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Nurses' experiences of perceiving violence and abuse of women in Saudi Arabia: A phenomenological study

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Abstract

Aim: To explore the practices, understanding, and experiences of nurses and nursing students about domestic violence and abuse in Saudi Arabia.

Background: Domestic violence and abuse is a well-known public health issue and a clear violation of human rights resulting in detrimental effects on women's health.

Introduction: Societal and cultural barriers in Saudi Arabia limit women's rights and disclosure of violence within marriage and families, preventing access to health care and support. There are few reports of this phenomenon in Saudi Arabia.

Methods: We used a hermeneutic phenomenological approach to acquire in-depth insights into nurses' perceptions and experiences regarding domestic violence and abuse. Eighteen nurses and student nurses were recruited from Riyadh, Saudi Arabia, using convenience sampling. Data were gathered between October 2017 and February 2018 through in-depth semistructured interviews, organized using NVivo 12 and analyzed manually to identify consistent themes. This study adhered to the consolidated criteria for reporting qualitative research.

Findings: An overarching concept of "being disempowered" was identified, which was present at three levels: a lack of nurses' professional preparation, insufficient organizational structures and processes, and wider social and cultural components.

Conclusion: This study provides an in-depth account of nurses' practices, understanding, and experiences of domestic violence and abuse, highlighting the sensitivity and difficulties of addressing the problem in hospitals across Saudi Arabia and potentially other similar countries.

Implications: The study's findings will inform the development of nursing education and practice in Saudi Arabia, as well as pave the way toward formulating effective strategies with needed modifications in curriculum, organizations, policy, procedures, and laws.

KEYWORDS

domestic violence and abuse, gender, nursing, Saudi Arabia

INTRODUCTION

Domestic violence and abuse (DVA) is a complex public health issue and a primary cause of poor health among women worldwide (Huntley et al., 2019). DVA threatens social and economic development and must be directly addressed to accomplish the Sustainable Development Goals

(Yount et al., 2022). The UK Home Office (2018) defines DVA as "any incident or series of incidents of control, coercion, threatening behavior, violence, or abuse between individuals aged 16 or older who are or have been intimate partners or family members, regardless of gender or sexual orientation. This abuse encompasses, but is not limited to, psychological, physical, sexual, financial, or emotional forms of abuse."

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DVA and intimate partner violence (IPV) are the most frequent forms of gender-based violence, affecting individuals, families, and communities across ethnicities, cultures, and socioeconomic groups (Akbari et al., 2021).

One-third of women globally are abused by their spouses (Muluneh et al., 2020), and 30% of women over 15 have experienced gender-based violence. One multicountry survey reported IPV prevalence rates ranging from 15% in high-income countries (e.g., Japan) to 71% in less developed areas (e.g., Ethiopia) (Muluneh et al., 2020). DVA victims suffer dread, bodily injury, psychological pain, suicidal ideation, and even death (Benebo et al., 2018; Hegarty et al., 2020; Muluneh et al., 2020).

DVA is not yet a policy issue in Arab countries, despite its catastrophic consequences and widespread prevalence. Culture and society shape violence against women. Despite recent improvements to women's position in Arab regions (i.e., equal gender representation in basic and secondary school and higher enrolment of women in higher education), Arab women continue to suffer impediments to social, economic, and political equality. All 14 Arab countries rank in the bottom 28 of 144 countries in gender inequalities in health, education, political empowerment, and economic involvement (Elghosain et al., 2019). In many cases, inherited patriarchal social norms, which are developed, changed, and enforced by individuals in light of their traditions, religion, and culture, permit and even promote DVA against women (Mojahed et al., 2022).

Islam is the predominant religion in Saudi Arabia (SA), and its teachings give Muslim women equal rights to men and provide a comprehensive code of conduct for both genders, emphasizing the elimination of inhumanity, inequality, violence, and prejudice against women (Patoari, 2019). However, the self-interpretation of religious teachings has led to widespread acceptance of violence against women in SA. DVA is complex and multifaceted. A systematic review of studies in Arab countries found risk factors for IPV against women at the individual (victims or perpetrators), family (marriage and conflict), community (extended family and marriage), and society (cultural setting, affected by political and religious backgrounds) levels (Mojahed et al., 2022).

In SA, limited evidence of DVA exists. A cross-sectional survey of 1883 married women in 18 primary health care centers and 13 private institutions in Riyadh found a lifetime prevalence of 43% for any type of violence, with controlling behavior (36.8%) being the most common (Alquaiz et al., 2021). Abolfotouh and Almuneef studied 400 married women aged 19 to 65 in Riyadh attending outpatient clinics and found a 44.8% lifetime incidence of DVA, including physical abuse (18.5%), emotional abuse (25.5%), sexual abuse (19.2%), and financial abuse (25.3%) (Abolfotouh & Almuneef, 2020).

DVA statistics are considered the tip of a potential iceberg because victims are reluctant to disclose their experience owing to stigma, humiliation, economic constraints, lack of understanding of available resources, fear of retaliation, and absence of laws (Muluneh et al., 2020). Moreover, IPV victims also have trouble accessing health care, have low hopes of receiving help, and believe that abuse symptoms are rarely

taken seriously (Alhalal, 2020). As nurses spend the most time with frontline patients, they are ideally suited to identify abuse victims and be their first point of contact (Machado et al., 2020). Healthcare settings might allow victims to confide in a trusted person, and, as patient advocates, nurses should be educated to identify and assist DVA survivors (Stewart et al., 2021).

However, research suggests that nurses struggle to respond to DVA. An integrative review by Alshammari et al. (2018) demonstrated that nurses did not receive sufficient training in their preservice or ongoing education to recognize, identify, or treat DVA (Alshammari et al., 2018). Clearly, DVA is a key social issue, and insufficient evidence exists from SA regarding nurses' role in addressing it.

Aim

This study aimed to explore the practices, understanding, and experiences of nurses and student nurses around DVA in SA.

METHOD

Research design

This was a qualitative study using a hermeneutic phenomenological methodology (Van Manen, 2016). We used a Heideggerian approach (Heidegger, 1962) to gather Saudi nurses' and student nurses' experiences related to DVA. The philosophical underpinnings of phenomenology as articulated by Van Manen include both a descriptive and an interpretive or hermeneutic approach to the lived experience of phenomena by humans. According to Van Manen, phenomenology pertains to the manner in which individuals position themselves in relation to their lived experiences, while hermeneutics refers to the manner in which individuals interpret the "texts" of their lives. Semiotics, on the other hand, is utilized to formulate a pragmatic approach to writing or language based on the methods of phenomenology and hermeneutics (Santiago et al., 2020; Van Manen, 2017).

Heideggerian hermeneutic phenomenology has been applied extensively in health research and was considered appropriate for this study because we sought to develop a deep interpretive understanding of DVA (Regan, 2012). The phenomenological approach was utilized in conducting interviews with nurses with the aim of delving into their lived experiences and providing them with the opportunity to share their personal narratives.

Study setting

The study was conducted at two sites in Riyadh, SA. Site A was an academic institution, selected to recruit local (Saudi national) nurses undertaking a bridging course (qualified nurses with a diploma, upgrading to a degree) and preservice student nurses (BSN students); it was the first university-level



College of Nursing, established in 1976 by the Ministry of Higher Education, that offered a nationally and internationally accredited BSN (Tumulty, 2001). Site B was a large Ministry of Health tertiary hospital selected for recruitment of qualified local nurses; with 1200 beds, it serves around 30,000 inpatients and 500,000 outpatients annually.

These sites were chosen not only for the access they provided to different groups of nurses but also for pragmatic reasons to allow the researcher to complete recruitment within the Doctorate study timeline. The researcher had been employed as an academic staff at site A and received her higher and advanced-level training and education at site B, which exposed her to the environment there. Hence, she was familiar with the context and had links to staff who could act as gatekeepers.

Study participants and sampling strategy

Two types of local nurses were included in the convenience sampling (Moser & Korstjens, 2018). The first group comprised registered nurses with 2.5 to 14 years of experience who were recruited because they practiced in an evolving healthcare system. Their participation was likely to provide needed knowledge of phenomena, and broadening the study samples by including qualified nurses would increase the richness and diversity of the dataset. The second group comprised final-year BSN students who were immersed in their core clinical practices and theory, and exposed to training in clinical settings. These participants were potentially knowledgeable about a certain phenomenon of DVA and could enrich the data. Due to SA's gender-segregated education system, the study exclusively included women and Saudi nurses to comprehend their cultural, historical, and social context.

Recruitment and sample size

For recruitment, details were pinned on bulletin boards at both sites to inform potential participants about the study. The researcher also presented the project at the end of lectures at site A and involved the hospital director, nurse manager, and heads of the nursing department at site B to facilitate recruitment. A total of 40 nurses and students were invited, of which 18 agreed to participate. Interested participants provided their details and were called within 24 hours to schedule an interview. The sample size was deemed appropriate (Crouch & McKenzie, 2006), as phenomenological research frequently uses a small sample to create voluminous and rich data (Greatrex-White, 2007; Tanyi et al., 2006; Van Manen, 1997).

Data collection

Data were collected from October 2017 to February 2018 using in-depth semistructured interviews lasting 30 minutes

to 2 hours. The questions in the interview guide were intentionally broad and open-ended to allow each nurse to have sufficient opportunity to extensively express their viewpoint. The questions centered on (i) how participants characterized domestic violence and abuse, (ii) what they felt about nurses' role, (iii) their views on the education they had received, and (iv) their experiences of, and responses to, DVA in clinical practice.

The interviews were conducted in a private room at each site for confidentiality. The interviews were conducted in the local language of the participants (Arabic) and then translated into English during analysis (see below). The researcher used a diary to document critical reflections from the interviews.

Data analysis

The recorded interview data were transcribed, translated, and organized using NVivo 12. The researcher listened to each interview multiple times and translated the Arabic transcripts into English. Expert assistance was sought for quality control and accuracy, with parts of the transcript reviewed by a bilingual academic expert. The English translations were compared and corrected to ensure accuracy. Some local concepts were retained in Arabic and explained in the text to accurately reflect the participants' perspectives.

The data analysis used a holistic thematic method based on line-by-line transcriptions to discover and interpret text meanings (Van Manen, 1997). Using a manual (paper-based) approach, meaning units were defined as a part of a sentence or paragraph of any length that presented a distinct item denoting a meaning or theme (Greatrex-White, 2007; Tindall, 2009; Van Manen, 1997). The work was then transferred from pen and paper to NVivo 12 for organizing and viewing. The meaning units and nascent themes were clustered by conceptual similarity and given descriptive labels. Using the identified themes, a structured classification of conceptual similarities was generated.

Iterative processes were used to modify and refine the emergent structure, develop new insights, and elicit new relationships and patterns among the nurses' views. A final schema containing numerous superordinate themes and sub-themes was developed. Direct quotes from the respondents were used to understand the meaning units in context. Common patterns and concepts across different verbatim quotes were explored. The completion of the process was followed by the write-up of a narrative for each theme.

Rigor

COREQ guidelines were used for reporting (Dossett et al., 2021). A team-based approach to interview guide development and data analysis ensured that any assumptions and interpretations were addressed, questioned, and agreed upon (Lincoln & Guba, 1985). By engaging in self-reflection, researchers can acknowledge any potential biases and

TABLE 1 Characteristics of the participants (N = 18).

Participant	Age	Years of experience	Educational status	Marital status
P1	28	4	Bridging-nurse	Married
P2	32	8	Bridging-nurse	Married
P3	22	None	Regular student	Single
P4	33	9	Bridging-nurse	Married
P5	28	5	Bridging-nurse	Married
P6	36	11	Staff nurse	Married
P7	25	2.5	Staff nurse	Single
P8	29	6	Bridging-nurse	Married
P9	38	14	Staff nurse	Married
P10	33	10	Staff nurse	Married
P11	21	11	Regular student	Single
P12	37	14	Staff nurse	Married
P13	25	2.5	Staff nurse	Single
P14	37	12	Staff nurse	Divorced
P15	22	None	Regular student	Married
P16	31	8	Bridging-nurse	Single
P17	33	10	Bridging-nurse	Divorced
P18	34	11	Bridging-nurse	Single

assumptions they may hold, thereby enhancing their ability to make informed interpretations of the data they have collected, and adding depth and meaning to their findings.

Ethical considerations

Ethical approval for the study was granted by the University of Nottingham (Faculty of Medicine and Health Sciences Research Ethics Committee reference number: 114-1709) and the ethical and organizational approval bodies of sites A and B. Written consent and recording permission were obtained prior to interviews.

RESULTS

The participants’ characteristics are listed in Table 1.

The study found DVA to be multifaceted and complex in nature—strongly shaped by culture, social norms, and religious interpretations. Furthermore, DVA was not an isolated event but an interplay of factors that operate at the individual, organizational, community, and public-policy levels.

The analysis developed an overarching concept of “being disempowered,” as well as three associated themes: (i) being unequipped, (ii) being silent, and (iii) being constrained by social contextual forces (Figure 1).

The study suggests that Saudi nurses need culturally aligned training to address DVA. Collaboration with national programs (e.g., the National Family Safety Program) could help prevent DVA and support healthcare practitioners and women (Alquaiz et al., 2021). Specialist nurses trained in assessment, screening, and treatment could also help address DVA as a national issue in SA.

Being disempowered

The overarching concept that emerged from the study was the disempowerment of nurses, which restricted them from having power, authority, or influence over DVA, despite their readiness to help abused women. The concept of disempowerment has several reinforcing components. Physical and structural components include a lack of systems or processes for reporting abuse within an organization, whereas more intangible contributors include a culture of silence that prevents or discourages nurses from voicing concerns. Placing nurses in a working environment such as a hospital with certain limitations to their professional authority creates for them a lack of abilities, competency, skills, and attitudes to help such patients. This study also identified barriers to empowering nurses, which were conceptualized as themes and subthemes that can be addressed by facilitators and other empowered nurses (i.e., elements that described the nurses’



FIGURE 1 Major themes and subthemes.



experiences and understanding of DVA and contributed to disempowerment).

Theme 1: Being unequipped

The study found that nurses felt unequipped to address DVA and were unaware of its features due to a lack of education and training. In addition, they lacked clarity about policies and referral systems, leading to feelings of powerlessness, uncertainty, and being left out, as exemplified by the following quote:

“We have never been provided any education or training about DVA. How to approach patient and ask her about her situation? We need this exactly in our curriculum and we need to be exposed and trained in the bachelor’s degree somehow!” (P16)

“Honestly, I don’t know because I am not well-equipped. I personally feel scared and unconfident to deal with these cases... and I have no clue how to start with her and ask her about abuse.” (P12)

The lack of awareness about DVA among victims often resulted in frustration and unmet expectations among participants, leading to powerlessness:

“She (abused woman) did not know if she was abused or not ...The level of awareness is almost zero among abused women. When I asked her about it, she didn’t think being abused was wrong, and she considered it normal... this stopped me from intervening.” (P3)

The participants believed that, as nurses are frontline workers, a lack of awareness can prevent violence from being identified and reported:

“I feel I am not skilled enough to deal with abused cases. {laughs} I’m not confident enough... I don’t have the basic knowledge to identify or report such cases. It usually requires clinical experience and understanding to know if women are oppressed or not.” (P3)

The nurses indicated that their insufficient knowledge of policies and procedures created uncertainty in providing effective care. They suggested the development of a policy to guide their work to improve their ability to provide sufficient care:

“There is nothing clear for us as nurses related to this issue! there aren’t any policies or services I know that can facilitate our job...” (P2)

“At the hospital, nobody in the orientation days gave me information about these cases. I mean for me, if I didn’t pass this situation, I would not know that there is a policy at the hospital ...technically... I was alone.” (P13)

Thus, the nurses were not properly equipped with knowledge of DVA or other relevant policies, and they had to figure them out on their own. It appeared that the nurses were not aware of whether these hospital policies even existed, indicating a lack of communication or proper training on DVA. These knowledge and support gaps resulted in the nurses feeling alone in their efforts to navigate these policies, and the lack of DVA education and training made domestic violence difficult to address.

Theme 2: Being silent

The study also uncovered a culture of silence whereby women and nurses remained silent because they were unwilling to intervene, which sometimes escalated and contributed to a culture of silence:

“Personally I try my best to do my job, but lack of knowledge and absence of support and policies leave me feeling powerless, and I often find myself staying silent in such situations. my patients usually are not willing to tell you too for their own reasons. I know being silent is not right, and I wish I could make a difference but my ability to effect change is constrained.” (P6)

Another instance that facilitated the culture of silence among nurses:

“She suffered from bleeding and, after her examination, she informed the doctor. A report was written about the situation, and then her father came to support her, but she gave up her right and solved the problem peacefully and [respondent laughs] I felt angry—! How could she just let go of all the abuse? Anyway, I wouldn’t help her again.” (P7)

The nurses reported that they lacked any legal authority to make DVA decisions and therefore felt unable to act. Thus, they remained silent because they felt it was not their duty to help abused women. The study found that when nurses were not assigned to report violence as part of their routine and clear policies, they were inclined to be silent even if they witnessed cases of DVA:

“We do not report DVA. We do not have the power and authority and it is not included in our job descriptions. The hospital policy restrains



nurses to do anything when encountering DVA cases... Hospital enforces us that it is not your business.” (P1)

Another participant stated that physicians were the ultimate authority, and the main role of nurses was documentation, according to hospital policy:

“In my hospital, we don’t have authority in DVA cases.... the doctor writes a case report, not nurses ...Do you know what happened that day? I reached out to a consultant doctor for help, but she said: ‘don’t interfere, it’s not YOUR business’. Nurses just assess patients and write nurse notes, not reports.”(P4)

The participants debated reporting DVA but acknowledged it was challenging because victims often have complex circumstances and manifestations and may be unwilling to completely disclose information. Families and abusers often intimidate women to hide injuries. Hence, the nurses faced ethical and reporting difficulties when policy and procedures suppressed them:

“In many cases, the effects of abuse are obvious in the form of bruises and marks and we felt that victims are reluctant to talk about it... I feel, women are scared of consequences of raising their voices... because they have to go to the same spouse and house.” (P8)

Participants also had the same concern regarding the lack of clarity about the further consequences of reporting a case that might disempower nurses and exacerbate the lack of reporting. The ability to report requires more clarity on the process of reporting and its consequences, which could decrease resistance among nurses:

“I cannot just report a case and neglect what will happen to her later! Where can she go? What will happen to her after that? Will she be in a safe place? And her kids, what will happen to them? If I encourage her to report abuse against her husband then what?! I should know as a nurse what the process is and whether anything dangerous will happen as a result. I must know this and at the same time, I must be a qualified person to talk about this kind of thing and protect this woman. Therefore, we have to improve and find the best referral system between services in the hospital and outside of the hospital to ensure the patient is safe. We can engage in this issue without feeling guilty.” (P13)

The participants also assessed the potential personal costs and benefits of reporting DVA, including their job security, where they feared losing their jobs upon disclosing DVA to

the hospital or local authorities owing to unclear reporting processes:

“I tried to help an abused WOMAN. She was scared and anxious. I cared for her and two days passed. Something then happened that shocked me ... uh... staff from Patient Affairs and nursing administration department called me...and said that someone and his wife complained about me! God! This affected my promotion and position ... Now I don’t want to help anyone {sad} I’ve had enough. I have to protect myself first as hospital will not protect me.” (P6)

The nurses also stressed the necessity for a comprehensive in/out hospital policy to guide nursing responses:

“We need laws and regulations from many authorities, such as hospital policy and regulation, the police, health organizations, family organizations, and counselling, ... I mean, there should be a high-level umbrella to protect those cases. Clear regulations for nurses in hospital on how to identify/deal with and investigate those cases, ..., I mean we really need updatable regulations to fit the requirements....” (P17)

Being silent manifested in different ways among nurses and included being unauthorized to report DVA (i.e., escalation processes not included in the job description) and feeling conflicted and unsafe. The participants displayed an apparent lack of empowerment when faced with cases of DVA. It is important to note that many of the nurses in the study were female nurses from SA, where being silent as a woman is deeply embedded in the prevailing culture.

Theme 3: Being constrained by social contextual forces

This theme refers to how social norms restricted nurses and/or victims from dealing with DVA, such as the normalization and acceptance of DVA, the stigmatization of battered women, and the guardianship position vs. law. The participants expressed concern that women may think abusive behavior is normal. On the other hand, some families were supportive in countering mistreatment. Family attitudes and behavior toward female victims affected DVA reporting experiences:

“I worked at the antenatal clinic and saw an abused woman. The victim chose not to mention this {abuse} since she believed it to be a common practice among couples. While some women urge you not to tell about it to anyone because they are afraid that they won’t

get legal protection or any support from their family.” (P1)

Stigmatization, or the undermining, labeling, and rejecting of victimized women, especially those who admit abuse, was prominent and connected with community stereotypes and categorizations of certain people and behaviors. A socially rejected abused woman may hide DVA, leaving nurses helpless:

“Divorced women are looked down upon in our culture... Men will always be respected... Women, on the other hand, will suffer from everything in their lives... if women are abused by their spouses and if they decide to raise voice, they cannot just leave their spouse and family; otherwise, the community will speak negatively about her and blame her for her actions that lead to violence. This attitude can also be noticed among nurses from older generation, as they might accept violence.” (P1)

The participants felt sorrow for victims but believed that they could not help unless the victims helped themselves. Some faulted women for not fighting for their rights:

“I feel sad for her, but I blame her because she didn't stop this violence, unless her circumstances are difficult. Anyone can think and find a solution for their problem.” (P6)

Nurses frequently expressed anger and frustration, and they blamed women for accepting abuse. If, however, women lacked support or remained in abusive relationships due to their children, nurses felt discouraged to assist them.

This finding highlights contextual factors that may impede victims from disclosing DVA, increasing their susceptibility. SA culture was shown to accept DVA as normal and acceptable for women:

“I believe that strong connection with our culture and tradition facilitates violence. Our community look at the woman as the one who should obey, so, in this case, even if you were humiliated, you need to tolerate it and be patient and not speak about it, and the abuser is pretty sure that he has the right to do whatever he wants.” (P5)

Most of the participants cited how families, and communities, can contribute to the justification and normalization of DVA. The participants noted that cultural and societal norms often prioritize men over women, leading to a lack of support and protection. Additionally, the associated stigma prevents victims from seeking help, making it difficult for nurses to provide care. The nurses' experiences showed that personal and professional beliefs were intertwined, and that navigating

these conflicting elements required a deeper understanding of how DVA can be addressed. The study raises the question of whether nurses alone can adequately address DVA.

DISCUSSION

Overall, this study found that nurses in SA perceived themselves to be disempowered in relation to DVA, which created barriers to taking action at three different levels: nurses' professional preparation, organizational structures and processes, and wider social and cultural components.

Our findings suggest that nurses need to feel empowered to influence patients, doctors, other healthcare workers, and each other, which, in turn, depends upon their competency, the healthcare organizational structure, and the social status of nurses. Research shows that empowered nurses provide better-quality care and support to victims of DVA (McGarry & Nairn, 2015). Conversely, disempowered nurses are more prone to burnout and depersonalization (Suprpto et al., 2021), and their patients suffer from the vacuum that develops in the support network.

The nurses in this study associated their sense of disempowerment with a lack of knowledge, training, skills, and experience related to DVA. They believed that SA nurses are not well trained. Therefore, they recommended education and training for caring for DVA victims (Wyatt et al., 2019).

Sociocultural and religious factors also impeded the nurses' ability to care for DVA victims. Even when nurses were well-trained and educated, abuse victims frequently did not disclose their painful experiences due to perceived victim-blaming, the normalization of domestic violence, a lack of a structured process to support victims, a lack of family support, and an inability to sustain an independent life. Such instances forced nurses to respect the victim's desire to withhold information.

The nurses also reported a lack of supportive institutions, an absence of disclosure policies, and insufficient awareness of DVA as practical hurdles. Due to a lack of mechanisms for supporting victims following disclosure and the risk to the nurses' own safety, the nurses felt conflicted about reporting violence. These findings were consistent with those of other studies. For example, Ahrens (2006) found that rape victims remained silent because they anticipated negative reactions from health professionals, close friends, and family, leading to self-guilt, as well as ambiguity and self-doubt about whether what they experienced was rape. DVA survivors are often unaware of their rights and view DVA as normal (Githui et al., 2018). Furthermore, our findings showed that nurses also stayed quiet because they worried about their personal safety, job security, and repercussions as a result of taking action.

The nurses cited SA culture and societal traditions as significant hindrances to their empowerment. These cultural norms functioned within the religious sphere through specific misinterpretations and misuses of religious teachings and ignorance to direct and justify destructive actions (Mobaraki & Soderfeldt, 2010). Patriarchal gender norms and values

perpetuate women's poor social standing and encourage men's violence toward women (Saeed, 2017). The nurses also noted that husbands' influence in women's decision-making was sometimes a cause of fear during health care visits. These findings show how culture, society, and policies affect DVA cases daily.

Strengths and limitations

The study's main strength is its novel exploration of nurses' experiences and understanding of DVA in SA. The study's findings may also be useful in understanding DVA for Muslim communities and nurses in Muslim societies.

One limitation of the study was that it only explored the perspectives of nurses and did not include other women or health experts who may have provided a more nuanced perspective.

CONCLUSION

Worldwide, DVA is a major issue and affects people of all races, ethnicities, and ages. This study shows that nurses in SA are potentially well situated to support an effort to take action against DVA but require training and support at multiple levels.

Future research

Future research should investigate the role and perspectives of other stakeholders, survivors, and perpetrators, and general male views surrounding DVA in SA. There is also a need to design and implement intervention studies to reduce DVA, including designing new programs, adapting existing ones to local contexts, and evaluating their impact.

Implications

- This research highlights the pressing need for education and training programs for undergraduate nurses, including the integration of interprofessional education into their curriculum.
- The SA Nursing and Midwifery Council should incorporate DVA training into their preregistration program.
- Policies should be developed and revised to support health-care providers in treating abused women through in-hospital service training, confidential policies/guidelines, transparent reporting, and an independent reporting system.
- The study's results also indicate that the Saudi government should educate and empower citizens, especially nurses, to feel comfortable discussing DVA by aggressively raising awareness and involving societal stakeholders in women's issues and socioeconomic develop-

ment. These proposals, with appropriate cultural and religious sensitivity, could help SA protect its women and people.

AUTHOR CONTRIBUTIONS

Study design: KF, CE, JM; data collection: KF; data analysis: KF, CE, JM; study supervision: CE, JM; manuscript writing: KF; critical revisions for important intellectual content: KF, CE, JM.

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No conflict of interest has been declared by the authors.

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ETHICS STATEMENT

The University of Nottingham's Research Ethics Committee (reference number: 114-1709) approved the study in terms of its ethical considerations, alongside the ethical and organizational approval bodies of sites A and B. Prior to conducting interviews, written consent and permission to record were obtained.

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