How healthcare workers experience violence against women and how it influences the care
A qualitative study

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Abstract

Violence against women (VAW) is a global problem existing in all cultures. This study is performed because there is a lack of knowledge about how healthcare personnel treat VAW to promote health and to alleviate suffering. The aim is to describe how healthcare workers experience violence against women and how it influences the care. Qualitative semi structured individual interviews were made with three nurses and one medical student in Egypt. The interviews were taped and transcribed before the text was analyzed by qualitative content analysis. The result showed that women were subordinated and discriminated in Egypt and in the healthcare. The care for the abused women was focused on first aid, and the respondents expressed that it was the woman’s own decision and responsibility to report or do any further actions. Often the violence was ignored or silenced. Violence and threats was accepted by the society and individuals as a mean for handling conflicts and was used in the healthcare settings as well. The respondents expressed a need for change and a wish for decreasing the violence, work for equality and stressed the importance of education in society. They also emphasised the need for women to gain more economic independence. Attitudes of healthcare workers need to be addressed and further investigation is necessary to prevent VAW.

Keywords: Violence against women, attitudes, Egypt, nursing practices, gender-based violence, human rights, women’s health.
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INTRODUCTION

I have chosen to do my examination essay in Egypt to enlighten an important issue faced all around the world; violence against women (VAW). To make this research possible I received a scholarship from the Swedish international development agency (SIDA).

The life in Egypt interests me because the most obvious thing for me as a European woman in Egypt is the woman’s secondary importance in the public life. The extent of VAW is a reflection of a continuous discrimination of women’s rights (United Nations Secretary General, 2006). VAW exists in all cultures but I am interested in how Egyptian healthcare workers and primarily in how nurses deal with this issue. There are very few previous studies in this area that were performed in an Arabic community and written in English.

United Nations Department of Public Information (2008) estimated that globally one in three women faces some form of gender based violence during her lifetime. Violence affects the whole health and well-being and it is a major challenge for healthcare workers to help abused women. The healthcare workers need to have knowledge and skills about the VAW phenomenon to be able to detect and address it. The way in which patients are cared for depends largely upon the healthcare workers’ way of thinking as well as their attitudes. Do the nurses and the healthcare workers recognize the woman’s pain, needs and wishes?

BACKGROUND

According to United Nations General Assembly (1993, p. 1) "the term "violence against women” means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.” Krantz (2004) claim that the word gender-based violence means that the violence is based in the social cultural construction where masculinity is superior to femininity.

A document from World Health Organization (2005a) defines VAW as physical, sexual, emotional and intimate-partner violence. Physical violence means an action that hurts or threatens to hurt the woman physical. For example being pushed, having her hair pulled, burnt or slapped. Sexual violence means when a woman being forced “to do something sexual she found degrading or humiliating” (ibid., p. 4). Emotional violence “includes, for example, being humiliated or belittled; being scared or intimidated purposefully.” (ibid., p. 4). Intimate-partner violence (domestic violence) means a woman have been subjected to any type of violence from an intimate partner or expartner.

The healthcare workers need to understand the patient from her perspective and consider how she experiences the world; her life-world. This theoretical perspective is caring-science (Dahlberg, Suserud, Nyström, Segesten & Fagerberg, 2003). For the healthcare workers not just understand how to do something but to be aware of how her/his actions in a given situation fit in a bigger context and affects the patient and her
family. All human beings are subjects that experience the world through her/his body. The purpose of caring-science is to profound our understanding and knowledge how we can ease the patients suffering and support their health. To care for a patient according to this the nurse has to continuously reflect upon every caring situation/encounter. Health is not just the absence of sickness but a feeling of well-being (Wiklund, 2003). However theories and models in caring science show little or no awareness about gender roles and power structures (Miers, 2000).

**VAW globally**

At least one in every three women will be abused by an intimate partner, physical, sexual or emotionally (United Nations Department of Public Information, 2008). VAW is the most common abuse of human rights, yet it is the least recognised one. The World Health Organization (2005b) multi-country study showed that VAW by intimate partners is “...common, wide-spread and far-reaching in its impact.” (p. viii). States and governments have a duty to acknowledge the VAW, through prevention and actions to prosecute and punish violence against women (ibid.). Almost every society in the world has social institutions that in some way allow or deny abuse (Belhadj, Bouasker, Douki, Ghachem & Nacef, 2003).

VAW is not restricted to a specific culture, religion or happens to special groups of women within a society. It exists in all countries no matter of income; the difference is displayed in whether the public condemn it or not (Belhadj, et al., 2003). This includes legal attitudes as well as treatment in society and the public view of official persons.

However, women’s experiences and the manifestations of VAW are shaped by factors such as nationality, age, ethnicity, class, sexual orientation, disability and religion (United Nations Secretary General, 2006). The violence results in pain, fear and misery for the women and their families. It stops the women from “fulfilling their potential, restricts economic growth and undermines development” (United Nations Secretary General, 2006, p. 1). VAW can only be eliminated by addressing the discrimination, promoting women’s equality and empowering of the women. The costs of VAW are enormous for the society (World Health Organization, 2005b) and everybody would gain benefit from ending this violence (United Nations Secretary General, 2006). Many billions of US dollars are each year spent on healthcare, legal systems, absence from work and lost productivity (Krug, Dahlberg, Mercy, Zwi & Lozano, 2002). Another cost that cannot be measured is human suffering. Victims of violence “have more health problems, significantly higher health care costs and more frequent visits to emergency departments throughout their lives than those without a history of abuse” (Krug, et al., 2002, p. 12).

According to documents from United Nations Department of Public Information (2008, p. 1) violence against women has its roots “in historically unequal power relations between men and women, and persistent discrimination against women”. There are several factors that put women in a greater risk for violence, example economic inequality between men and women, male authority and less educated women (World Health Organization, 2005a). “Within the broad context of women’s subordination, specific causal factors for violence include the use of violence to resolve conflicts,
doctrines of privacy and State inaction. Individual or family behaviour patterns, including histories of abuse, have also been correlated with an increased risk of violence.” (United Nations Secretary General, 2006, p. 1).

**VAW and Egypt**

A survey (Affi & von Bothmer, 2007) showed that 34% of women in Egypt had been beaten by their current husband at least once and 16.4% had been exposed to physical violence during the prior year. “In Arab and Islamic countries, domestic violence is not yet considered a major concern despite its increasing frequency and serious consequences.” (Belhadj et al., 2003, p. 165). The common tendency in Arabic communities is to view domestic violence as a private matter, justifiable response to misbehaviour, the husband’s own concern or a way to preserve the honour of the family. VAW exists in all countries over the world (World Health Organization, 2005b) but several studies show that the violence is more widespread in communities were women’s rights are questioned and when the abusing men seldom faces the court (Belhadj et al., 2003; United Nations Secretary General, 2006). The Arab society supports male dominance and subordination of women in the public and private sphere. Indifference can be seen in the whole community, from victims and abusers to healthcare professionals and police officers; and if the woman speaks out she and her family risks to be ostracized by their community and blamed for undermining family stability (Belhadj et al., 2003). Prejudices are attitudes that often lead to discrimination of whom it is directed towards (Rosén, 2010). According to (Belhajd et al., 2003) some people justify the violence by their religion, using some excerpts from the Koran to prove that men who abuse their wives are following God’s commandments. However the study states that a fair reading of the Koran shows that wife abuse more likely is a result of culture (ibid.).

Most nurses in the Egyptian healthcare have a previous education with 8-9 years basic education and 3 years in nursing school. Generally the nurses are women and come from a poor background. The salary is often low in comparison to the amount of working hours. This makes Egyptians consider nursing as a job with low status although the nurses are called the white angels, to describe their unselfish mission to help other humans. According to Miers (2000), cultures that value economic success, theoretical knowledge and autonomy consider nursing a low status job.

**VAW and Health care**

When women report abuse to healthcare professionals it is often denied, minimized, interpreted as delusional or ignored. Health professionals also underrate the consequences of the violence (Belhadj et al., 2003). They should treat women with respect, provide appropriate care and not reinforce feelings of stigma or self-blame. Providers of healthcare should reassure women that violence is unacceptable and no woman deserves to be beaten, sexual abused or to suffer emotionally (World Health Organization, 2005b).

Ever-beaten women seek healthcare more often and need more medical care than never-beaten women (Becker, Campbell & Diop-Sidibe´ a, 2006). Yet victims of violence
who seek care from health professionals often have needs that providers do not recognize, do not ask about, and do not know how to address (John Hopkins University, 1999). In a report from World Health Organization (2005a) it is stressed that healthcare workers in reproductive health should receive education in how to recognize VAW and they should have a referral system to ensure the women get appropriate care and support. “Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering.” (International Codex for nurses, 2006. To care is to promote health and relieve suffering. The professional care includes the natural care, scientific knowledge, experiences and an obligation towards the patient, as well as an ethical code to consider (Wiklund, 2003). However theories and models in caring-science do not take into consideration gender or power issues. It is important for nurses to recognize how gender-power relations affect their care for patients (Miers, 2000). Healthcare providers should also reflect over his/her own power in the situation (Wiklund, 2003).

The healthcare sector should have/has a vital role in preventing violence and supporting the exposed women (World Health Organization, 2005b). World health organization made recommendations for strengthening the health sectors response to VAW and describes the importance of right attitudes among healthcare providers (ibid.). These attitudes reflect how the healthcare workers relate to and care of women who have been abused. A report from World Health Organization (2009c) lifts how gender inequalities inhibit the ability of women to seek protection. A survey published in 2006 (Becker et al., 2006) concluded that 52% of abused women in Egypt did not seek healthcare. Most of these women thought it would be of “no use” to contact the healthcare services. Several women considered the violence normal or not serious, felt fear of escalating the violence or to be stigmatized. Some thought they would not be believed or that it would not make a difference to their situation (Belhadj et al., 2003; World Health Organization, 2005b). It is described that the health care service has an essential role in addressing the reluctance to seek help. VAW will not be fought effectively if nurses and healthcare workers do not consider it an issue.

Gender

The term gender is central in the discussion about VAW. All societies are based on a gender system, a social structure that is shaped by tradition, culture and economical differences that are seen as changeable factors. The hierarchy in the gender system contributes to women’s and men’s disparities (Hirdman, 1988); supports dichotomy of work, characteristics and behaviours of men and women. “Patriarchal disparities of power, discriminatory cultural norms and economic inequalities serve to deny women’s human rights.” (United Nations Secretary General, 2006, p. 1). The relationship between men and women is seen as unequal, where superiority is traits of masculinity and subordination characterise femininity (Hirdman, 1988). Dominance can involve an exercise of power that may result in violence. The healthcare cannot be separated from gender hierarchy and power in the caring relation (Miers, 2000). Gender is not mentioned as a direct risk factor for being subjected to violence and some claim that gender is not the problem. The problem is the inequality between the genders (Gullvåg Holter, 2004).
According to Krantz (2004) the cause of violence can be divided into two parts. One is the direct trigger factor that often is trivial and the indirect factor is more complicated. The indirect trigger factor is based on the gender order in society that results in unequal relationships and different living conditions between men and women (Krantz, 2004). Heimer, Tönnesen & Posse (2004) discussed intimate partner violence and they claim it to be an expression of inequality between the genders and a way in which the man states his power. Attitudes to gender and acceptance of gender inequality can support VAW and put women in a greater risk (World Health Organization, 2005b). Eliasson (1997) claimed that all attitudes are highly influenced by the surrounding community and society. Interventions that challenge these attitudes and norms are widely used (World Health Organization, 2009a). Attitudes relating to central or important things in an individual’s life are stable and attempts to change them will meet psychological resistance within the individual (Rosén, 2010). There are social and cultural norms that allow men to have control over women (Gullvåg Holter, 2004).

FORMULATION OF ISSUE

This study is performed because very little is known about how healthcare workers and nurses experience VAW. Few studies have been found on the subject in general and none in Egypt. The attitudes reflect our behaviour and actions, and furthermore the care for our patients. What are these factors that influence and shape the caring for these women? Patients who seek healthcare need care; do they receive the care required? Do the nurses and the healthcare workers have a holistic view, aiming to care for the woman’s mental and emotional need or does she/he only take physical needs into consideration?

VAW is a worldwide problem and the most common action violating human rights is intimate partner violence. Some research claims the culture has a big impact in passively or actively allowing the man to hit his wife, for example as a fostering action. Do the nurses and healthcare workers consider VAW as a problem or as a natural part of life which the woman has to endure? Does the healthcare provider see the woman’s individual wishes and seek to support her in this?

AIM

The aim is to describe how healthcare workers experience violence against women and how it influences the care.

METHOD

A qualitative method was selected to explore how healthcare workers experience violence against women. Conventional qualitative content analysis was used with an inductive approach to analyze as openly as possible and to extract common themes or patterns (Hsieh & Shannon, 2005). The aim of Conventional content analysis is to describe a phenomenon (ibid.).
In this study the term “abuse” is used frequently as a synonym for violence. The patient or the woman is used as synonyms for women who have been abused. The interviewed healthcare worker will also be called respondent.

**Data collection and recruitment**

The criterions for choosing participants was that they were to be different from each other in regard to age, religion and sex which would enable the researcher to collect different thought and views. A governmental hospital in Cairo was chosen and two nurses were provided by the hospital. They worked at two different wards and both were head nurses and responsible for the nurses working there. A Christian hospital in a smaller town in Upper Egypt was chosen where one of the working nurses agreed to participate. To get a view of a man, one respondent was found by personal connections, a man who studied to be a doctor in Cairo. The three nurses were women and all was married and had children. The doctor student was unmarried without children. They had a median age of 29.5 and a range from 22 to 41 years old. Three of the respondents were Muslims and one was Coptic Christian. Due to ethical considerations the respondents will not be presented further.

Before conducting the interviews the respondents were informed about the purpose and method of the study and that their participation was voluntary (Vetenskapsrådet, n.d.). The interviews were taped with the respondents’ approval and transcribed afterwards. All of the interviews were interrupted at some time during the interview due to working duties even if time was reserved for the interview, no other choices were available.

A semi structured interview guide was developed (see appendix 1), slightly standardized to encourage the respondents to express themselves about the subject. Qualitative interviews were conducted according to Trost (2005) guidelines. As introduction a few initial questions about the respondents and their job were asked, to establish a relationship with the respondents. To get an understanding about how the respondents viewed the issue the first question about the actual subject was: “How would you define violence against women? What do you think it is?” The respondents were encouraged to express own their thoughts and follow-up questions were asked to clarify or deepen the answers.

**Analysis of the collected data**

Qualitative conventional content analysis was used to analyze the data (Hsieh & Shannon, 2005). The transcriptions from the interviews were repeatedly read to get a sense of the whole and first impressions and thoughts were written down in the margin. Meaning units and key sentences were identified and codes were derived directly from the text (Hsieh & Shannon, 2005). Next the codes were sorted into categories based on similarities and differences. All codes within a group were inspected again, some were combined and other split into subcategories and definitions for the categories and subcategories was created. The categorization was discussed with my supervisor to validate the analysis. (Hsieh & Shannon, 2005). Four categories emerged from the interviews and seven subcategories. Example of the process can be found in table 1.
Ethical considerations

Violence against women can be a sensitive subject especially if you talk about own experiences. It is important to protect confidentiality to ensure the women’s and interviewer’s safety and data quality (World Health Organization, 2001).

In this research four ethical principles was followed (Vetenskapsrådet, n.d.). The participants were informed before the interview about the aim of the study and the terms of participation; that it is voluntary and that they have the right to end the interview at any time. Informed consent was obtained, the respondents’ participation was kept confidential and the collected material was only used for scientific means (Vetenskapsrådet, n.d.). In this study was I as the interviewer aware of the risk that the respondents might become distressed by an insensitive interview, or from having to recall painful experiences. The interviewer should be able to deal with such a situation in a constructive way (World Health Organization, 2001). Personal experiences were not asked about but some respondents chose to share some experiences.

Women who participate in interviews can be subjected to more violence if the abuser find out she been talking about it. World health organization (2001) states that the risks involved for people who participate in a study should be in proportion to the benefit gained from the study, both on the individual level and in the study as a whole. The respondents could gain benefit by making their voice heard and share their experiences and thoughts. The risks were kept low as their participation was anonymous and they decided which questions to answer and how.

Only one person from each family was interviewed in order to minimize the risk for the woman to be beaten because of what was discussed at the interview (World Health Organization, 2001).

The impact of interpretation and the cultural setting

Culture and language can lead to misunderstandings. Interpretation introduces several threats to the validity and it is important that the researcher is aware of this. Questions and answers are repeatedly translated back and forth. The researcher may not be able to tell if the interpreter has modified the responses or not. By using a professional interpreter who has the proper linguistic abilities and is trained in the research field this risk can be minimized (Kapborg & Berterö, 2002). The first interpreter had no official training in translating but had profound experience in translating at diverse settings including at hospital environment. The second interpreter was authorized and had a doctor’s degree of medicine. Both interpreters had knowledge about both Egyptian culture and European culture and when needed they translated the cultural impact of the answers, as typical expressions or general knowledge among Egyptians.

As VAW is not something discussed openly in Egypt (Ellsberg & Heise, 2002), it should be treated as a sensitive subject and it is important to be humble, respectful and not pass any judgment. To get truthful information from the respondents they have to have confidence in both the researcher and the interpreter. A part of this is to show respect for their culture and religion and to dress appropriately (Trost, 2005). An example is to have clothes that are not noticed and covering the shoulders, arms and legs. As well as the respondents may want to make a good impression, avoid critiquing.
their own culture or tell things that they think the interviewer wants to hear, for foreigners to get a good impression of Egyptians and their culture.

RESULT

Four categories were found and seven subcategories. See table 2 for an overview. The experience of violence against women is individual and complex. The result shows some similarities but diverse opinions also exist. All respondents consider both emotional and physical violence to be common and needs to be handled better.

Table 2
An overview of the categories.

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
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<tbody>
<tr>
<td>Subordination and discrimination of women in care</td>
<td>Humiliation of nurses in care – women’s subordination</td>
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<td></td>
<td>Nurses exposed to violence</td>
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<tr>
<td>Hiding and ignoring violence in caring settings</td>
<td>Ignoring the woman’s need of help – it is her responsibility and pain</td>
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<td></td>
<td>Hiding the violence – to not speak about it</td>
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<tr>
<td></td>
<td>Nowhere to go – family the only support for women</td>
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<tr>
<td>Accepting violence in care and society</td>
<td>Traditions and gender roles – women are week and need to be protected</td>
</tr>
<tr>
<td></td>
<td>Violence is women’s fault – she should avoid provoking</td>
</tr>
<tr>
<td>Awareness decreases violence in healthcare and society</td>
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</tr>
</tbody>
</table>

Subordination and discrimination of women in care

Women were described to be discriminated very often in their daily life. Women are subject to all kinds of violence but humiliation was by far the most discussed issue among the respondents. The respondents explained that women were subordinated to men in all different settings including in healthcare.

Humiliation of nurses in care – women’s subordination

All respondents experienced that often women are not treated the way they should be treated. They described that women are frequently humiliated, emotionally hurt and that they are not getting their rights when working in healthcare. They described the humiliation as consisting of words, the way someone looks at her, limit her movements or restrict her decisions.

“Psychological it’s a state where someone constantly feels humiliated, constantly feels insecure because she can be subjected to this situation at any time.” (Interview 2)
The nurses experienced that the manager suppressed them and did not listen. One respondent described a situation when she saw hygienic issues that needed to be addressed. The boss told her to shut up and mind her own business. This made her feel powerless and undermined and that she could not do her best for the patients. The respondents also felt discriminated because they were obliged to work extra hours without being paid and could not complain as they needed the work and could not afford to lose it. One respondent described the problem when she was forced to work extra hours in surgery and got tired;

“If I complain I’m too tired to focus, they punish me to reduce the salary.” (Interview 1)

One respondent told about a husband that did not want his wife to work as a nurse so he came to her working place and started yelling at her and called her names. When the nurse responded him the husband started beating her in front of her colleagues and she was severely hurt.

“He knew before he get married that she was a nurse and she needs to work, he shouldn’t object to this.” (Interview 1)

**Nurses exposed to violence**

The respondents/nurses described they were feeling afraid of being physical abused at work. When they cared for a patient who had been abused they had to protect her from the abuser and that put them at risk. The respondents worried about this and did not like to be put in that kind of situations. Also relatives to non abused patients could behave violently towards the nurses. The respondents believed that one reason for this violence could be that the relatives felt afraid or wanted to protect the family member. This was said by one of the respondents describing a situation at work;

“He started screaming at me using bad words. This was a situation where I felt I was attacked.” (Interview 2)

**Hiding and ignoring violence in caring settings**

Although the respondents described that women are constantly discriminated most of the respondents showed no awareness about the woman’s need to speak about the issue. The respondents expressed an unwillingness to support the women through listening and interfering with her decisions.

The respondents explained that not all hospitals helped the abused woman with a medical report to the police. They said that most private hospitals only offered first aid to the abused women and then they were sent to a general hospital, where they accepted to do a police report.
Ignoring the woman’s need of help – it is her responsibility and pain

The respondents stated that it was up to the woman if she wanted to do something about her situation or not. They described that the doctors pressured the husband to not hit his wife and at the same time all respondents stated that they could not pressure the woman to do anything about it. They said it was up to the woman to make her own decisions without interfering; they did not want to get involved. The respondents did not think that they as healthcare workers or as friends could stress her to make a police report or that she would leave her husband.

“I can’t pressure her to destroy her family she has the freedom to choose whatever she likes.” (Interview 4)

The only thing the hospitals can do is to provide the women with the opportunity to make a police report. However, one respondent thought that the hospital should be able to report abuse directly to the police. Now the police will only do something if the woman herself makes a statement.

“If she accepts the humiliation there are nothing more we can do.” (Interview 2)

Hiding the violence – to not speak about it

The nurses described that they supported the woman by soothing her, tapping on her shoulder and giving her a piece of advice but they said nothing about talking about the violence. The respondents explained that women often do not even dare to speak about the violence. The reasons given for not speaking were several. One was that if the woman did, she risked her own and her family’s reputation. Another was that she would be afraid to be ill-treated or ostracized in the community. Not contradicting this fact a respondent also said that it could be good for her to confide into someone, but it has to be someone she already know, it should not be made public. Another respondent talked about girls who had been subjected to rape;

“The girls wouldn’t have the courage to say anything and they only speak about it if pregnancies happen or something. The result of that is often that the family killed the girl or they ill-treat them, it has drastic effects.” (Interview 3)

The respondents stated that women seeking healthcare rarely tell the truth, they reject questions or avoid answering. The respondents said that even though the women are offered that the doctor could make a police report, the majority of the women refused it and choose to be silent. The respondents agreed with the women’s silence without further questioning this behaviour.

Nowhere to go – family the only support for women

The respondents expressed a concern that women who want and need help had nowhere to go. The respondents said that many women do not have anyone to support them and they have to bear the situation by themselves. They said the woman often stays in the marriage because of the financial dependency and the social situation. The respondents explained that there is no support except her own family to help her to take care of
herself and the children. If the woman did not have any family to support her it made it hard on her. The respondents described that the healthcare did not offer any support to women who wanted help to get out of the abusing relationship. The respondents wished to change this and to help the women who wanted and needed it.

“I would like to provide them with a homely place, with a place where they can get helped to raise their children properly and to be protected. I prefer it to be a home, I prefer it to be their own home, which is not always possible.” (Interview 2)

Accepting violence in care and society
The respondents spoke of how violence was accepted in the society, by families and by individuals. Also in healthcare the use of violence as threats could be accepted. Respondents regarded the woman as the weaker part and the one carrying most responsibility in an abusive relationship. They said the women should learn how to behave to not provoke their husbands.

Traditions and gender roles – women are weak and need to be protected
The respondents spoke about the tradition as a problem causing violence; the tradition saying that girls should be provided for and taken care of. The respondents still agreed that it is the woman’s duty to take care of the children and the household, even if she also has a job.

“If the husband treats his wife well, she can attend to 80 % of the duties in the house. If he doesn’t treat her well he has to provide 80 % and she has to provide 20 %. If she is in a psychological good state she can provide a lot.” (Interview 3)

One respondent also thought that in the beginning of the marriage life most women are victims to domestic violence as she provokes her husband. The respondents said that it is natural to abuse women because she is the weaker part. They believed men are the stronger and the dominating person who has to protect the woman. They also thought that the general opinion in the society is that women should have a man to support her and protect her from the outside world.

“The weakness is either materialistic or psychological or physical. You have people that are weaker and people that are stronger. It’s a human reaction that people abuse in this situation.” (Interview 2)

The respondent said if she does not have a husband to protect her, her son or her brother will take this position. They said that a woman cannot manage herself in the society. The respondent also explained that doctors tried to protect the woman by using violence and that they were not aware of the fact that they did this. The doctors used to threaten and lie to the husband, in front of his wife, to make him tell the truth and feel afraid.

“...make him feel afraid like a little girl.../...he has to feel afraid first, he has to feel pressure by the community, he has to feel unsafe. So he can connect that bad action or abusing his wife with the pain, so it can affect him.” (Interview 4)
Violence is women’s fault – she should avoid provoking

The respondents described that the violence is considered in the society to be the woman’s fault. They should avoid provoking the husband and learn how to contain him, to not make him nervous or jealous. However, another respondent said that if the man is negative the woman does not have any responsibility for the violence.

“The community blame the man for hitting the woman. And put the blame on her for doing that kind of mistakes.” (Interview 4)

This attitude was also expressed by other respondents, that the woman is the one who should change her behaviour. The reputation of the woman will be harmed if the violence against her is made public. The respondents also explained that if the woman wanted a divorce she would be the one blamed for separating the family.

“A man is a man, and she should learn how to deal with him and how not to use this overconfidence to provoke him.” (Interview 2)

One respondent said that violence happens because women work too much and that she does not have time to take care of the children. The respondent blamed the woman for not having time to be a good mother and not have the time to teach her daughters how to deal with men and sons how to not be violent. The respondents explained that nurses could give this type of advice to a woman;

“...we tell her to shut up, so she is not exposed to further violence.” (Interview 2)

Awareness decreases violence in healthcare and society

The respondents believed that education for both men and women could improve equality and strengthen the women. The respondents considered violence against women to be a discrimination that limited the woman. They had a wish to change this and to do this they believed decisions should be made together by men and women. Firstly the basic education needed to be improved.

The respondents thought that better education was needed as an action to prevent violence and education should be obligatory. They explained that every child needs the discipline in school and to learn right from wrong. The respondents thought it was a good thing that education enables the woman to have a job and be financially independent.

“If the woman has no job, has no skills, has no good education she has no freedom to choose whatever she likes.” (Interview 4)

One respondent believed that through education you will be taught how to improve yourself, you will understand different point of views. They said that this would give you a greater understanding and respect for different opinions. One respondent explained that different opinions could cause violence if you did not try to reach a
solution that satisfied both. It was described that if the problem was discussed and a third alternative was chosen then you would have a successful life and a happy family. Another respondent however did not think many men had this view.

“We should carry each other.” (Interview 1)

The respondents also said that if women got education they would know their rights and this would improve the woman’s strength and ability to act properly. For example the nurses would feel strengthened and could claim their rights to a better working environment.

“Education plays a big role and the women would know much more about their rights and would be much, much stronger if they had a better education.” (Interview 3)

One respondent said that religion should be inserted in the education. The question about religion was answered and expressed with strong emotions from the respondents. They said that religion has nothing to do with violence. That religion shows respect for everybody and it tells you to be nice to other people. All respondents strongly believed that if religion would have any effect on violence it would have improved the situation.

“Good treatment for wife exactly like good worship, good prayer to God.” (Interview 4)

DISCUSSION

Method – limits and strengths
There are both limitations and strengths in this study, it had few respondents which is a limitation. Still little is known about this subject and further investigation is needed.

The design of this study could be used in a similar setting and get similar result as the findings is comparable with other existing research (World Health Organization, 2005a; 2005b; 2009a; 2009b; 2009c; Krug et al., 2002). All interviewed nurses were women and this could have influenced their view but the man in this study had similar views as the women.

The aim was to get five interviews but as neither a qualified interpreter nor nurses available were found during the short time of data collection the plan had to be rearranged. The selection of the participants was narrow and they were selected randomly. The selection of participants could be claimed to be a selection bias but as the aim was to get different views (Granheim & Lundman, 2008) on the issue it did not have any negative impact on the study.

The interview questions were semi structured and the interview could have been more open, less structured and with fewer questions to make the respondent lead the interview and the focus within the subject (Trost, 2005). However an interview guide with specific questions were appropriate because of my limited experience as an interviewer, and the interview guide should be adjusted to the interviewer (Trost, 2005). It is also important to note that the interviews and the questions were improved as the
process continued. As Trost (2005) says a study is a process and processes are defined by changes. Also questions about feelings were asked due to the cultural setting even though Trost (2005) did not recommend it.

In three out of four interviews an interpreter was used. There was a clear difference between these interviews. In the interview without an interpreter it was easier to follow the respondent’s thoughts and ask follow-up questions. With the interpreter the connection to the respondent was more difficult to establish (Trost, 2005). Using an interpreter threatens the validity of the information received by the interviews. The translations back and forth could include some misunderstandings due to language and cultural differences. This is often the case when the researcher does not have English as a native language (Kapborg & Berterö, 2002). Both interpreters used in this study had knowledge about European culture and experience of this kind of assignments which was an advantage. Although the effect the translations may have had on the answers cannot be ruled out (Kapborg & Berterö, 2002), the communication with the interpreter was good and the interpretation seemed adequate. Since the interviews were recorded the focus could be put on the conversation rather than writing and it also made the data easier to analyze (Trost, 2005). However, it would have been beneficial to have had another interpreter listen to the recordings. Unfortunately there was no opportunity to do this as this study had limited resources.

A lot of ethical considerations arouse during this process. Concerning the setting in which the interviews were held, none were held in a separate room where we could avoid being distracted or disturbed. This could make the data less valid (Trost, 2005). This could have influenced the answers or rather the unsaid answers. The respondents could have said something that someone overheard that put them in a difficult situation. Still the respondents seemed to speak their mind and expressed strong opinions without hesitation. World Health Organization (2001) has a lot of safety recommendations for research about VAW. But as this was a small study it was not possible or adequate to apply all recommendations.

My supervisor had a validating role throughout the analysis process, to increase the credibility (Lincoln & Guba, 1985). The analysis process followed the concrete substance in the text but was also abstracted and interpreted to make the result comprehensible and meaningful (Granheim & Lundman, 2008). In the result examples from the interviews were given so that the reader may be able to reflect upon the answers and the validity in the study (ibid.).

**Discussion of result**

The result in this study indicates that healthcare workers, even though they want to help, they do not know how, as remarked in a study by John Hopkins University (1999). The respondents wanted to do more for the women but they did not dare as the society including healthcare workers put the blame the woman and believed it was her own responsibility. Many women do not seek healthcare because they are afraid of how they will be treated (Becker et al., 2006; Belhadj et al. 2003). In this study the nurses told the women to shut up so she would not be exposed to more violence but according to other studies this reinforces the woman’s feeling of stigma and self blame and that should not
be done (Oudshoorn, 2005; Wiklund 2003; World Health Organization, 2005b). In a study it is stressed that “…victim blaming and normalization of violence is created in which women feel unable to report crimes of violence against them.” (p. 38, Thapar-Bjorkert & Morgan, 2009).

The results also indicated that abused women often do not want to report this or speak about it. The respondents described that it was up to the woman to decide what she wanted to do about the abuse. Nothing was said about discussing the matter with the woman so that they could try to ease her suffering (Wiklund, 2003). Instead of helping the woman with the suffering related to the abuse, that certainly affects her whole life-world, one can assume that they added more pain when the healthcare workers did not listen to her. This is an example of pain related to the care according to Wiklund (2003). However, this could be explained by the fact that women working in healthcare, the respondents, accepted violence themselves, therefore they felt helpless in the situation. The nurses saw themselves as the weaker gender where the man has the power. These power structures and discriminating cultural norms disallow women their rights and supports VAW (United Nations Secretary General, 2006).

In the result it is shown that doctors, who often are men in a position of power, misdirected and abased this power to act violently and threatening the abusing men. It seemed that the respondents thought this abuse was justified by the situation. However everybody, no matter of actions, should be treated with respect and dignity (International Council of Nurses, 2006; Socialstyrelsen, 2005; Wiklund, 2003). The respondents perceived that the doctors wanted the husband to feel like a little girl. Again, this brings up the gender order, were women is perceived as weak which allow men to have control over women (World Health Organization, 2009a). Healthcare workers have power and possibility to influence and help patients but they can also disabuse this power (Wiklund, 2003). Nurses have power by their professional knowledge and through their professional position in the healthcare system but are not always aware of it (Oudshoorn, 2005). The respondents thought the threatening had an effect that would minimize the violence in the short term, but did not seemed to consider about that it could increase the violence when the man gains to claim his superiority. According to Hearn (1998 cited in Miers, 2000) do men practice dominance through exaggerated masculinity as an effort to reject dependency and femininity.

When asked for how violence could be minimized the respondents said they wanted the man and the woman to help each other and make decisions together. These are one of the things World Health Organization (2009a) promotes. But even though the respondents wanted equality in this area nothing was mentioned about household tasks and that it should be divided equally. Gullvåg Holter (2004) claims unequal shared responsibilities at home is a cause to that VAW exists. Also suggested was that general and basic education would reduce violence and that women would feel empowered and that it would open up for a possibility to employment which World Health Organization (2005a) also presented. It is evidence for that less educated women are put in greater risk for being ill treated (ibid.). However it is also stated that in some societies educated women are put at greater risk because they challenge the traditional gender roles. Tradition could be a problem and women who act against the tradition are put at greater risk to be more abused (World Health Organization, 2009a) as mentioned in the result.
Also mentioned by the respondents was that children who witnessed violence will adventure their psychological health and there is a risk that the children will use violence themselves when they grow up which also is in line with the World Health Organization (2009b) study.

The respondents said that the responsibility to avoid violence is mostly the woman’s; she should not provoke her husband. And if she gets a divorce she will be blamed for separating the family. In a study it is explained that “violence is not the responsibility of women or the result of an individual pathology but a problem of the entire society, particularly the norms and attitudes that harbour prejudices relating to women victims of violence.” (p. 51, Thapar-Bjorkert & Morgan, 2009). Violence is an abuse against the human rights, healthcare workers should reassure the woman that it is not her responsibility and that violence is always wrong (World Health Organization, 2005b). Also mentioned was that women can be violent to women, however this was not expressed as significant as men’s violence against women. Although violence is always an abuse of human rights (World Health Organization, 2005a) the respondents may have thought that it was not as common. The woman needs to feel supported and that someone listen to her (Wiklund, 2003). The result presented that they did not want to interfere, they believed this to be a private matter (Belhajd, et al., 2003). But healthcare workers have a responsibility to teach and support patients to promote health and prevent illness and when needed encourage a changed way of life (Socialstyrelsen, 2005). Healthcare workers should invite the patient to speak about their life and feelings in general, as women and mothers; they feel disempowered when healthcare workers fail to listen or ignore their individual needs (Miers, 2000). The women need to feel supported and healthcare providers have an essential role in empowering the women. This can only be done in a caring relationship were a room for growth is established. The patient needs to feel worthy, seen and get affirmation to be able to express her desires, needs and problems (Wiklund, 2003). One explanation for the healthcare workers inaction could be that the respondents thought violence was a part of human nature. If it is human nature, can anything be done about it except avoiding the problem?

The women need to feel empowered to be able to make decisions that improve their feeling of well-being (Wiklund, 2003; World Health Organization, 2009c). Some practices in healthcare acts disempowering patients such as stigmatizing (Oudshoorn, 2005) that also were discussed in the result. Power and empowerment exists both in macro and micro level and it needs to be addressed to not perpetuate inequality. To make a change possible people need to reflect on their situation (Oudshoorn, 2005) also mentioned in the result.

One study researched the possibility to improve nurses’ attitudes towards intimate partner violence with an educational program (Agrawal, et al., 2003). Fifty-two nurses participated and the study showed that the nurses attitudes was changed after attending a 1-hour session for them who had previous education in the subject and after a 3-hour session if they had no previous education about intimate partner violence. However if the change in attitudes improved the caring for the women or not was not established in this study. The respondents lived with and accepted violence for themselves, how can
their attitudes be changed when they are internalized? As Rosén (2010) remarks, an effort to change central attitudes will meet great resistance within the individual.

Conclusion

This study identified and described a variety of ways relating to violence towards violence against women. These healthcare workers had a way of acting and perceive violence that ignored VAW. The result showed that women are subordinated and discriminated in Egypt and in the Egyptian healthcare. The care for the abused women was focused on first aid, and respondents expressed that it was the woman’s own decision and responsibility to further act and often it was ignored or not spoken about. Violence and threats was accepted in the society and individuals to handle conflicts and was used in the healthcare settings as well. The respondents expressed the need to and wish to decrease the violence, work for equality and the importance of education in society about violence and specific for women to gain more economic independence. The attitudes of healthcare workers need to be addressed and further investigation is necessary to prevent and eliminate violence. These attitudes exist within individuals but also in the society. It affects the care of patients and the attitudes and knowledge need to be improved. To achieve change the whole society and community must be involved. It would be interesting to look into how patients/abused women experience the care in an Arabic community, how attitudes can change in a community where violence is widely accepted, how nurses experience their situation at work and the abusers point of view.

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REFERENCES


APPENDIX 1

Examples of questions from the interview guide.

- How would you define violence against women? What do you think it is?
- Do you think of physical violence or do you think of something more?
- Can you tell me about your experiences of violence against women?
- Why do you think violence exists?

- What reasons can the woman give for the man hitting her?
- Would it be any circumstances that it is okay for the man to abuse his wife?
- When violence happens, who has the responsibility to that?
- Is it always possible to get a divorce?

- If you meet a woman in the hospital who has been abused, what do you do?
- What effect do you think the violence has on the woman’s health?
- What effect does this have on the family’s health?
- Do you think it is only up to the woman to report this to the police?

- What do you think have influenced your view of violence against women?
- How do you think society could limit violence against women?
- Could culture have any effect?
- Do you want to add anything I have not asked about?

Explaining questions:

- Can you tell me a little bit more about...?
- What happened? What did you do?
- How did you feel?
- Could you give me an example?
**TABLE 1**

Examples for the used analysis process in qualitative content analysis.

<table>
<thead>
<tr>
<th>Sentence unit</th>
<th>Condensed unit</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I start to work from 8 o’clock until 8 o’clock, they ask me for more work, if I complain that I am too tired to focus, in operation I need much concentration. They punish me to reduce the salary for 3-5 days.</td>
<td>If I complain I’m too tired to focus, they punish me to reduce the salary.</td>
<td>Punish nurses</td>
<td>Humiliation of nurses in care – women’s subordination</td>
<td>Subordination and discrimination of women in care</td>
</tr>
<tr>
<td>I can’t pressure the wife to make a report for her and go to the police station and to take the way of law. I can’t pressure her to destroy her family she has the freedom to choose whatever she likes.</td>
<td>I can’t pressure her to destroy her family she has the freedom to choose whatever she likes.</td>
<td>Cannot pressur e the woman</td>
<td>Ignoring the woman’s need of help – it is her responsibility and pain</td>
<td>Hiding and ignoring violence in caring settings</td>
</tr>
<tr>
<td>The problem is women work too much. Women left their duty at home and went to work so they don’t raise their children properly, they don’t give them enough advise, they don’t give them the proper image of the relationship.</td>
<td>Women left their duty at home and went to work so they don’t raise their children properly.</td>
<td>Women work too much</td>
<td>Traditions and gender roles – women are weak and need to be protected</td>
<td>Accepting violence in care and society</td>
</tr>
<tr>
<td>The girls say, they think because they work they are overconfident, and that they think I am a woman and I’m working and I’m even better than my husband, this is where the friction comes. A man is a man, and she should learn how to deal with him and how not to use this overconfidence to provoke him by this overconfidence.</td>
<td>A man is a man, and she should learn how to deal with him and how not to use this overconfidence to provoke him</td>
<td>Woman should not provoke</td>
<td>Violence is women’s fault – she should avoid provoking</td>
<td>Accepting violence in care and society</td>
</tr>
</tbody>
</table>