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Competence and Preparedness of Professional Nurses in Managing Gender-Based Violence: A South African Qualitative Study

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ABSTRACT

Background: Gender-based violence (GBV) is a significant public health crisis in South Africa. Nurses in health clinics at higher education institutions (HEIs) are often first responders for survivors. However, their preparedness to manage GBV cases remains unclear, and nursing curricula may not adequately equip them for this role. ***Purpose*:** To investigate the preparedness of professional nurses at HEI health clinics in managing GBV and to identify related educational gaps for undergraduate nursing curriculum enhancement. ***Methods*:** A qualitative, descriptive case study was conducted at two HEIs in Cape Town, South Africa, between January and February 2025. Purposive sampling was used to recruit five professional nurses. Data was collected through semi-structured online interviews and analyzed using thematic analysis. The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines. ***Results*:** Key findings revealed significant gaps in formal education, with nurses relying heavily on informal, on-the-job learning to develop competence in GBV management. Three themes emerged: (1) Educational and Systemic Barriers to GBV Competence; (2) Development of Competence through Experiential Learning; and (3) Skills and Ethical Foundations in Managing GBV and OBV. Barriers included a lack of structured GBV content in nursing curricula, leading to inconsistent care. Core competencies, such as empathy and communication, were developed experientially. Stigma and challenges with survivor disclosure further complicated case management. ***Conclusion*:** The findings suggest that the professional nurses interviewed in this study feel underprepared to manage GBV due to deficiencies in their formal nursing education. An apparent disparity exists between the practical demands of their role and the training that they receive, highlighting the need for urgent curriculum reform. ***Implications for Nursing*:** There is an imperative need to integrate dedicated, practical GBV modules into undergraduate nursing curricula. Continuous professional development and standardized institutional protocols are essential to enhancing the competence and confidence of practicing nurses in providing effective, survivor-centered care.

Keywords: Gender-based violence, Nursing education, Professional competence, Preparedness, Qualitative research, South Africa.

What does this paper add?

1. This paper adds context-specific evidence on the preparedness of professional nurses working in higher education institution health clinics in South Africa to manage gender-based violence cases.
2. While previous studies have examined nurses'

responses to gender-based violence in broader primary healthcare settings, this study focuses on campus health clinics, where nurses may be among the first professionals to encounter students or staff who disclose abuse.

Introduction

Gender-based violence (GBV) is a global human right violation and a significant public health crisis that transcends all societal boundaries (United Nations, 2020). The World Health Organization (WHO) estimates that approximately one in three women worldwide will experience physical or sexual violence in her lifetime, with profound consequences for their physical, mental, and social well-being (WHO, 2022). In South Africa, the rates of GBV are alarmingly high, with statistics indicating that over a half of all women have experienced some form of violence (Statistics South Africa, 2024). Higher education institutions (HEIs) are not immune to this societal scourge, often reflecting and perpetuating the broader community's challenges within their own environments (Department of Higher Education and Training, 2019).

Understanding GBV requires examining the deep-seated sociocultural norms that shape societal behavior. In South Africa, as in many global contexts, patriarchal structures and traditional cultural beliefs significantly influence gender dynamics. Naicker (2025) highlighted that the intersection of culture and religion often forms the foundation of societal structures that enable and perpetuate GBV, normalizing male dominance and female subjugation. This cultural backdrop creates an environment where violence is sometimes justified or silenced, making disclosure incredibly difficult for survivors. These sociocultural challenges are not unique to South Africa; for instance, Alsawalqa (2021) noted in the context of Jordan that gender stereotypes and patriarchal dominance are primary drivers of domestic abuse, illustrating the global nature of these entrenched social constructs.

Professional nurses, particularly those working in campus health clinics within HEIs, are frequently the first and sometimes only point of contact for survivors of GBV (Oparinde & Matsha, 2021). Their role is critical in identifying signs of abuse, providing immediate care, offering psychosocial support, and facilitating appropriate referrals. However, the effectiveness of their response depends on their knowledge, skills, and preparedness. Research suggests that many nurses feel ill-equipped to manage GBV cases, often citing a lack of formal training and education in their undergraduate and postgraduate studies (Alshammari et al., 2018; Sepeng et al., 2022a). While studies have explored nurses' preparedness in primary healthcare settings (Sepeng et al., 2022a; Oparinde & Matsha, 2021), there remains a significant gap in the literature regarding nurses' preparedness, specifically within HEI health clinic contexts. HEI clinics serve a distinct population of students and staff who may present with unique vulnerabilities and disclosure patterns compared to the public. The specific competencies required within this setting, and whether nurses in HEI clinics are adequately trained to address them, remain insufficiently explored.

Despite the WHO (2019) calling for all healthcare providers to receive focused training on survivor care, a significant gap persists in South African nursing curricula regarding GBV management. This deficit limits nurses' ability to provide competent, confident, and empathetic care, potentially leading to missed opportunities for intervention and support. For this study, the aim was to investigate the readiness of professional nurses with direct clinical experience in GBV case management at higher education institution health clinics to manage GBV and to identify related educational gaps for undergraduate nursing curriculum enhancement. These nurses are considered experienced by virtue of their active practice in GBV-related case management within HEI settings, regardless of years of service.

Throughout this manuscript, the term "GBV" is used consistently to refer to gender-based violence, which encompasses physical, sexual, psychological, and economic abuse perpetrated based on gender. While related terms, such as "violence against women" and "domestic abuse", appear in cited literature, this study adopts GBV as the primary and standardized term in alignment with South African policy frameworks (Department of Higher Education and Training, 2019).

Background Including Literature

GBV encompasses a range of harmful acts perpetrated against individuals based on their gender, including physical, sexual, psychological, and economic abuse (Aubert & Flecha, 2021). The health consequences for survivors are severe and long-lasting, including bodily

injuries, chronic pain, mental health disorders, such as depression and anxiety, and an increased risk of sexually transmitted infections (United Nations Women, 2022). In South Africa, the high prevalence of GBV is exacerbated by socio-cultural norms, economic inequality, and systemic barriers. The concept of Ubuntu interconnectedness is a core African value, yet it is often overshadowed by patriarchal interpretations of culture that demand female submission and silence survivors (Naicker, 2025). Consequently, survivors face immense stigma, impeding their access to justice and healthcare (Mathews & Abrahams, 2020).

Nurses are uniquely positioned within the healthcare system to address GBV. Their role extends beyond treating physical injuries to include providing emotional support, conducting sensitive screenings, documenting evidence for legal purposes, and connecting survivors with a network of support services, including social workers, psychologists, and legal aid (Klazinga et al., 2020). However, fulfilling this role effectively requires specialized competencies that are often not included in standard nursing education. Studies from various contexts have highlighted a global deficit in nursing curricula concerning domestic abuse and violence against women (Alshammari et al., 2018; Clark et al., 2020). Alshammari et al. (2018) conducted a systematic review. They found that undergraduate nursing programs consistently failed to provide adequate content on GBV, while Clark et al. (2020) demonstrated that even nurses in large healthcare systems lacked confidence in screening for intimate partner violence. These findings, drawn from the UK and the United States, respectively, suggest a pattern of systemic educational neglect that is not confined to low-resource settings.

In South Africa, the Bachelor of Nursing program, regulated by the South African Nursing Council (SANC), has been critiqued for its limited focus on the social determinants of health, including GBV (Sepeng et al., 2022b). While modules on social sciences exist, they often lack the depth and practical application needed to prepare nurses for the complexities of GBV management. Sepeng et al. (2022a) argued that nurses require specific skills in forensic evidence collection, survivor-centered communication, and navigating the criminal justice system competencies that are largely absent from current curricula.

Empirical studies on nurses' preparedness confirm these educational gaps. Research in Nigeria found that many nurses lacked adequate knowledge for forensic evidence collection (Okafor et al., 2019), while a UK-based study revealed that undergraduate nurses lacked confidence in handling GBV cases due to limited training and poor communication skills (Alshammari et al., 2018). In contrast, studies from Australia and Mexico showed that integrating comprehensive GBV training into nursing curricula, including scenario-based learning and simulations, significantly improves nurses' confidence and competence (Crombie et al., 2017; Jiménez-Rodríguez et al., 2021). Taken together, these findings illustrate a critical and recurring pattern: where structured GBV education is absent, nurses rely on informal experience, resulting in inconsistent and potentially suboptimal care. This body of evidence underscores a critical disconnect between the expectations placed on professional nurses and the educational foundation that they receive. This study seeks to explore this disconnect within the specific context of South African HEIs, focusing on the lived experiences and perspectives of professional nurses on the front lines of GBV response.

Methods

This study's reporting adheres to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist, which is the appropriate EQUATOR network guideline for qualitative research (Tong et al., 2007).

Design

A qualitative, exploratory, and descriptive case study design was employed to gain an in-depth understanding of professional nurses' competence and preparedness in managing GBV. The "case" in this study is defined as professional nurses working within HEI campus health clinic settings, a bounded, real-life context in which GBV management unfolds. A case study approach was selected over other qualitative designs, such as phenomenology or qualitative descriptive design, because the study sought to examine how contextual, institutional, and systemic factors within HEI health clinics shape nurses' preparedness and competence. This represents a multiple-case design, as two HEIs were included, allowing for cross-institutional comparison while maintaining a focus on the shared contextual features of HEI campus clinics. This approach is suitable for exploring complex phenomena in their real-life context, prioritizing participants' subjective experiences and perspectives (Creswell & Creswell, 2018).

Setting and Sample

The study was conducted at two HEIs in the City of Cape Town, South Africa. Both institutions are public higher education institutions offering health sciences programs, and each operates a campus health clinic that provides primary healthcare services to students and staff. Professional nurses staff the campus clinics and serve as the first point of care for health-related concerns, including GBV-related presentations. A purposive sampling strategy was used to recruit participants who could provide rich and relevant information. Subjects were selected and recruited by sending formal email invitations through the respective campus clinic managers, who acted as gatekeepers. Interested nurses then contacted the researchers directly to ensure voluntary participation, free of institutional coercion. No participants declined participation. The sample consisted of five professional nurses employed at the Campus Health Clinics of the selected institutions. Inclusion criteria were being a professional nurse registered with the South African Nursing Council (SANC), the statutory body entrusted with setting and maintaining standards of nursing education and practice in the Republic of South Africa; working at one of the chosen campus clinics; and having direct experience in managing or responding to GBV cases. Nurses not directly involved in GBV case management or who did not consent to participate were excluded.

Data Collection

Data was collected between January and February 2025 through individual, semi-structured online interviews via Microsoft Teams. The primary researcher (SDH) conducted all the interviews. The interviews were conducted entirely in English, as it is the primary professional language used in South African higher education and healthcare settings. Following the interviews, the audio recordings were transcribed verbatim into English by the primary researcher (SDH) to ensure deep familiarization with the data. To maintain privacy during the online interview process, interviews were conducted in private settings, and participants were advised to ensure that they were in a confidential space during the session. No third parties were present during the interviews.

An interview guide with open-ended questions was developed to explore participants' knowledge, skills, experiences, and perceptions of their educational preparedness regarding GBV (see Table 1). The guide comprised seven main questions across four domains (see Table 1). The guide was pilot tested with two professional nurses (not included in the final sample) to ensure clarity and relevance. All interviews lasted between 30 and 45 minutes, were audio-recorded with participants' permission, and were transcribed verbatim for analysis. Data collection continued until data saturation was achieved, which occurred after five interviews. Data saturation was determined inductively: the primary researcher monitored the emergence of new codes and themes after each interview. After the fifth interview, no new codes or themes were identified, and the primary researcher, in consultation with supervisors, confirmed that saturation had naturally occurred during the analysis.

Table 1. Semi-structured interview guide

Domain	Main Interview Questions
Educational Preparedness	1. Can you describe the training or education that you received regarding Gender-Based Violence (GBV) during your undergraduate or postgraduate nursing studies? 2. How adequately do you feel that your formal nursing education prepared you to handle GBV cases in a clinical setting?
Clinical Competence & Experience	3. Walk me through your experience of managing a survivor of GBV who presents at your campus clinic. What specific skills do you rely on? 4. How did you develop the competencies required to manage these cases if they were not covered in your formal training?
Challenges & Barriers	5. What are the main challenges or barriers that you face when providing care to GBV survivors in your current role? 6. How do sociocultural factors or stigma influence the way how survivors disclose abuse and the way how you provide care?
Recommendations	7. In your opinion, what specific changes should be made to the nursing curriculum to better equip future nurses for GBV management?

Ethical Considerations

Ethical approval was obtained from the Institutional Research Ethics Committee at the Durban University of Technology (Approval Number: IREC 045/24) and the

respective gatekeepers at the participating HEIs. The study strictly adhered to the ethical principles of respect for persons, beneficence, and justice. All participants were provided with a letter of information detailing the study's purpose and procedures. Written informed consent was obtained before the interviews. Participants were explicitly informed that their participation was voluntary and that they could withdraw at any time without penalty or negative consequences. Anonymity and confidentiality were ensured by using participant codes and storing all data on password-protected devices. As interviews were conducted online via Microsoft Teams, privacy was maintained by ensuring that all sessions took place in private spaces and that external parties did not record. The researchers did not retain any identifying metadata from the platform.

Analysis

The transcribed data was analyzed using thematic analysis, following the systematic steps outlined by Tesch (1992), which are comparable to the phases described by Braun and Clarke (2006). The process involved familiarization with the data, generating initial codes, searching for themes, reviewing themes, and defining and naming themes. The primary researcher (SDH) conducted all coding and initial analysis. The coding process was reviewed collaboratively with the supervisors (VN and NN), and any disagreements were discussed and resolved by consensus. No qualitative analysis software was used; the analysis was conducted manually using printed transcripts and handwritten annotations. The researchers engaged in constant comparison to refine categories and ensure that themes were grounded in the data. To ensure the rigor of the qualitative findings, the four criteria of trustworthiness were strictly applied (Lincoln & Guba, 1985). Credibility (confidence in the truth of the findings) was supported through prolonged engagement with the data and member checking with participants. Transferability (applicability to other contexts) was achieved by providing a thick description of the research setting, methodology, and participant demographics. Dependability (consistency of findings) was addressed through a detailed audit trail of the methodology and peer debriefing with the research supervisors. Finally, confirmability (objectivity) was ensured by maintaining a reflexive journal to mitigate researcher bias and ensuring that the findings were clearly derived from the participants' narratives rather than the researchers' preconceptions.

Results

The analysis of interviews with five professional nurses yielded rich insights into their competence and preparedness to manage GBV. The demographic characteristics of the participants are presented in Table 2. Three main themes emerged from the data: (1) Educational and Systemic Barriers to GBV Competence; (2) Development of Competence through Experiential Learning; and (3) Skills and Ethical Foundations in Managing GBV and OBV. While the primary focus of this study is GBV management, Theme 3 extends to Obstetric Violence (OBV) as a conceptually related form of gender-based harm. The inclusion of OBV reflects participants' own discussions of the transferability of GBV competencies to other forms of violence against women. It is presented as an analytical extension rather than a separate focus area.

Table 2. Demographic characteristics of professional nurse participants (N=5)

Characteristic	Category	Frequency (n)	Percentage (%)
Gender	Female	4	80%
	Male	1	20%
Age Group (Years)	20 – 30	1	20%
	31 – 40	2	40%
	41 – 50	1	20%
	> 51	1	20%
Highest Qualification	Undergraduate Degree	1	20%
	Postgraduate Qualification	4	80%

Theme 1: Systemic and Educational Barriers to Competence

A significant and recurring finding was the profound lack of formal training and education on GBV within the participants' nursing programs. This theme highlights the structural deficits in nursing education that leave professionals feeling ill-equipped.

Subtheme 1.1: Lack of formal GBV training in nursing curricula

Nurses reported that their undergraduate and postgraduate curricula did not include structured or dedicated modules on GBV management, leaving a critical gap in their foundational knowledge. One participant stated, "What I have is not taught to us in my postgrad or undergrad. We never had training on that" (Participant 3-Female, 31-40 years, Postgraduate Qualification). Another echoed this sentiment, saying, "Gender-based violence management was not part of our curriculum when I studied… I don't think or even remember attending any subjects or modules on GBV management" (Participant 2-Female, 41-50 years, Postgraduate Qualification).

Subtheme 1.2: Inadequate foundational knowledge for complex case management

This curriculum gap meant that nurses entered practice with only a "basic knowledge of assessments" and were limited to identifying overt physical signs like "bruises or bleeding" (Participant 5 – Female, 31–40 years, Postgraduate Qualification), rather than possessing a comprehensive understanding of the psychological and emotional manifestations of trauma. The participants unanimously agreed on the need for curriculum reform, with one suggesting, "I think it would help a lot if GBV management is part of the curriculum. This will make nurses aware from when you are studying and equip you to deal with GBV survivors" (Participant 2-Female, 41-50 years, Postgraduate Qualification).

Theme 2: Experiential Development of Competence

In the absence of formal training, participants described developing their competence primarily through practical, on-the-job experience. This informal learning process involved direct interaction with survivors, learning from colleagues, and adapting to challenges as they arose.

Subtheme 2.1: Reliance on on-the-job learning and direct experience

Experience was cited as a key factor differentiating a prepared nurse from a novice. As one nurse explained, "I would say that experience has helped a lot. Unlike somebody who has just come, and they don't know they don't have the know-how of working with gender-based violence survivors" (Participant 4 – Male, 20–30 years, Undergraduate Degree). Another participant described the skills as something that comes "automatically when the person sits in front of you," emphasizing the intuitive and responsive nature of experiential learning (Participant 1 – Female, > 51 years, Postgraduate Qualification).

Subtheme 2.2: Value of exposure to specialized units

Some nurses had gained valuable insights from brief exposures to specialized units during their training, such as a Rape Crisis Center. This experience was highly valued, but was presented as an ad hoc opportunity rather than a structured component of their education. One participant reflected, "I worked a couple of hours at the Rape Crisis Center during undergrad... it's something that needs to be investigated, updated maybe to be part of the psychiatric placements" (Participant 3-Female, 31-40 years, Postgraduate Qualification).

These accounts reflect the considerable variation in experiential learning opportunities available to nurses, underscoring the degree to which competence development is left to individual circumstance rather than systematic training.

Theme 3: *Competence* and Skill in Managing Violence, Including Obstetric Violence (OBV)

Participants identified that the competence to manage various forms of violence, including GBV and more specific forms like Obstetric Violence (OBV), is built on a foundation of empathy, communication, and an understanding of human rights. Although participants worked primarily within HEI health clinics where OBV is not a direct focus, they explicitly discussed the transferability of GBV competencies to other forms of violence against women, including OBV. The inclusion of OBV in this theme reflects participants' own narratives and is grounded in their discussions rather than the researchers' interpretation.

Subtheme 3.1: A non-judgmental approach is foundational to all violence management

While OBV was not the direct focus in the HEI clinics, the underlying skills of non-judgmental care and patient advocacy were seen as transferable and essential for managing any form of violence. One nurse articulated a core principle applicable to all violence survivors: "As when you approach someone who has been... sexually violated... You do not judge them; you do not impose the idea that it is their fault (Participant 4 – Male, 20–30 years, Undergraduate Degree). This non-judgmental stance is critical in OBV, where women are often disempowered. Another added that nurses must be "welcoming" and "show support so they can trust us" (Participant 4 – Male, 20–30 years, Undergraduate Degree), a key element in creating a safe space for any survivor to disclose their experience.

Subtheme 3.2: Human rights and ethical policies as a cornerstone of competence

The importance of understanding human rights and ethical policies was also highlighted as a cornerstone of competence. A participant noted, "Every individual has the right to life stipulated in our Constitution, so no individual must be subjected to additions; they are not lawful" (Participant 4-Male, 20-30 years, Undergraduate Degree). This rights-based approach is fundamental to recognizing and addressing violations like OBV and GBV. The skills to manage violence, therefore, stem from a combination of experiential learning and a deep-seated ethical framework, which participants felt was not adequately formalized in their training.

Discussion

This study aimed to investigate the preparedness of professional nurses at HEI health clinics in managing GBV and to identify related educational gaps. The findings suggest that the professional nurses interviewed in this study feel underprepared, primarily due to significant deficiencies in their formal nursing education. The heavy reliance on on-the-job learning to build competence in GBV management is a consistent theme that aligns with previous research highlighting global gaps in nursing curricula (Alshammari et al., 2018; Clark et al., 2020).

To fully understand the challenges nurses face, these educational gaps must be contextualized within South Africa's broader social and cultural landscape. The pervasive nature of GBV in the country is deeply intertwined with patriarchal norms and traditional cultural beliefs that often-subordinate women and normalize male dominance (Naicker, 2025). In many South African communities, cultural and religious interpretations are misused to enforce female submission, creating an environment where violence is tolerated and survivors are stigmatized. This sociocultural reality directly impacts nursing practice. When survivors present at clinics, they are often burdened by shame, fear of community backlash, and a culturally ingrained reluctance to disclose abuse against a partner. Nurses, therefore, are not merely treating physical wounds; they are navigating complex webs of cultural silence and trauma.

This dynamic is not exclusive to South Africa. As Alsawalqa (2021) observed in the Jordanian context, gender stereotypes and the social construction of masculinity and femininity create prejudices that foster cultural acceptance of domestic abuse. In both contexts, the societal expectation for women to endure hardship silently places an immense burden on healthcare providers to proactively identify and gently coax disclosures from survivors. Without formal training in culturally sensitive, trauma-informed care, nurses are left to rely on their personal intuition, which is insufficient for addressing systemic, culturally entrenched violence.

The absence of dedicated GBV modules, as reported by participants, means that nurses are not systematically equipped with the theoretical knowledge or practical skills required for this complex area of care. This finding supports the call by Sepeng et al. (2022a) for curriculum reforms in South Africa to include specific competencies, such as forensic evidence collection and understanding legal processes. When nurses' training lacks such content, their responses become reactive and variable, potentially compromising the quality and consistency of care provided to survivors. Beyond individual educational gaps, the findings also reveal deeper institutional barriers: the absence of standardized GBV protocols within HEI health clinics, limited supervisory support for nurses managing GBV cases, and the broader health system's failure to designate GBV response as a formal nursing competency all contribute to a fragmented care environment. These institutional

and systemic barriers compound individual nurses' sense of unpreparedness and must be addressed alongside curriculum reform. Furthermore, cultural stigma around GBV, particularly the normalization of intimate partner violence in some communities, creates additional workplace challenges for nurses, who must navigate patients' reluctance to disclose while managing their own emotional responses to traumatic disclosures.

The development of core competencies, like empathy and communication through experience rather than formal training, is particularly concerning. While experiential learning is valuable, it is not a substitute for structured education that provides a foundation in trauma-informed and survivor-centered principles (WHO, 2019). This reliance on informal and incidental learning pathways results in inconsistent, non-standardized levels of competence across the profession and an interpretive conclusion drawn from the convergence of participant accounts, supported by the broader literature (Alshammari et al., 2018; Sepeng et al., 2022a). International models have shown that integrating such training into curricula enhances nurse confidence and improves survivor outcomes (Crombie et al., 2017).

The skills for managing violence discussed in Theme 3, including the principles applicable to OBV, reinforce that a rights-based, empathetic approach is universal to all forms of violence against persons. It is important to note that OBV was not a central aim of this study, and its appearance in Theme 3 reflects participants' own articulation of how GBV competencies transfer to related forms of gender-based harm within healthcare settings. The discussion of OBV is therefore presented as an analytical extension, grounded in participant data, rather than a primary finding. Future research may more directly investigate OBV within HEI or primary care contexts. However, leaving the development of these essential skills to chance, depending on individual nurses' personal attributes and clinical encounters, is a systemic flaw (Crombie et al., 2017).

Furthermore, the study highlights that an educational framework must go beyond clinical skills to prepare nurses to navigate the psychosocial and cultural complexities of GBV. Nurses must be trained to understand the concept of Ubuntu interconnectedness and shared humanity as a tool for healing, countering the patriarchal narratives that isolate survivors (Naicker, 2025). Without a deep understanding of these cultural nuances, nurses may struggle to build the trust necessary for effective intervention, as noted by Klazinga et al. (2020).

Limitations

This study has some limitations. The findings are based on a small, purposively selected sample of five professional nurses from two HEIs in one metropolitan area. Therefore, the results may not be generalizable to all professional nurses in South Africa. However, the depth of the qualitative data provides valuable insights that align with broader literature and can inform future, larger-scale research. The use of online interviews may have limited the researchers' ability to fully observe non-verbal cues, although it facilitated access to participants.

Additionally, the findings are context-specific to HEI campus clinic settings in Cape Town and may not be transferable to other healthcare settings or provinces. Response bias is also acknowledged, as participants may have presented their experiences in a socially desirable manner. Furthermore, as the primary researcher conducted both data collection and data analysis, the potential for researcher influence in the interpretive process cannot be fully eliminated. However, reflexivity measures were employed to mitigate this.

Implications for Nursing

- The findings of this study have significant implications for nursing education, practice, and policy in South Africa. Firstly, for nursing education, there is an urgent and compelling need to reform undergraduate and postgraduate curricula. Nursing education institutions must move beyond mere mention of GBV and integrate dedicated, mandatory modules that cover its theoretical, clinical, and psychosocial aspects. This training should include practical components, such as simulation-based learning, case studies, and structured clinical placements in relevant settings, including GBV clinics or crisis centers.
- Secondly, for nursing practice, healthcare institutions, including HEIs, must acknowledge the educational gaps and provide robust support for practicing nurses. This includes offering regular, accredited continuous professional development (CPD) workshops on GBV. Furthermore, the development and implementation of clear, evidence-

based institutional protocols for GBV response are essential to standardize care and support nurses in their clinical decision-making.

- Thirdly, for nursing policy, regulatory bodies, such as the SANC, should consider mandating a minimum level of GBV competency for nursing registration and re-licensure. Establishing GBV management as a core professional competency would drive curriculum reform and ensure that all nurses possess the foundational skills to provide safe and effective care to survivors.
- **Implications for Future Nursing Research:** Based on this study's findings, future nursing research should focus on evaluating the effectiveness of specific GBV educational interventions and simulation-based training programs on nurses' clinical competence. Additionally, there is a critical need for longitudinal, mixed-method studies to explore how sociocultural factors impact nurses' attitudes and practices regarding GBV across different provinces in South Africa. Research should also investigate the psychological impact of secondary trauma on nurses who frequently manage GBV cases, aiming to develop evidence-based support systems for healthcare providers.

Conclusion

The ultimate take-home message for the nursing profession is clear: empathy and clinical intuition, while essential, are not sufficient substitutes for structured, evidence-based training in the management of gender-based violence. Nurses are the frontline defenders of human rights in the healthcare system, yet they are currently fighting a complex, culturally entrenched pandemic of violence without the necessary educational armor. To truly provide survivor-centered care, the nursing profession must demand and implement comprehensive curriculum reforms that equip every nurse not only with clinical and forensic skills, but also with the cultural competence to navigate the deep-seated societal norms that silence survivors. The absence of structured GBV content in nursing curricula represents a significant gap in nursing education that must be urgently addressed. Until GBV management is treated as a core, non-negotiable competency in nursing education, the healthcare system will continue to fail both its nurses and the vulnerable populations they serve.

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Data Availability

The data supporting this study's findings is available from the corresponding author, Siphesihle D. Hlophe, upon reasonable request. This manuscript is a dataset from an ongoing doctoral study at the Durban University of Technology and is not yet available in a publicly accessible repository.

Conflict of Interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced their writing or publication of this article.

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Author Contributions

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