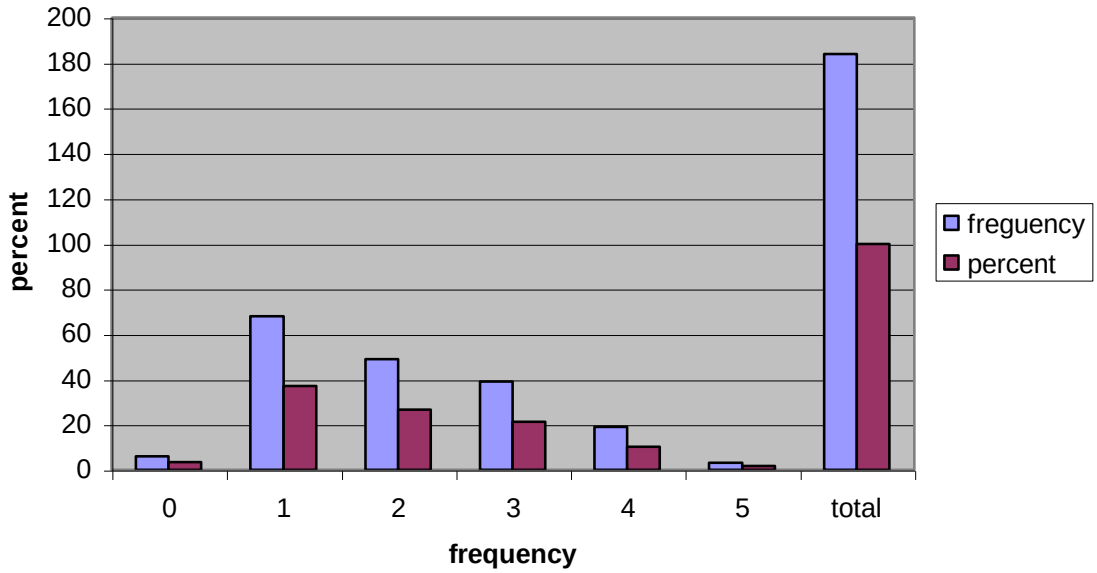


4.4.3.5 Number of children (N=184)

In this item the number of children was determined to establish the relationship between number of offspring and viewpoints/perceptions on domestic violence. The result can be seen in Figure 4.5, and it indicates that 68 (37%) respondents delivered for the first time,

while 3 (1.6 %) of the respondents delivered for the 5th time. The remaining group (63,4%) delivered between 2nd and 4th times.

Figure 4. 5 numbers of children (N=184)



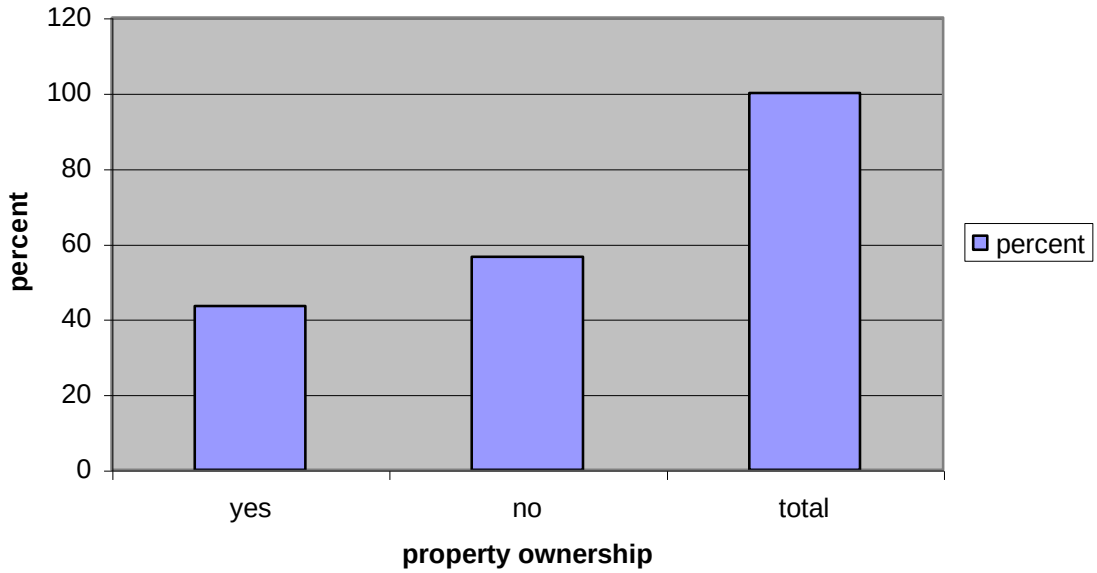
No correlation was found between the number of children and maternity patients' views/perceptions on any items on domestic violence.

4.4.3.6 Property ownership (N=184)

This item tested the relationship between ownership of property, and viewpoints/perceptions on domestic violence. The findings revealed that 104 (56.5%) of

the respondents did not own their own property while 80 (43.5%) did have their own property.

Figure 4.6: Property ownership (N=184)



A correlation was found between being a property owner and agreeing that an inadequate economic situation might be a reason for male partners to abuse their female partners. Respondents who own property believe that it is not a reason for abuse while respondents without property believe it is a reason. ($\chi^2 = 5.722$. P = 0.057).

Another correlation was found between property ownership and the views about whether ignoring the partner is abusive or not. Respondents without property regard it as not abusive while those with property regard it as abusive (χ^2=13.399. P=001).

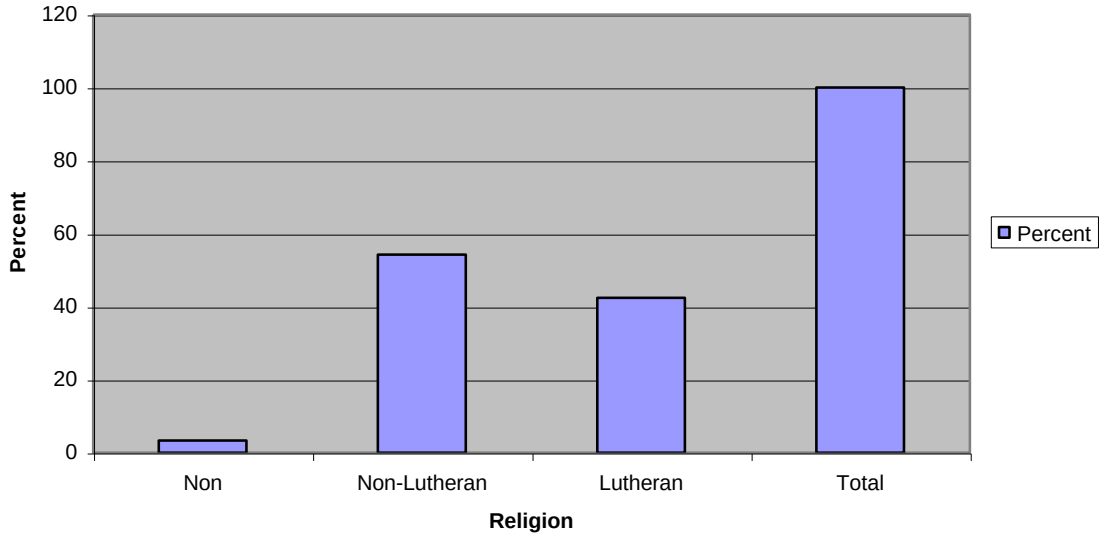
The same group, respondents with property, also indicated that they would not approach relatives once maltreated by the partner, while those without property would definitely approach relatives. (χ^2=6.705. P=035).

It is therefore concluded that in this study being a property owner influenced the respondents' views/perceptions on certain aspects of domestic violence.

4.4.3.6 Religion (N=184)

This item was included to determine the influence of religious orientation on the viewpoints/perceptions on domestic violence. In Figure 4.7 an outline of the distribution of religions/ denominations is provided.

Figure 4.7 Religious orientations (N=184).



As can be seen in figure 4.7 (54,3%) of the respondents belongs to non-Lutheran, 42.4 to Lutheran and 3.3% of the respondents do not belong to any religion. In this study a correlation was found between religious orientation and viewpoints/perceptions of certain aspects of domestic violence. A correlation was found between religion and the views/perceptions on withholding money from a partner as being abusive or not abusive. Lutheran respondents regard it as abusive, while non-Lutheran respondents regard it as not abusive. (χ^2=14.221. P=007).

Being Lutheran also was found to have an influence on what to do once maltreated by a partner. Non-Lutheran respondents would prefer to read the Bible once maltreated (χ^2=15.534. P=004).[4]

This aspect of "turning to religion" once maltreated or abused was also confirmed in a study by Rose-Junius et al (1998:65). The author indicated that religion is used as a coping mechanism.

It is therefore concluded that religious orientation is a modifying factor with regard to certain viewpoints/perceptions on domestic violence.

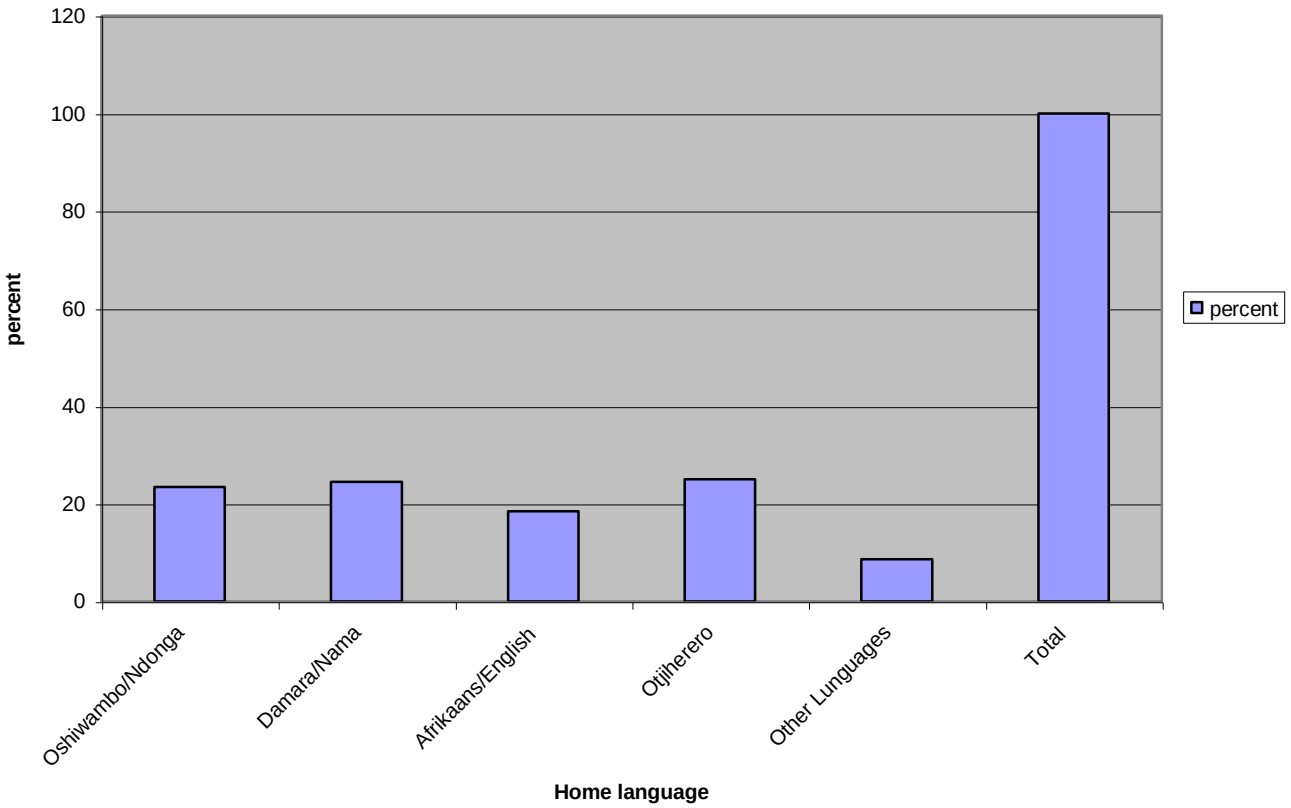
3 see page 47 for statistics description

4.4.3.7 Mother tongue (N=184)

Although not implicitly true in every situation, mother tongue (language) provides an indication of ethnic grouping. In a study on domestic violence, the variations in viewpoints between different ethnic groups needs to be explored. This is noted in the study done by LeBeau (1996:21) where she stated, "Different ethnic groups have different views/perceptions and beliefs on domestic violence".

See Figure 4.8 for the different language distribution among the participants.

Figure 4.8: Mother tongue (N=184)



When correlation statistics were applied, a significant difference was found between the different ethnic groups. Different ethnic groups held different views/perceptions on reasons of the role alcohol plays in domestic violence. Oshiwambo speaking respondents believe that it is true that alcohol contributes to abuse while Otjiherero respondent argue that it is not true or a reason for abuse (χ^2=10.283. P=0.036).

The same ethnic group, the Oshiwambo speaking respondents, indicated that male partners abuse women due to offensive behaviour by a woman, while the Damara/Nama speaking respondents believe this is not a reason for abuse (χ^2=23.524. P=0.003).

Mother tongue was also found to have an influence on whether to approach lifeline once maltreated. Otjiherero speaking respondents would approach lifeline, while Oshiwambo speaking respondents would prefer not to approach lifeline (χ^2=29.983. P=0.000).

It is concluded that in this study mother tongue (language) influenced the respondents' views/perceptions on different aspects with regard to domestic violence.

4.4.4 Views on domestic violence (N=184)

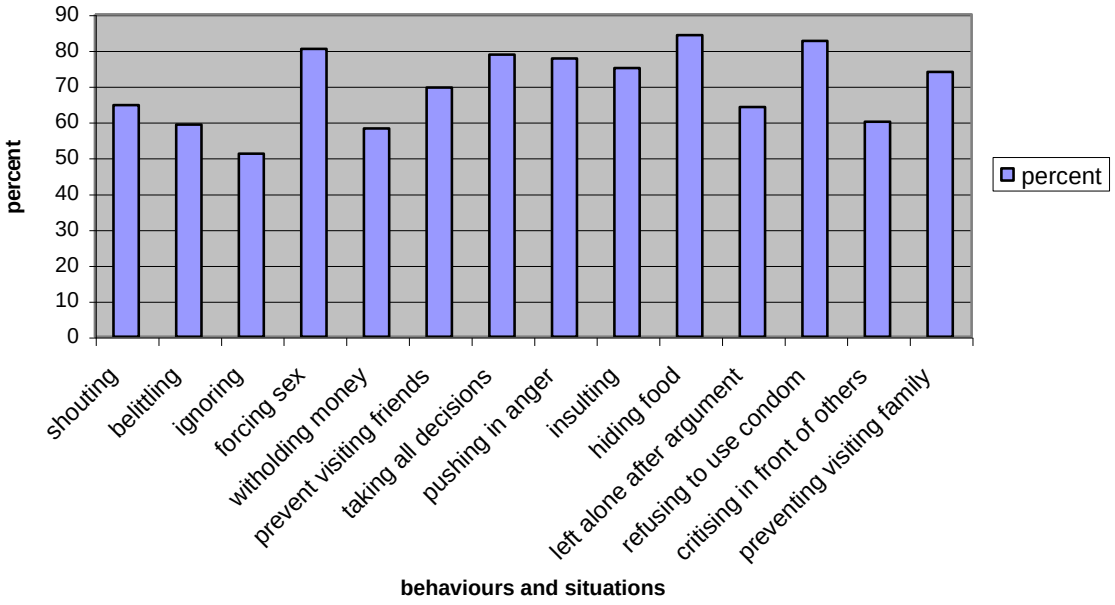
This specific aspect was determined in section 2 of the instrument (see Appendix 2). The respondents were asked to indicate situations and behaviors that they view as being examples of domestic violence. This section utilized fourteen items that were constructed

based on the male partner/companion or husband's behaviours. In figure 4.9 the fourteen items or behaviours are outlined which the respondents had to respond to.

As can be seen from figure 4.9, in all fourteen items the majority of the respondents indicated they were to be abusive in nature. All fourteen items received a score of 50% and more. Items like forcing sex, hiding food and refusing to use condom received scores of 80% and higher.

This viewpoint is confirmed in the literature. In a document from the Ministry of Health and Social Services in Namibia (MOHSS, 2003:3) it is stated "emotional, mental and psychological abuse is most pervasive in the home, and it includes behaviour such as constant criticizing, yelling, screaming, name-calling and threats".

Figure 4.9 Views on domestic violence



In South Africa a definition is provided in the Domestic Violence Act 116 of 1998. This definition includes similar behavior patterns that are indicated in Figure 4.9. Domestic violence in this act is defined as physical abuse, sexual abuse, emotional abuse, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, etc.

It is concluded that in this study the fourteen (14) behaviour patterns that have been classified as being representative of domestic violence (see also chapter 2) are viewed by the majority of respondents as being abusive.

In the discussion on the demographic data in section 4.4.3, the significant correlations between the demographic data and the views on domestic violence as depicted in Figure 4.9 have been discussed. For clarity sake they will be tabled once again. They will not be discussed in detail again. In Table 4.1 these correlations are indicated.

Based on the data in table 4.1, it is concluded that in this study there is a significant correlation between viewpoints on domestic violence (as indicated in Table 4.1) and certain demographic characteristics (as indicated in Table 4.1), and also as discussed in section 4.4.3.

Table 4.1 Significant correlations between demographic data and viewpoints on domestic violence

Demographic data	**Views on domestic violence**
(1) Age: 36 years and older group	(1) Regard being denied to visit family as abusive, to be left alone after argument as abusive.
(2) Property ownership: Group that do not own property	(2) Held the viewpoint/perception, that ignoring a partner was not being abusive.
(3) Educational level: Respondents who did not complete grade 7 school education	(3) Held the viewpoint that male partners could make all decisions on behalf of female partners
(4) Employment status: employed	Regard shouting at a partner as an abusive situation.
(5) Relationship status: In relationship	Regards being left alone after an argument as abusive
(6) Religion: non-Lutheran.	Regard withholding money from a partner as not an abusive situation.

4.4.5 Reasons for abusing women

In this section the respondents (maternity patients) had to indicate their views/perceptions as to why women are being abused. Based on the literature, they were provided with eight (8) "reasons" to select from.

These eight (8) reasons are depicted in Table 4.2 with the percentage of agreement indicated.

Table 4.2: Reasons why women are abused

Reasons	**Percentage of respondents in agreement of reason provided**
1. Due to alcohol consumption by male partner	73%
2. Due to alcohol consumption by female partner	48%
3. Due to stress experienced by male partner at work	48%
4. Due to offensive behaviour on part of female partner	39%
5. Due to female disagreement / argumentation with male partner	45%
6. Due to the unsatisfactory economic situation	55%
7. Due to cultural beliefs	40%
8. Due to male partner's belief that it is his right to discipline female partner	53%

Seventy-three percent of the respondents viewed alcohol consumption by the male partner as a reason why their female partners are abused. This is in line with research done by Le Beau (1996:12). In her analysis she found that the most commonly given cause for domestic violence was alcohol and drug abuse. This was also supported by a study, which was done by MOHSS in 2003, where it was established that 49% of the respondents in the study indicated that alcohol is the major cause leading to violent situations in relationships. The only other provided reasons which more than fifty percent of the respondents agreed upon, were the contribution of an unsatisfactory economic situation, as well as the belief of male partners that discipline could be forced by them. Several authors also agreed to the above statement. Heavy alcohol consumption by men is associated with intimate partner violence. (Jewkes, 2002:1425) Unemployment, economic deprivation, job dissatisfaction and over population are important factors in family violence. (Rose-Junius et al, 1998:35)

It is concluded in this study that alcohol consumption, an unsatisfactory economic situation, and the male partner's belief in his right to enforce discipline, are viewed by most of the respondents as contributing to domestic violence.

4.4.6 Reasons for not reporting situations of abuse or violent behaviour

This part was covered in section 3 of the instrument /questionnaire. (See appendices 2)
By means of open-ended questions twenty-nine (29) viewpoints/perceptions were obtained from the one hundred and eighty-four (184) respondents. Some of the

viewpoints/perceptions were mentioned more than once. It was possible to classify these viewpoints into patterns[5]. These patterns are outlined in Table 4.3. The respondents were asked what their views/perceptions were on the reasons why abused women were not reporting abusive behaviors caused by their male partners.

Similar results were reported in a study done by Nordien, Alpaslan& Pretorius. (2003: 49) In the mentioned study the women (target population) identified the following factors for why they remain in abusive marital relationships: economic dependence, staying for the sake of the children, fear of rejection, protection of the male partner's image and hope for change. In addition, studies in the United States of America revealed that women might also not report situations of abuse due to bad experiences with the police. Or they might be reluctant to report due to potential embarrassment. Arrest of their partners might also cause financial hardship. (Curran and Renzetti, 1996:225)

It is concluded that in this study the respondents identified similar reasons, described as patterns by the researcher, to those identified in the literature.

[5] Patterns in this study do not equate to a qualitative research approach. The comments of the respondents were regarded as naïve and more thin descriptions than thick descriptions associated with qualitative research.

Table 4.3: Reasons for not reporting domestic violence

Pattern	Reasons (Literal descriptors)
○ For appearance sake	○ Afraid family will know what is going on in relationship. ○ Don't want to expose partner to public. ○ Don't want to involve police. ○ Afraid partner will lose status, especially if it is a high ranked person.
○ Financial considerations	○ Afraid to lose financial support. ○ Afraid to lose at end of "case". ○ No place to go if partner is jailed
○ Cultural	○ Some cultures believe that it is the right of male partner to beat female partner
○ Logistic reasons	○ Police station might be too far
○ Cognitive reasons/lack of information	○ Don't know where to go ○ Communication problem-female partner might be unable to speak both Afrikaans and English. ○ Might be unaware of her rights
○ Lack of trust in legal and police system.	○ Police make no effort to follow up cases of domestic violence. ○ Police officers side with the male partners. ○ No need to report- the abuser will receive light sentence. ○ The women are not protected after reporting domestic violence cases and retaliation is possible.
○ Rationalization	○ Beating by a male partner is a sign of love ○ Beating is a way of disciplining a female partner ○ Abuse is part of marriage ○ It is a private matter ○ One day it will change.
○ Self blaming	○ The female partner is the cause
○ Fear of abandonment	○ Might lose the male partner at the end of a court case. ○ Female partner not ready to divorce or leave partner and to start own life.

4.4.7 Reasons why women tend to endure domestic violence (N=184)

This specific aspect was determined in section 4 (see Appendix 2). Nine items were constructed where the respondents had to indicate whether the given situations (descriptions) are reasons why women tend to endure domestic violence.

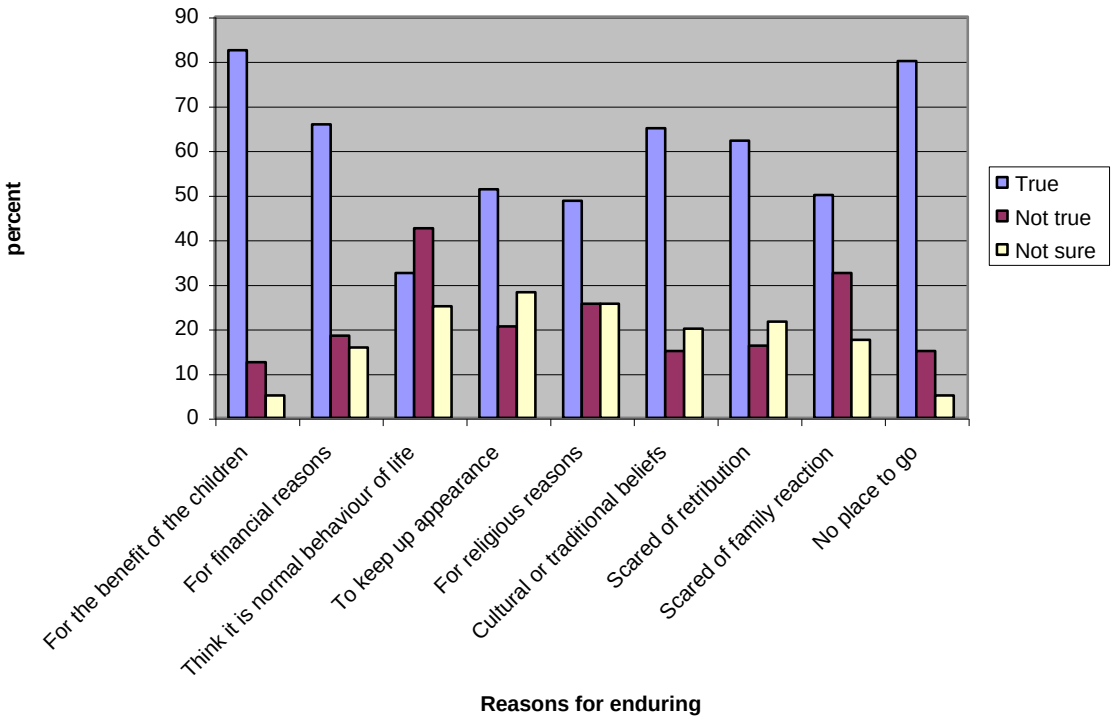
On eight (8) of these items the majority of the respondents were of the opinion that these are valid reasons why women tend to endure violence. A mean agreement on the nine items of 60 percent was obtained, meaning that they agreed 60 percent of time that these were the correct reasons.

A non-agreement of 22 percent was obtained on all nine items meaning that 22 percent of the time they do not believe these were the true/correct reasons. Eighteen percent of the time the respondents were not sure.

Figure 4.10 indicates the results of the nine items on which the respondents indicated the reasons for enduring violence.

It can be seen that 152 (82.5%) of the respondents indicated that women tend to endure violence due to the benefit of the children.

Figure 4.10:Enduring domestic violence



A woman's decision to stay in an abusive relationship appears to follow logically from power disparity and the cultural rules she has learned about marriage, the family, and the woman's role as traditionally defined. It is, after all, common cultural knowledge that women have been charged with and have largely accepted the emotional and social work of keeping families together in domestic tranquility. (Hoff, 1993:43)

One hundred and forty seven (80%) of the respondents also indicated that women tend to endure abusive relationships because they have nowhere else to go. This "nowhere else to go" is related to an economic dependence on the male partner. This aspect of economic dependence is also identified by Nordien et al (2003: 49), where they stated it as one of

several reasons why women remain in abusive marital relationships. This was also quoted by Rose-Junius et al, 1998 in Finemanm & Mykitiuk (1994) that " In Africa women accept being abused as part of married life". They continue to say that victims generally have little or no information about what to do and are unaware of their rights in such a relationship. The mother decides to stay in an abusive relationship because she believes that her children will benefit from the ongoing presence of an adult male. Another factor is the rationalization of the husband's behaviour, blaming it on the use of alcohol at the time of his violent outburst. This means that the husband's drinking can be blamed for the unacceptable behaviour, thus removing the responsibility from the husband for his action.

A significant relationship was found between languages spoken by the respondents and their viewpoints on why abused women endure domestic violence. The Oshiwambo and Afrikaans-speaking respondents agree that partners stay in an abusive relationship for religious purposes, while Herero speaking respondents disagree with religion as being a reason (χ^2 =25.790. P = 0.004).

It is concluded that most of the respondents in this study are of the viewpoint/perception that female partners endure domestic violence due to the reasons indicated in Figure 4.10.

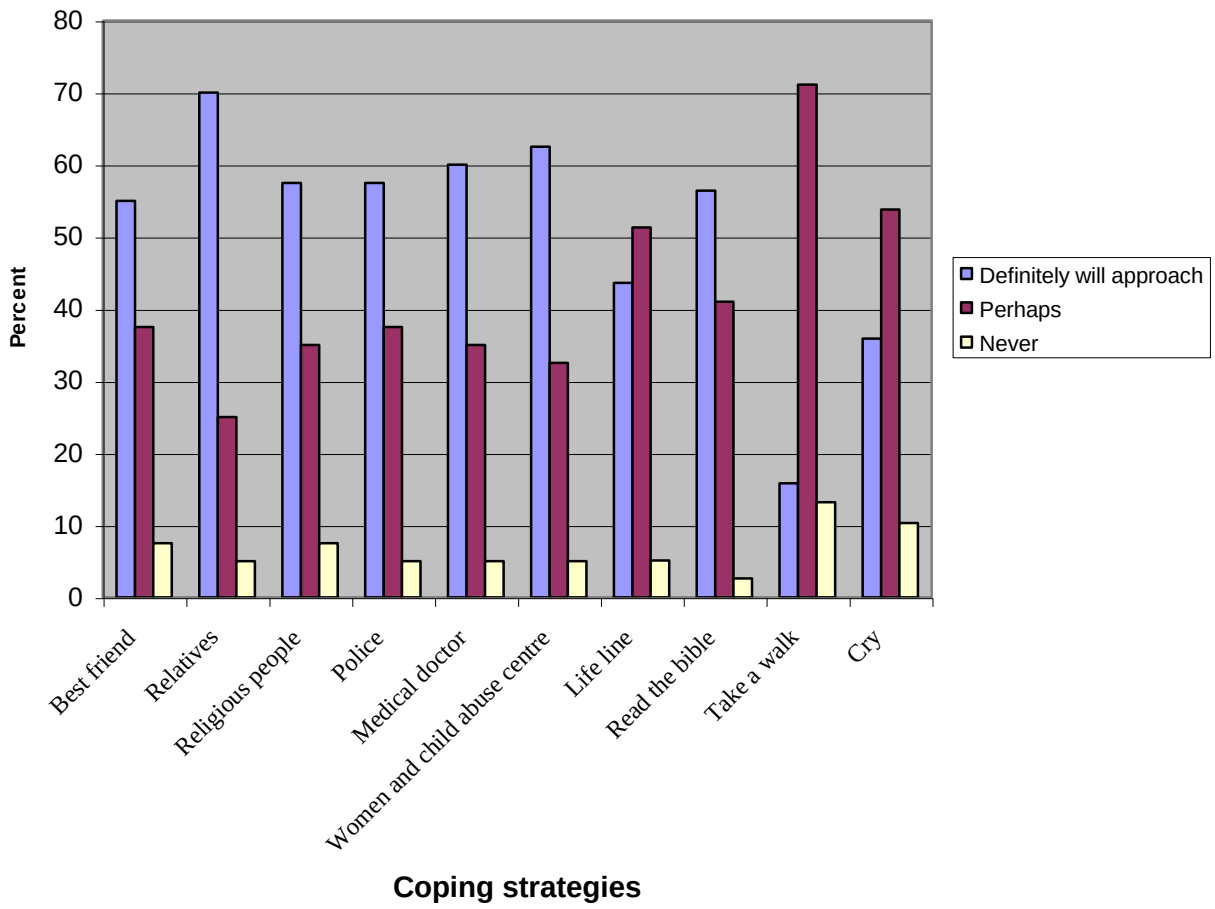
4.4.8 Coping strategies (N=184)

This specific aspect was determined in section 5 of the questionnaires (see Appendix 2). The respondents were asked what approach they would follow should they ever become victims of domestic violence. For this section ten (10) items were constructed. These items plus the responses to them are presented in Figure 4.11.

From Figure 4.11 it can be seen that 129 (70%) of the respondents viewed approaching relatives as an appropriate coping mechanism when confronted with domestic violence.
The role of family support during situations of stress is discussed by Urden et al (2002: 69), where they mention that family members can truly understand each other's experiences, even when little is said.

One hundred and ten (110) (60%) of the respondents regarded contact with a medical practitioner as a coping strategy. In Namibia the medical practitioners do receive high acclaim and trust from patients. (Personal observation from the researcher). A significant correlation was found between owning property and approaching the medical practitioner as a coping strategy. Respondents who own houses would approach a medical practitioner when abused while those without houses would not. (χ^2 =5.630. P=0.060

Figure 4.11:Coping strategies (N=184)



These findings are, however, in contrast to a study that was done by the Ministry of Health and Social Services of Namibia in 2003. The findings of this study were that only ten percent of women indicated that they would report an incidence of domestic violence to a medical practitioner. (MOHSS: 2003:47)

One hundred and seven (58%) of the respondents were also of the opinion that contact with religious people could be regarded as a coping strategy. This corresponds with a report by

Urden et al (2002: 69) showing that spiritual beliefs and practices may provide people with some measure of acceptance of illness, as well as a source of hope, as well as the strength to endure the current stress.

These results however are in contrast with a study conducted by the Ministry of Health and Social Services in Namibia. In this study it was found that women who were exposed to domestic violence were not always willing to approach religious people. They believe that they will be sent back to their abusers, and they will be seen as sinners in front of the church. (MOHSS, 2003:48) The following quotation comes from the same report:

> *It became clear that women, caught in a situation of partner violence, are hesitant to approach the church for help, because of the ignorance and disbelief of church leaders, which they often encounter. When the abuser is a respected member of the congregation, there could be either disbelief or discomfort on the clergy's side, and the victim is often sent back with attitudes and promises of prayers and support from the church.* (MOHSS, 2003:48)

A significant relationship was also found between language spoken and going for a walk as a coping strategy. Damara/Nama women would prefer to take a walk to release stress should their partner maltreat them, while the other respondents do not prefer to take a walk. ($\chi^2 = 6.705$. $P = 0.035$)

It is concluded that respondents in this study would apply a variety of coping strategies should they be confronted with a situation of domestic violence. (See Figure 4.11)

4.4.9 Empowering women (N=184)

This specific aspect was determined in section 6. The respondents were asked to indicate whether they believe they should have control over their body, emotions, decisions and physical well-being. Being in control over these components is regarded as a prerequisite to being empowered.

The results are depicted in Figure 4.12 below.

Figure 4.12:Empowering women (N=184)

As it can be seen that 94.6% of the respondents indicated that they have a right to determine what happens to the body, 95.1% indicated that they have right to determine

their well-being, 96.2% indicate that they have a right to determine their emotional well being and 91.8% indicated that they have a right to take their own decisions.

On the results in the graph, it is concluded that nearly all the respondents regarded it as essential to determine what happened to their bodies, control their own physical and emotional well being, as well as to take their own decisions. They appeared to be knowledgeable on what empowerment entails.

4.5 Summary

In this chapter the data was analyzed. One focus of the analysis was on the biographical data of the respondents. The biographical data was correlated with the respondents' viewpoints/perceptions on domestic violence, their views/perceptions on why victims do not report domestic violence and tend to endure it, as well coping strategies that could be used or are indeed used by the victims. A final analysis was on whether the respondents knew their human rights as a prerequisite of empowerment.

The conclusions and recommendations regarding this analysis will be discussed in Chapter 5.

Chapter 5

Summary of findings, conclusions, limitations and recommendations

5.1 Introduction

This study focused on the views/perceptions of maternity patients on or about domestic violence directed against females.

The motivation to conduct this study originated from the need to assist and support maternity patients directly or indirectly. Directly could be when maternity patients acknowledge being abused and indirectly could be by means of a health education programme on domestic violence. However, there was no data available to be used for a situation analysis in assisting patients or in compiling such a programme. As the education programme was to be used in the maternity section in the State Hospital in Windhoek, the ideal persons that would be able to provide data for this situation analysis were the maternity patients themselves. Therefore it was decided to obtain their viewpoints\perceptions on certain aspects concerning domestic violence.

These “aspects” were formulated as objectives that are presented below for clarity sake.

Table 5.1: Study objectives

• *To explore and describe the views/perceptions of maternity patients on reasons for domestic violence* • *To explore and describe the views/perceptions of maternity patients on reasons for not reporting domestic violence*	• *To explore and describe the views/perceptions of maternity patients on reasons why women may tend to endure domestic violence* • *To explore and describe the views/perceptions of maternity patients on coping strategies*

The summary of the findings, conclusions and recommendations will be presented in association with each objective. Limitations of the study will also be discussed.

As part of the study, it was necessary to compile a profile of the respondents as this biographical data was correlated with the viewpoints of the respondents. Thus a discussion of the biographical data will also be presented.

Where applicable the integration with the Health Belief Model will be demonstrated.

5.2 Findings, Conclusions and Recommendations

A summary of findings and conclusions on the biographical data and stated objectives will be presented. In some discussion points the recommendations will only be allured to as some of the objectives will have similar recommendations.

5.3 Biographical data

The following aspects were addressed:

- Age
- Educational information
- Employment status
- Relationship status
- Number of children
- House ownership
- Religion
- Mother tongue (Language)

5.3.1 Findings and conclusions on biographical data

The results indicated a normal distribution with regard to expected age for women in labour. The data further revealed that at least 68 (37%) of the respondents had completed grade 12 with a further 12 (6.5%) who had obtained tertiary qualifications. In addition, eight (43.5%) of the respondents also owned their own houses; this indicates that these patients are financially well established. It was noteworthy that only 20 (11%) were unemployed.

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Table 5.2:Significant correlations between viewpoints/perceptions and biographical data.

Items	Correlations
(1) Age: 36 years and older group	(1) Regard being denied to visit family as abusive, and to be left alone after argument as abusive
(2) Property ownership: Group that do not own property	(2) Regard ignoring a partner as not being abusive
(3) Educational level: Respondents who did not complete grade 7 school education	(3) Held the viewpoint that male partners could make all decisions on behalf of female partners
(4) Employment status: employed	(4) Regard shouting at a partner as abusive situation
(5) Relationship status: In relationship	(5) Regards being left alone after an argument as abusive
(6) Religion: non-Lutheran.	(6) Regard withholding money from a partner as not abusive.

The clumping together of these three (3) components indicates to a fairly educated group and reasonable independence. They could therefore provide broad and varied viewpoints/perceptions on domestic violence. From the analysis of the demographic data expected varied responses were discovered when significant correlations were done between biographical data and viewpoints/perception on domestic violence.

These significant correlations between viewpoints/perceptions and biographical data are presented below

It is concluded that certain viewpoints on domestic violence are influenced by the age of maternity patients, their ownership of property, religion, relationship status, employment status and education level.

5.3.2 Integration of the biographical data with the Health Belief Model

In chapter 2 it has been argued that the *Health Belief Model* is a value expectancy theory. An assumption from this model is that an individual might have certain characteristics (values) that could influence how such a person will react to stressful situations. Some of these characteristics are called modifying factors, and they act as cues to action. This implies that these factors will positively direct action to improve health or uncomfortable situations. Examples of these factors are age, socioeconomic status and knowledge. (Glanz et al, 1997)

In this study the biographical data revealed significant relationships between age, educational level, employment status, ownership of property, relationship status, religion and views/perceptions on domestic violence. As discussed in Chapter 4, it implies that a more mature person, a better-educated person, and a person who owns property, demonstrated less tolerant views on certain aspects of domestic violence. (See Table 5.2.)

In the discussion and analysis of the biographical data, it has been concluded that viewpoints are influenced by age, knowledge and socioeconomic status; therefore they act as modifying factors, because they modify the viewpoints/perceptions of maternity patients.

5.3.3 Recommendations based on the findings from the biographical data

The following aspects need to be considered when planning to assist maternity patients who might have been abused:

- Age

Family contact and interaction is regarded as important by the older maternity patients. This aspect should be enhanced as a cue to take action.

- Educational background

Consideration should be given to the fact that less educated maternity patients might believe that decisions should be taken on their behalf. These patients may need more information on exactly what domestic violence entails.

- Economic status (owner of property and being employed).

Maternity patients who are employed and do not own property might not regard being ignored or shouted at as abusive. These patients may also need more information on the definition of domestic violence.

The remaining of the recommendations will be presented with each applicable objective of the study.

5.4 Objective One: To explore and describe the views/perceptions of maternity patients on reasons for domestic violence

One hundred and eighty-four (184) maternity patients received questionnaires, or when necessary, the questionnaire was used as an interview instrument. Fourteen (14) items were presented to the respondents to comment on. These items were based on the concept clarification of domestic violence that is described in Chapter 2, Table 2.2.

5.4.1 Findings and conclusions on the views/perceptions of maternity patients on domestic violence

Maternity patients indicated their views/perceptions on 14 items constructed to present situations of abusive behaviour.

A summary of some of the high scoring items are: the forcing of sex (80.4% agree with statement on questionnaire), refusing to use a condom (82.6 % agree with statement on questionnaires), taking all decisions for female partner (78.8% agree with statement on statement), and the hiding of food (84.2% agree with statement on questionnaire).

A significant correlation was found between level of education and decision making for the female by the male partner as well as between level of education and approaching an abuse centre once maltreated by a male partner. Maternity patients with better educational levels regarded male partners making the decision as abusive, while less educated maternity patients do not necessary agree. Respondents with higher education would also more likely approach an abuse centre for support.

It is concluded in this study that the respondents (maternity patients) did regard all the behaviours and situations as grouped in these 14 items as abusive in nature.

5.4.2 Integration of the views/perceptions on domestic violence with the Health Belief Model

In the *Health Belief Model* the component of perceived susceptibility is addressed. This explains whether people believe that they will contract an illness, or in this study whether maternity patients believe certain behaviours are indicative of abusive behaviour.

With the significant correlations that were found between lesser educated patients and regarding it as abusive should all decision be made for them, the conclusion is made that the certain components of perceived susceptibility is not acknowledged by them.

5.4.3 Recommendations with regard to the views/perceptions on domestic violence

In formulating the outline for their commended health education programme, provision should be made for the non-acknowledgement or not recognizing the component of perceived severity and perceived susceptibility of abuse.

In assisting maternity patients, the idea of perceived susceptibility should be introduced, either through direct discussions or through the health education programme. They should be informed that if they are abused, it could be bad. Health education also should be given on why non-physical forms of abuse violate their human rights and take away their free choices.

5.5 Objective Two: **To explore and describe the views/perceptions of maternity patients on reasons for not reporting domestic violence**

One hundred and eighty-four, (184) maternity patients received questionnaires to complete, or if necessary, questionnaires were used as an interview instruments by the researcher**.** Respondents were asked to indicate whether all cases of domestic violence are reported or not all reported. Ninety percent of the respondents indicated that cases are not reported. The reasons for not reporting were classified as patterns, which are mentioned as follows:

- For appearance sake
- Financial consideration
- Cultural reasons
- Logistic reasons
- Cognitive reasons/lack of information
- Lack of trust in legal and police system
- Rationalisation
- Self-blaming
- Fear of abandonment

5.5.1 Findings and conclusions on the views of maternity patients on reasons for not reporting domestic violence

Most of the cases are not being reported according to the respondents. The views of maternity patients with regard to domestic violence are in line with what is described in literature. No differences in such viewpoints/perceptions have been shown to be attributed to differences in backgrounds. These aspects were not regarded as modifying factors that may influence the reporting due to different health beliefs.

It is concluded by 90% of the respondents that not all cases of domestic violence are reported. The reasons were classified as nine patterns.

5.5.2 Integration of the non-reporting of all cases of domestic violence with the Health Belief Model

In the Health Belief Model the component of "likelihood of action" is addressed. This explains the perceived benefits minus the perceived barriers to take action against domestic violence. From the reasons reported it appears the respondents viewed non-reporting as being due to barriers such as financial problems, cultural constraints and logistic problems.

It is concluded in this study that the respondents view non-reporting of domestic violence as being due to barriers experienced by the abused female partner.

5.5.3 Recommendations with regard to non-reporting of all cases of domestic violence

Maternity patients need to be sensitized on the following:

- Availability of the Women and Child Protect Unit
- Legal steps that are available
- Places of safety
- Contact number of Women and Child Protection Unit, Legal Aid and social welfare and support groups.
- Group discussions on views of self-blame

5.6 Objective Three: To explore and describe the views/perceptions of maternity patients on reasons why women tend to endure domestic violence

Nine (9) items were presented to the respondents to consider.

5.6.1 Findings and conclusions on reasons why women tend to endure domestic violence

As indicated in Figure 4.10 Chapter 4, the majority of respondents indicated that these items are representative of the reasons why women tend to endure domestic violence. Items that scored the highest were: For the benefit of the children (82,5% agreement), financial

reasons (67% agreement), and no place to go (80% agreement). The views/perceptions of maternity patients with regard to reasons for not reporting domestic violence were in line with the literature. A battered woman may choose to stay with, or return to her abuser for many complex reasons. She stays or returns for many of the following reasons: financial constraints, societal and familial pressure, and because of the children. For many women, staying in the relationship may be preferable to single parenthood, inadequate housing, and financial deprivation. (Campbell et al 1993:169)

It is concluded that the respondents had a mean of 60% agreement that these nine (9) items are reasons women tend to endure violence.

5.6.2 Integration of the reasons why women tend to endure domestic violence with Health Belief Model

These nine items (presented as reasons) could be regarded as both perceived benefits (financial) as well as perceived barriers (cultural and religious).

5.6.3 Recommendations with regard to the reasons why women tend to endure domestic violence

Based on the above discussion the following aspects should be addressed in an educational programme:

- An insight into the current belief system with regard to endurance
- Availability of alternative options

5.7 Objective Four: To explore and describe the views of maternity patients on coping strategies

Ten (10) items were presented to the respondents to comment on. These items were based on the coping strategies available for domestic violence that are described in the literature.

5.7.1 Findings and conclusions on the views/perceptions of maternity patients on coping strategies

The following coping strategies were identified by most of the respondents. Talking to relatives (70% agreement), approaching women and abuse centre (62% agreement), and consulting of medical doctor (60% agreement).

It was also found in the literature review in Chapter 2 that women prefer to consult their relatives once their partners maltreat them. There were differences in viewpoints/perceptions that relate to differences in biographical background. Ownership was found to have an influence on whether women would approach a doctor when being maltreated. Respondents who own houses would prefer to approach the doctors, while those without houses do not prefer to approach the doctor. ($\chi^2 = 5.630$. $P = 0.060$)

The views/perceptions of maternity patients with regard to domestic violence in this study are in line with what the MOHSS: 2003 found in their research, in that 35% of their respondents prefer to consult their parents once they are maltreated, while 26% will prefer to consult siblings.

It is concluded that in most of these items agreement is obtained that they are definitely coping strategies.

5.7.2 Integration of the views/perceptions of maternity patients on coping strategies with Health Belief Model

In the Health Belief Model, modifying factors are regarded as change agents or survival strategies. Certain characteristics of behavioural patterns are regarded as being modifying in nature and therefore influencing coping efficiency.

In the analysis of the viewpoints/perceptions on coping strategies in this study certain characteristics were identified that could be regarded as modifying factors. A correlation

was found between property ownership and coping. Maternity patients with property would visit a doctor when abused. It is thus concluded that ownership of property act as a modifying factor within the framework of the Health Belief Model.

5.7.3 Recommendations with regard to the views/perceptions of maternity patients of coping strategies

When submitting/compiling guidelines for an educational programme, the following aspects should be kept in mind:

- The role of family support in coping
- The role of the Women and Child Abuse Centre
- The role of the medical practitioner
- The economic background, (for example maternity patients who owns property)
- Self esteem
- Psychological effect of abuse
- Cycle of abuse

5.8 Limitations of the study

- In this study a quantitative approach was employed. The researcher acknowledges that a triangulation of methods (qualitative and quantitative) might have provided as deeper inside information). As this study was conducted in a specific context (the State Hospital, Maternity Ward) these results cannot be generalised to the broader population.
- A specific middle class population participated. This population is not representative of the maternity patients in the rest of Namibia.

5.9 Recommendations

Although the research cannot be generalized, recommendations are made that are specifically applicable to health education. Recommendations and suggestions for future research are also submitted.

5.9.1 Health education

It is recommended that these guidelines be implemented in the health education programme, and that these guidelines be evaluated and adapted if necessary.

5.9.2 Further research

It is recommended:

- That this study is repeated using a qualitative approach. This study can be used as a pilot study for research on a larger scale. A comparative research study can be done regarding the effectiveness of these guidelines at the same unit after the implementation of these guidelines, to determine whether the knowledge of maternity patients on domestic violence has improved.
- That the study be duplicated in maternity patients from a lower socio-economic background to provide a more representative view

5.10 Summary

In this study the views/perceptions of maternity patients on domestic violence were examined, including reasons for not reporting, reasons for enduring and coping strategies available. Final conclusions for each objective were provided for, and recommendations, which addressed the utilisation of educational guidelines as well as ideas for further research, were provided.

References

Babbie, E. & Mouton, J. 1998. The practice of social research. Cape Town: Oxford University Press.

Batterers' Intervention Programs. No Author Obtained from Internet on 2005/03/02. (http://www.dc.state.fl.us/pub/batters/content.html

Brink, H.I.1996. *Fundamentals of research methodology for health care professionals*. Cape Town: Juta Press.

Burns, N. & Grove, S.K. 1997 *The Practice of nursing research: Conduct, critique& utilization.* 3rd Edition. Philadelphia: Saunders.

Chinn, P.L & Kramer, M.K. 1991. Theory and Nursing. A Systematic Approach. 3rd edition. London: Mosby.

Campbell, J. & Humphrey, J. 1993. Nursing care of Survivors of family Violence. 2nd edition. Glen Myers.

Cowie, A P. 1994. Advanced Learner's Dictionary. Oxford: Oxford University Press.

Curran, D.J. & Renzetti, C.M. 1996. Social Problems. Society in Crisis. 4th edition. Boston: Allyn and Bacon.

David, L, 1989. Family violence in cross-cultural perspective. Frontiers of Anthropology Volume 1. SAGE Publications.

Dictionary.LaborLawTalk.com.Downloaded on the 19 March 2005. http://encyclopedia.laborlawtalk.com/empowerment

Glanz, K. Lewis, B. & Rimer, B. 1997. Health Behaviour and Health Education: Theory, Research and Practice. San Francisco: Jossey-Bass publisher.

Government of the Republic Namibia, Convention on the Elimination of all forms of Discrimination Against Women (CEDAW): First Country Report Republic of Namibia, Department of Women Affairs, GRN, Windhoek, 1993a.

Government of the Republic of Namibia, (GRN) Namibia, An Assessment of the nature and consequences of intimate-male partner violence in Windhoek, Ministry of Health and Social Services, 2003.

Government of the Republic of Namibia, (GRN) Namibia, Constitution of the Republic of Namibia, GRN, Windhoek, 1990.

Greaves, I. & Porter, K. 1999. Pre-hospital medicine. The Principles and practice of immediate care. London: Arnold press.

Haber, V., Krainovich-Miller, B., McMahon, A.L & Price-Hoskins. 1997. Comprehensive Psychiatric Nursing. 5th edition. London: Mosby.

Hancox, T. 2003. Know your rights Torture.1st edition. Legal Assistance centre. Windhoek: Huricon publisher.

Hayward, R. 2000. Breaking the earth jar. Asia: Jagadamba press.

Hoff, A. 1993. Battered women as survivors. London: Mosby.

Hubbard, D. & Wise, D. 1998. Domestic violence: Proposal for law reform. Windhoek: Legal Centre.

Hubbard, D. 1999. Law reform and development commission. Windhoek: Legal Assistance Centre.

Iipinge U. & Williams M. 2000. Gender & Development. University of Namibia: Pollinations publishers.

Iipinge, S. & Hofnie, K, 2003. Desk Views of cases reported at the Women and Child Protection Unit and subsequent course of action taken in Windhoek. Windhoek: University of Namibia press.

Iipinge, U. & LeBeau, D. 1997. Beyond Inequalities, Women in Namibia. Gender Training and Research Programme. Windhoek: Pollinations publisher.

Jewkes, R. 2000. Intimate partner violence: causes and prevention. Volume 359.London: Lancet publisher.

Johnson, B.S. 1993. Psychiatric-Mental Health Nursing. Adaptation and growth.3rd edition. Toronto: JB Lippincott Company.

Johnson, M. & Maas, M. 1997. Nursing Outcomes Classification (NOC). St. Louis: Mosby.

Kindersley, D. 1998. Oxford Dictionary. New York: Oxford Dictionary press.

Kishor, S. & Johnson, K. 2004. Profiling Domestic Violence. Calverton: MEASRE DHS.

Kitt, S. & Kaiser, J. 1990. Emergency Nursing. A physiologic and clinical perspective. London: LB Saunders.

Le Beau, D. 1996. The nature, extent and causes of domestic violence against women and children in Namibia, Windhoek. Windhoek: Pollinations publisher.

Leininger, M.M. 1991. Culture care diversity and universality: A theory of nursing. New York: National League for Nursing Press

Lent; Morris. & Rechner, S. 2000. Effects of domestic violence on pregnancy and about.http://www.cfpc.ca?English/cfpc/programs/patient%20care/maternity/violence/default

Lorie, H. 1987. The health and development policy project, USA.

MacEwen & Barling. 1998. (www.nnh.org/risk/chap2-Risk Factor male.htm

Mahlungula, S.N. & Uys, L.R. May 2004. Volume 27 number 2 (445). Spirituality in Nursing: An analysis of the concept.

Moreno, G. 2002. Dilemmas and opportunities for an appropriate health-service response to violence against women. Volume 359.London: Lancet publisher.

Mouton, J. 1998 Understanding Social Research. Pretoria: Van Schaik.

Mukangara, F. & Konda, B. 1997. Beyond inequalities, women in Tanzania. Tanzania gender networking programme (TDNP): Tanzania press.

Newton, E.R. 2003. http://www.emedcine.com/med/topic3268.htm.

Nordien, R., Alpasan, N. & Pretorius B. 2003. Muslim women's experience of domestic violence in Nelson Mandela Metropole: Health SA Gesondheid. Volume 8 (4).

Oliveira, A. 1997. Violence during pregnancy. WHO.

Pokroy, Mayer., A, Stuart, A. & Pretorius H.G. 1999. Coping styles and defence mechanisms utilized by patients suffering from irritable bowel syndrome. Health SA Gesondheid Volume 14.

Polit, D. & Hungler, B.1997. Nursing research. Principles and methods. Toronto: JB Lippincott.

Rose-Junius, S.M.H., Tjapepa, V.N. & De Witt, J. 1998. An investigation to assess the nature and incidence of spouse abuse in three sub-urban in the Karas Region, Namibia. Windhoek: Pollinations publisher.

Ruth, B. & Brown, L. 1989. Myles Text Book for Midwives. London: Longman Group Ltd.

Sheehy, S.B & Lenehan, F. 1997. Manual of emergency care. 5th edition. London: Mosby.

Sheehy, S.B & Lenehan, F. 1999. Manual of emergency care. 6th edition. London: Mosby.

Anonymous. 2003 November 26.Domestic violence in Namibia. The Namibian Newspaper: 3. Windhoek.

UN, 1993. Strategies for confronting domestic violence: A Resource Manual. New York: United Nations Press.

Urden, L.D., Stacy, K.M. & Lough, M.E. 2002. Thelan's Critical Care Nursing, Diagnosis and Management.4th Edition. London: Mosby.

Uys, H.H.M. & Basson, A.A. 1991. Research Methodology in Nursing. Pretoria: Haum.

WHO, 1996.5-7 February. Violence against women. Geneva.

WHO. 1997. Violence Against Women. Geneva.

WHO.1999. Population Reports. Ending Violence Against Women. Geneva.

Widding, Per and Olof, J. 2000. Domestic violence during pregnancy. Acta Obstetricia et Gynecologica Scandivavica Vol. 79/8: 625.

Wright, R.J. 1998. Exposure to violence. (http://www.macses.ucsf.Research/Psychosocial/notebook/violence.html

Appendix 1

Consent to be interviewed

My name is Erica Libuku; I am doing my Master's in Public Health at the University of Namibia. I am conducting a study on the **Views/perceptions of maternity patients on domestic violence**. I would very much appreciate your participation in this study. I would like to ask a few questions on how do you view domestic violence. The information obtained will be used for study purposes and also to plan for the domestic violence educational programme, which will be held in the maternity ward for your own benefit. The interviews will take 30 minutes. All information you will provide will be treated confidentially and anonymously.

If you have any question before I start with the interview you can ask.

Appendix 2: Interview schedule

SECTION 1: DEMOGRAPHIC DATA

1. Age in years

18-25	
26-35	
36 years and older	

2. Educational information

Completed grade 4	
Completed grade 7	
Completed grade 10	
Completed grade 12	
Completed tertiary education	

3. Employment status:

Employed	
Unemployed	

4. Relationship status:

1 Married	
2 In a relationship	
3 Single	
4 Divorced	

5.Period of marriage…….or relationship…….

6. Number of children……

7.Children's ages

Children	Ages
1	
2	
3	
4	

8.Owner of the house/property……

9.Religion…….

10.Home language……

SECTION 2: VIEWS AND REASONS FOR DOMESTIC VIOLENCE

11. How would you rate the following situations, as being abusive or not abusive? Indicate with a tick mark in the specific columns. A "5" indicates a definite abusive situation while a "1" could not be regarded as an abusive situation

	Not an abusive situation				Definitely an abusive situation
Situations	1	2	3	4	5
1 Shouting at a partner					
2 Belittling a partner					
3 Ignoring a partner					
4 Forcing sex with a partner					
5 Withholding money from a partner					
6 Preventing a partner to visit friends or to be visited					
7 Preventing a partner to visit relatives					
8 Criticizing a partner in front of others					

9 Taking all decisions on behalf of a partner					
10 Pushing a partner in anger					
11 Insulting a partner in a form of joke or anger					
12 Hiding food from a partner or not allowing a partner to have access to food.					
13 leaving a partner alone at home for more than one day during an argument					
14. Refusing to use a condom during sex					

12. From the list below, which reason best explains why their partners might abuse women? Indicate with a tick mark in the specific columns. A "5" indicates a definite reason while a "1" could not be regarded as a reason.

Reasons	Not a reason				Definite reason
	1	2	3	4	5
Due to alcohol consumption or drug by a partner					
Due to alcohol consumption by the women					
Due to behaviour a partner found offensive					
Due to stress experienced by a partner at work or in the family.					
Due to women disagreeing with the partner.					
Due to economic situation					
Due to cultural belief on the right of the man to physically punish his wife.					
Due to partner's belief that he must correct or have a right to discipline the wife.					

SECTION 3: REAONS FOR NOT REPORTING DOMESTIC VIOLENCE.

13.Do you believe all cases of domestic violence are reported?

Yes	
No	
Not sure	

Yes or no. If no what do you think are the reasons for not reporting?

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SECTION 4: WHY WOMEN TEND TO ENDURE VIOLENCE

14. From the list provided below, which reasons could best explain why women stay with their partners, even though it is evident that they are maltreated?

Reasons	True	Not true	Not sure
For the benefit of the children			
For financial reasons			
Think its normal behaviour of life			
To keep up appearances			
For religious reasons			
Cultural or traditional beliefs			
Scared of retribution			
Because no place to go/no other choice			
Scared of family reaction			

SECTION 5: COPING STRATEGIES

15. Should it happen that you have been injured/maltreated in one or other way by your partner, whom would you approach/or what would you do for support and help?

Persons/institutions to approach	Definitely will approach	Perhaps	Never
1 Best friend			
2 Relative			
3 Religious affiliation/minister/pastor			
4 Police			
5 Medical doctor			
6 Women and Child Abuse Centre			
7. Life line			
8. Read the bible			
9.Take a walk			
10. Cry			

If you have indicated a "never" in the above options, would you care to explain why?

……

…….

SECTION 6: EMPOWERING WOMEN

16. How would you rate the following situations as your right or not your right? Indicate with a tick in specific columns. A"5" indicates a definite not your right, while a 1 could be regarded as your right.

	Agree				Totally disagree
	1	2	3	4	5
1. Women have the right to determine to what happens to their bodies e.g. decide on sex, pregnancy time and health					
2.Women have the right to determine for her physical well being or safety					
3.Women have the right to determine their emotional well being e.g. not to be assaulted, not to be shouted at and belittled.					
4. Women have the right to self-determination e.g. take their own decisions, say no to dislikes and have their own opinions and views on things.					

Appendix 3

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 **Ministerial Building** **Tel: (061) 2032507**
Windhoek **Harvey Street** **Fax: (061) 227607**
Namibia **Windhoek** **E-mail: sowoses@mhss.gov.na**
Enquiries: Ms. S. Owoses **Ref.:** 17/3/3/AP **Date:** 11 May 2004

OFFICE OF THE PERMANENT SECRETARY

Ms. E. Libuku
P O Box 98145
Windhoek

Dear Ms. Libuku,

THE VIEW OF MATERNITY PATIENTS ON DOMESTIC VIOLENCE

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

2. The proposal has been evaluated and found to have merit. However, some issues in the proposal need to be revisited. Please find attached comments/recommendations for consideration.

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

3.1. The data collected is only to be used for your Masters degree;
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.

Wishing you success with your project.

Yours sincerely,

DR. K. SHANGULA
PERMANENT SECRETARY