How Nurses in Johannesburg Address Intimate Partner Violence in Female Patients: Understanding IPV Responses in Low- and Middle-Income Country Health Systems

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Abstract
One in three women, globally, experiences intimate partner violence (IPV). Although 80% of the world’s population resides in the low- and middle-income countries (LMICs), health system responses to IPV are poorly understood. In 2013, the World Health Organization released new guidelines for IPV but universal screening was not recommended in LMICs due to perceived lack of capacity and insufficient evidence. South Africa, with IPV prevalence estimated at 31% to 55%, offers a window into LMIC health systems. South African women seek health care for partner abuse, yet no guidelines exist to direct providers. This research aimed to understand how and why nurses respond to IPV. Using a descriptive design, 25 nurses from five health facilities were interviewed, generating rich narratives of provider actions. Themes

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were coded and analyzed. An iterative process of constant comparison of emergent data was undertaken to verify and confirm final themes. In the absence of IPV guidelines, nurses employed interventions characterized as counseling, ascertaining abuse, and referral. Nurses’ actions were motivated by fear for patients’ survival, perceived professional obligations, patients’ expectations of receiving treatment, personal experiences of IPV, and weak police responses to IPV. Findings indicated nurses were responding to IPV in a routine manner, yet comprehensive guidelines remain essential to govern and locate their actions within the framework of a public health response. South Africa yields lessons for enhancing understanding of IPV responses in LMICs, while contributing to a slim evidence base of the “how” and “why” of provider actions toward IPV in patients.

Keywords
intimate partner violence, domestic violence, universal screening, health systems, nurses, South Africa, low- and middle-income countries, HIV, women’s health

Introduction
Thirty percent of all women, worldwide, have experienced some form of intimate partner violence (IPV), rendering IPV a global public health problem (World Health Organization [WHO], 2013b). IPV has been defined as behavior by a current or previous partner that causes psychological, physical, or sexual harm (Saltzman, Fanslow, McMahon, & Shelley, 2002; WHO, 2013b). Latest available data have indicated IPV prevalence was highest among the Africa, Southeast Asia, and Eastern Mediterranean regions, where an estimated 37% of ever-partnered women have reported physical or sexual IPV in their lifetimes (WHO, 2013b). IPV-related injuries have been well documented. These include fatalities associated with murder of women by partners (femicide) and suicide, as well as nonfatal injuries including bruising, lacerations, sprains, broken bones, and contusions. Longer-term health consequences for survivors have encompassed chronic pain, HIV acquisition, anxiety, posttraumatic stress disorder, depression, memory loss, and low self-esteem (Campbell, 2002; Heise, Pitanguy, & Germain, 1994; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Ludermir, Lewis, Valongueiro, de Araujo, & Araya, 2010).

The Centers for Disease Control and Prevention (CDC) estimated the costs of IPV in 2003 exceeded US$5.8 billion in the United States alone. Two
thirds of IPV-associated costs were captured by health care (CDC, 2003). In recognition of the public health and social costs of IPV to countries, state commitments to prevent and address IPV have evolved substantially. These can be located in three historic phases. Embedded within this trajectory is a growing recognition of the role of health systems and health providers in addressing IPV (García-Moreno et al., 2015).

**Phase 1. Standard Setting: Domestic Violence Moves From Private to Public Concern**

In 1979, the United Nations (1979) Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) defined discrimination against women, for the first time, as:

> any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women . . . of human rights and fundamental freedoms.

CEDAW created a legal obligation for states and reporting mechanisms for monitoring substantive commitments to protect women against discrimination (Amnesty International, n.d.). One year later, in another first, the phrase *domestic violence* entered into UN official documents to become an obligation of member states (United Nations, 1980). The Second World Conference on Women in Copenhagen heralded the beginning of a first phase in the historical evolution of international norms and standards surrounding violence against women generally and IPV specifically. The use of the term *intimate partner violence* rather than domestic violence marked a seminal shift in the evolution of understanding and responses toward IPV—not only in language but also in responsibility. In moving partner violence from the private realm to the public sphere, the effect was to require both government recognition of the problem and subsequent action in response (Morvail, 2002).

**Phase 2. Legal Responses: International Community Recognizes IPV as Human Rights Violation and Government Responsibility**

In the second historic phase, the international community recognized IPV as a human rights violation, creating a positive obligation for governments to actively protect bodily integrity, and human dignity. The major advance took place in Vienna at the World Conference on Human Rights in 1993 (de Haan, 2010). In the resulting Declaration, governments became responsible for
preventing and addressing IPV, whereby, “Responding to the phenomenon clearly became a government responsibility (as opposed to the responsibility of individuals and nongovernmental organizations [NGOs] alone)” (Morvail, 2002, p. 3, emphasis in original; United Nations, 1993). By 2002, the WHO published the first-ever global report on violence and health, systematically documenting the pernicious effects of partner and sexual violence on women’s health over the life course. This served to highlight the evidence base, while emphasizing the role of health systems in addressing IPV in patients who seek treatment (Krug et al., 2002).

**Phase 3. Norm Setting: Model Strategies and Guidelines for IPV Emerge**

In the third and current phase, states’ roles in addressing IPV became further amplified. Model strategies, guidelines, and approaches to legislation and enforcement have become the norm, with multisectoral stakeholder responses central to these. Each resolution and protocol since 1979 laid another brick in the foundation of law and practice within this developing edifice of women’s rights to health, comprising reproductive health and sexual rights, bodily integrity, as well as freedom from violence (Gerntholtz, Gibbs, & Willan, 2011; Petchesky, 2003). Today, IPV has become illegal in a majority of countries. Most nations specify responsibilities for the police, legal, and justice systems to act in connection with domestic violence complaints and acts. Many social welfare organizations (shelters and other NGOs) have been established to support the needs of women who require safe shelter from abuse (Hagen & Postmus, 2000). Nevertheless, within these increasingly sophisticated national and global responses to IPV, there is one sector that has remained controversial: the health sector and the role of health providers in “asking” about violence, referred to as routine inquiry or universal screening (Nygren, McInerney, & Klein, 2004; Ramsay, Richardson, Carter, Davidson, & Feder, 2002).

**Role of Health Systems in Addressing IPV Concretizes**

The focal points of debate turned on whether harm to women could be minimized when providers engaged women in discussions about violence and whether women’s safety could be assured once they left clinical settings. A corollary question considered was what overall benefits to patients and costs to health systems resulted when providers inquired about violence? These debates were unfolding in national contexts of financial recession, austerity, shortages of health personnel, and rapid health care reform (Basile, Hertz, & Black, 2007; Taket, Wathen, & MacMillan, 2004).
Yet a notable shift had taken place in recent years. WHO had begun to increasingly recognize the role of health providers as frontline staff in the IPV response, globally. They emphasized, “the health sector has a key role to play in preventing and responding to the problem, as part of a robust multi-sectoral approach that engages governments and civil society, on the local, national and international level” (WHO, 2013b). Nonetheless, routine inquiry for violence against women in clinical settings has remained contested (Feder et al., 2009; Klevens et al., 2012; MacMillan et al., 2009).

In 2013, these debates took on fresh dimensions when the United States and WHO issued new clinical IPV guidelines, both based on systematic reviews of available evidence. The U.S. Preventative Services Task Force (USPSTF) premised resulting recommendations on the evidence of “both benefits and harms” to women in the United States and a balance between the two (i.e., they found the benefits of asking about violence to be greater than the potential harm). The USPSTF recommended, “clinicians screen women of childbearing age for intimate partner violence . . . and provide or refer women who screen positive to intervention services” (USPSTF, 2013).

USPSTF also stressed that these recommendations applied to women who did not have visible signs or symptoms of abuse. The upshot: Based on new clinical IPV guidelines issued in 2013, the United States effectively elected universal screening for violence across states. In contrast, WHO did not.

When WHO issued new policy and clinical guidelines, they took care to unequivocally recognize the role of health personnel in seeing and treating women in health care settings, stating: “A health-care provider is often the first contact for survivors of intimate partner violence or sexual assault” (WHO, 2013b, p. 10). They highlighted the mounting data, indicating the evidence that women subjected to violence sought health care more often than women who were not abused (WHO, 2013b). WHO also underscored how health personnel are perceived by patients: “Women living with partner violence identify health-care providers as the professionals they would most trust with disclosure of abuse” (WHO, 2013b, p. 10).

Unlike the United States, WHO considered the feasibility of health system responses to violence against women, globally, grouping countries by low income, middle income, and high income. Despite the fact that low- and middle-income countries represented 80% of the world’s population, only a slender evidence base on IPV responses in low- and middle-income countries (LMIC) health systems has emerged. In recognition, WHO concluded that universal screening for violence against women was not recommended in LMICs due to insufficient evidence and perceived lack of resources (WHO, 2013b). Significantly though, WHO recommended for all countries, “local policies and protocols defining roles and responsibilities, and procedures related to identification and
management of survivors need to be developed and implemented (with appropriate training and continual support)” (WHO, 2013b, p. 39). WHO recommended that training of health providers in IPV and sexual assault be added to basic professional education curricula and offered as continuing education for providers who are the most likely to encounter women (WHO, 2013b). Last, WHO set forth minimum requirements for health providers to ask about partner violence, including (a) training on “how to ask about violence” should be offered (whether a minimum response or beyond), (b) a private setting for discussion between the patient and provider must be provided, (c) confidentiality for the patient must be assured, and (d) a referral system must be in place (WHO, 2013b, p. 19).

The WHO report raised a number of questions for researchers, health officials, and professionals, including whether and how health providers in LMICs should respond to IPV in their patients, given that protocols and policies are often absent, with acute shortages of health personnel (García-Moreno et al., 2015). South Africa offers a view into one LMIC setting, adding to a thin base of published literature on IPV responses in developing countries, which may hold lessons for other LMICs.

**IPV Responses in LMICs and the South African Health System**

South Africa, classified as an upper-middle-income country, had a population of 54 million in 2013 (Statistics South Africa). IPV has been widely accepted as a grave public health and social problem, nationally. Studies estimating IPV prevalence in South African women matched global IPV prevalence at 31% (Gass, Stein, William, & Seedat, 2010; Hoque, Hoque, & Kader, 2009). However, health facility–based studies reported higher prevalence—55% prevalence of physical or sexual violence in pregnant women—and IPV has been consistently under-reported (Dunkle et al., 2004; Jewkes et al., 2006). Similar to other countries, South African women who experienced IPV-associated injuries sought care from the public health system more frequently than women who were not abused (Gass et al., 2010). The first study of femicide in South Africa estimated that four women per day were killed by their partners, underscoring the fatal health effects of IPV (Mathews et al., 2004). South African femicide was cast under the global spotlight during the recent trial of the paralympian Oscar Pistorius for allegedly murdering his partner, Reeva Steenkamp (Mathews, Abrahams, & Jewkes, 2015).

South Africa’s high HIV prevalence has posed an additional threat to women’s health: average HIV prevalence in pregnant women in 2012 was 29.5% (Government of South Africa, 2012). Women in the age group 30 to 34 years have the highest HIV prevalence, estimated at an astonishing 42.8%
in 2012. South Africa’s HIV epidemic is feminized: More than 60% of people living with HIV are women or girls (Shisana et al., 2014). Statistically, then, in 2012, one in three pregnant women was living with HIV, with one in three women experiencing some form of IPV, making these interactions significant. The health risks and effects posed by the relationship between IPV and HIV have increasingly been documented (Jewkes et al., 2006; Jewkes, Levin, & Penn-Kekana et al., 2003; Kaye, 2004; Silverman, 2008).

A distinguishing feature of the newly democratized South Africa has been its enabling legal framework for socioeconomic rights, with the 1996 Constitution lauded internationally for its highly progressive approach to health and human rights for all (Bilchitz, 2008; Government of South Africa, 1996; Sunstein, 2000). This commitment was tested during a protracted struggle and, ultimately, successive legal victories, led by civil society organizations against the government to secure access to antiretroviral treatment for South Africans with HIV to be made freely available through the public health system (Heywood, 2003). The Constitution also contained a significant commitment to the right to security, bodily integrity, and to women’s substantive equality, thereby affording women the right to be free from violence, including IPV (Government of South Africa, 1996). IPV in South Africa was broadly defined in the Domestic Violence Act of 1998 (DVA) as physical, sexual, or psychological abuse (Government of South Africa, 1998). In this third global phase of model strategies, guidelines, and approaches to IPV legislation and enforcement, South Africa has aligned with international norms of best practice and re-affirmed its enforcement of the DVA in later court judgments (Government of South Africa, 1998; Vetten, 2005). However, the DVA has been criticized for its ineffective implementation, problematic oversight, and lack of evaluation (Government of South Africa, 2009).

Although the DVA required the police to find health care, counseling, and shelter for women, setting forth explicit obligations for the police, legal, and justice departments, there was no corresponding obligation for the Department of Health (DoH) and the Department of Social Development to provide health services or address the health needs of women (Government of South Africa, 1998; Vetten, 2005). The still-transforming South African public system has been beset by infrastructural, operational, and human resource constraints and generally regarded as overloaded by dual HIV and tuberculosis epidemics (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Sprague, Chersich, & Black, 2011). In recent years, a primary health care policy was tabled; a task force recommended training in domestic and sexual violence for health providers; and a high-level roundtable comprising national and provincial health officials discussed a health system response. Despite these efforts, no DoH guidelines for health providers to screen for IPV or other
types of violence, with accompanying protocols, resulted (Government of South Africa, 2000, p. 57; Tshwaranang Legal Advocacy Centre [TLAC], 2008). The roundtable report concluded, “Violence against women is one of the most pervasive ills . . . yet there has been little focus on defining the health sector’s role in addressing domestic violence” (TLAC, 2008, p. 18).

In this context, several South African studies found nurses recognized violence to be a problem in female patients and were willing to engage it through screening (Joyner & Mash, 2012; Kim & Motsei, 2002; Naidoo, Knight, & Martin, 2013). What had not been established was whether, in the absence of guidelines, nurses and other health providers in South Africa had already begun to address violence in female patients. This research was positioned in that gap.

**Study Objective and Research Questions**

The study aimed to understand the responses of nurses toward IPV in female patients, for example, screening for violence, case finding, counseling, or lack of action. Research questions were exploratory, due to the sensitive subject matter and the conduct of interviews with nurses in their professional workplaces (which could hinder their openness). They encompassed the following:

- **Research Question 1**: Do nurses engage female patients to ascertain whether they have experienced violence (e.g., through screening and case finding)?
- **Research Question 2**: What actions do nurses take in relation to IPV in female patients, if any?
- **Research Question 3**: What are their predominant attitudes and motivational factors toward IPV in patients?

**Method**

This qualitative research was grounded in an interpretive paradigm (Marshall & Rossmer, 2006). Female nurses were purposively selected as a cadre, due to their proximity to female patients and their location at the very coalface of health threats and responses in South Africa. Nurses and other health professionals in South Africa work under high-stress conditions in the public sector where a chronic shortage of health providers has persisted (Health Systems Trust, 2008). Purposive sampling was utilized in the five facilities to identify and then recruit nurse participants. We identified and interviewed nurses who were working in the following wards: antenatal care, maternity, termination
of pregnancy, and obstetrics and gynecology. This choice of wards reflected key points in the care continuum for women who might present for IPV-related injuries, with important health implications for pregnancy, labor, delivery, abortion services, and care. This selection also enabled us to explore whether health provider actions might differ by location in the health system, where a different pace, work flow, injury type, operating procedures, or urgency might result.

Recruitment and interviews were conducted by three researchers trained in qualitative methods, including the first author, who has 15 years of experience interviewing populations on topics of a sensitive nature. All researchers were female and had knowledge of the setting, the health system, and IPV. None of the researchers had relationships with the participants, thus minimizing bias and influence. This also allowed for sufficient distance between respondents and interviewers, and facilitated participants’ confidentiality and freedom to share their experiences. Two interviews took place in isiZulu and were translated and transcribed into English by the researcher who conducted those interviews.

From August 2013 to August 2014, interviews were undertaken with 25 nurse participants, using a semi-structured interview guide that allowed for conversations with health personnel to take place in their natural hospital or clinic setting. Nurses were recruited until a point of saturation and convergence was reached, with common themes emerging across the five facilities. Five of the nurses had been trained in IPV through a special intervention. The remainder had never received any training in addressing violence against women or IPV.

During the process of explaining the study purpose and seeking informed written consent from participants, IPV was defined in the study information sheet and then verbalized as emotional, physical, or sexual abuse—attempted or completed—by a current or former partner. From an initial focus on understanding the health of women who experience violence, each conversation sought to peel back the layers of the respondents’ experiences as nurses who treated female patients routinely. In protracted discussions with nurses about their experiences with patients who undergo partner violence, we shifted the conversation from the patients’ experience to the providers’—probing (as appropriate) nurses’ experiences of partner violence in their own lives. This qualitative approach depended on gaining sufficient trust to access the nurses’ life stories. It required creating a safe space for respondents to share their views not only as professionals but also as women who see violence in patients or experience violence themselves. Interviews crossed the boundary from the professional to the personal and back again (Cannon, 1992; Dickson-Swift, James, Kippen, & Liampittong, 2007).
Setting and Sites

The research took place in urban Johannesburg, Gauteng province, with an estimated population of more than 12 million. A high percentage of residents were classified as poor (42%), reliant on public health services (78%), and unemployed (24%) (Gauteng Provincial Department of Health and Social Development, 2011; Statistics South Africa, 2013).

Research sites were purposively selected to encompass a range of hospitals and clinics in Johannesburg: (a) Shandukani Maternal and Child Health Facility in Hillbrow catered to women of reproductive age and their children in the inner city, situated within Hillbrow Community Centre; (b) Hillbrow Community Health Centre, serving the needs of those living in the densely populated, inner-city slum areas; (c) Bez Valley Clinic served women from the surrounding areas of the inner city; (d) South Rand Hospital provided services to a diverse population in the southern suburbs; (d) Hillbrow Community Health Centre met the needs of those living in the densely populated, inner-city slum areas; and (e) Charlotte Maxeke Johannesburg Academic Hospital, a tertiary facility and teaching hospital for the University of the Witwatersrand, serviced inner-city residents with a range of more complex health needs.

Ethics approval was granted by the University of the Witwatersrand Human Research Medical Ethics (M130671) and the University of Massachusetts Boston (2013133). All respondents gave their written informed consent to be interviewed; 21 of 25 consented to be recorded.

Data Analysis

Interviews were recorded and transcribed verbatim. Detailed notes were collated for the four participants who declined voice recording. Transcriptions, nurse reports of cases (patients they had seen), and their social-demographic data were the primary data collected and analyzed. The stages of data collection and analysis used were as follows. First, two researchers conducted independent coding of themes to create concepts that emerged from participant descriptions. This coding framework was revised by the researchers, in collaboration with the first author. The first author then led a process of constant comparison among the group to confirm dominant themes arising, with a recoding of themes where needed. Finally, a set of analytical findings was prepared by the first author, followed by discussion and confirmation among the group to reflect on and verify final themes.

For the 25 interviews, we used reliability procedures that encompassed documenting emergent themes and cross-checking transcripts for failure of
participants to answer questions honestly or freely (trustworthiness and authenticity) and for mistakes (fact-checking and errors); use of clear definition of codes and categories, cross-checking of codes; and later, emergent themes identified by the researchers; with comparison of the results identified independently by coauthors (Creswell, 2009).

**Results**

In terms of demographic characteristics, 24 of 25 nurse participants were Black South Africans of African descent (96%). Ages ranged from 35 to 61, with an average age of 44 years. Nurses were generally experienced professionals: All had worked in the public health system for many years, including in different health facilities in Johannesburg, 17 (68%) worked in antenatal care (prenatal) wards. Six of the 25 nurses (24% of the sample) disclosed direct experiences of IPV in which they had experienced partner abuse themselves. All 25 disclosed indirect experiences of abuse, for example, IPV in the family (e.g., a sister or cousin) or community (generally a neighbor). Participants, through their statements, were already familiar with the definition of IPV, through the DVA and exposure to IPV in their work, and in some cases their own lives. Names presented are pseudonyms to protect respondents’ identities.

The resulting findings were dominant patterns that emerged as typical, shared participant accounts, actions, and realities across the 25 interviews. We first discuss the “how” of provider actions before moving to the “why.”

**Theme 1: How Nurses Respond to IPV in Female Patients**

In this first theme, some nurse actions constituted a series of sequential steps that followed a discernible, consistent pattern easily identifiable across participant accounts.

This pattern was characterized as “talking” (asking patients about abuse and counseling), ascertaining abuse (probing patients’ for their experience of psychological, sexual, and physical abuse and checking for apparent physical signs), and then referral (referring women primarily to social workers on-site in the same clinics). Owing to high HIV prevalence in women, such counseling and psychosocial services were available in many public clinics and hospitals, particularly in locations were women could access them (such as prenatal care), and where they regularly made use of those services (Black, Sprague, & Chersich, 2011).

The first quote by sister Lehlohonolo (South African nurses are commonly referred to as “sister” regardless of their rank) captured her process of
engagement with patients about IPV, through “talking” to ascertain whether she had been experiencing abuse:

Maybe you find that she first cries and then you try to find out what’s wrong and then she’ll tell you a story. (Lehlohono)

By “story” here, she referred to accessing the patient’s life story and also her medical history. “Talking” served as an entry point to “ask” women about violence. This was recurrent among participants, indicated below, where Mary stated that to engage IPV in her patients, she relied on her observations of nonverbal cues to probe for IPV in women:

When you take the [patient] history, you could see facially an expression . . . [indicating she has a larger problem]. [Mary asks] “Is there anything that is worry[ing] you?” and I say “look, talk to me.”

These two accounts illustrate how nurses recognized signs or symptoms, whether evident or hidden. Those signs served as “cues” prompting nurses to “ask” their patients about violence. They then did so with some variation of “let’s talk,” through which they gleaned the patient’s physical health and experiences of violence in their relationships.

Illustrated in the next quote is nurse Joseline’s response to evident physical violence in a female patient. Here, she indicated that there was a process of immediate “assessment” by nurses taking place to determine the extent of an injury to the patient and related action to be taken:

How does the patient present? If the patient need immediate attention . . . when she was beaten, she was pushed against the wall, maybe the pregnancy was affected, then with that one, we don’t refer to medical [medico-legal services] because it need emergency attention . . . But for [the] patient who says, “I was beaten, but only on the face” . . . those ones we usually refer to medico-legal clinic [a specialized clinical forensic service].

While Joseline referred to a patient sent to emergency services, some nurses emphasized downward referral of each patient to a social worker for psychosocial support in hospital settings. Sindiso communicated that nurses in tertiary settings were utilizing the network of social workers to assist patients who experienced IPV:

We refer them to the social worker. In the hospital we’ve got social workers that are dealing with social problems of the patients . . . in fact, we do try and counsel them in the ward, and then after that we refer.
Priscilla outlined her pattern of referral in the following way, encouraging patients to wait for an appointment and return. In doing so, she captured the highly cyclical dimensions of IPV, as well as wait times indicative of the public health system:

I refer so many to the psychologists and so far . . . they get there and they come back to you and [say] “they couldn’t do anything for me and it’s fully booked” . . . Normally what I say is “just wait for an appointment, when it comes [available], you go there.” Because you can see they need continuous support. It’s not like somebody who needs counseling for today and she’s okay. She must be continuously helped with the situation.

The first theme thus offered a picture of an IPV response, mounted by nurses, fairly routinely and consistently, with similar actions and steps taken, which accorded with their skills, training, and expertise as nurses. This reality begged the question: What motivated these nurses to respond? The second theme spoke to the “why” of nurses’ behaviors.

Theme 2: Why Nurses Respond to IPV: Patient Expectation and Nurse Response

In probing attitudes and perceptions of respondents toward violence in patients, nurses indicated they were well aware that screening for violence was not indicated by the DoH and that they were going beyond what was required. In that environment, we queried their underlying motivations. A dominant finding that emerged was a dynamic interaction between patient and provider, that of “expectation and response.”

The professional obligation of nurses to meet patients’ health care needs. Female patients undergoing abuse reportedly held the expectation that they would be treated or supported, according to nurse accounts. Some patients appeared to actively seek out nurses, and those nurses, in keeping with their professional obligations as providers of care, responded. In understanding this interaction, a number of nurses explained their motivations. Captured in the following accounts, they discussed the health risks and effects of IPV as core to their professional duties. Here, two nurses described actions to address IPV, stating concerns over women who were at risk of self-harm:

She [the patient] said you know, since you talk to me I felt so [better], I felt so happy because . . . I was confused. What I’m going to do to myself [indicating the high potential for suicide]. (Tumelo)
Sister Puleng remarked on the patient’s expression of suicidal intentions on the day of her visit:

And then this one [patient who was experiencing abuse] was crying, and also wanted to commit suicide on that day when she came here, she even told me she wanted to drink some poison so that she just ends her life.

Ann also referenced an incident where the patient appeared to be suicidal:

Last week we had a lady who was being verbally . . . and mentally abused by her husband. You could already see from her posture that she was very depressed. She came to us, she was already 20 weeks . . . She had taken an overdose of wood polish . . . and only found out then that she was pregnant. The husband was [saying]: “You must abort. You’re using me for my money.”

Nurses highlighted the physical consequences of violence resulting from extended periods of abuse. Kagiso mentioned the loss of the fetus as a result of repeated abuse:

You know physical violence by boyfriends. And then they lose their babies through that.

Ann, in the termination of pregnancy ward, spoke about a patient with leg fractures that resulted from violence by her partner:

I had a lady who, the boyfriend was trying to rape her, and she jumped out the window. And she broke her legs.

Similarly, Tumelo, who worked in antenatal (prenatal) care, spoke of the inability of women to bear children in future as a consequence of injury sustained through a screwdriver:

You know last time the doctor show us a picture of a woman [a patient] . . . [and] they made cesarean section to take out the dead baby inside. The man put a screwdriver in the woman’s vagina. And I don’t know what happen . . . The uterus has also perforated.

The expectation of women undergoing abuse to be seen by a nurse was cited by Mandisa. She indicated that patients with IPV actively sought out nurses to provide care, treatment, or support:
They come to us with the bruises and what not, that’s when we see [they are being abused]. Or, if they trust you enough they can be able to come to you and say “Sister, can I talk to you about this and this and this?” Even if the patient came in with a leg injury, if they trust you enough, if they feel safe enough, they can be able to call you and say that this is what is happening.

**IPV-HIV linkages: Disclosure triggers violence and abandonment.** A minor theme that emerged as expected was the co-existence of partner violence and HIV. Given the HIV prevalence estimates in women of reproductive age referenced earlier, the importance of further understanding these links between HIV and IPV became evident. In ascertaining abuse, nurses consistently mentioned that HIV could be a trigger for violence in their patients:

> We do refer [to social workers] . . . you might find that she’s just been diagnosed with HIV, when she informs the partner, the partner becomes violent. (Lindi)

Similarly, Priscilla stated,

> These . . . women [on receipt of HIV diagnosis], they leave the clinic and go home. When they get there, they tell their partner [disclosing their HIV status]. Their partner gets so angry [and] beat her up.

Priscilla referred to a patient who was abandoned by her husband, following disclosure:

> She went home and told her husband [her HIV status] and the husband just disappeared. And the husband is the one who is paying the bills and everything. Now, she’s got two kids. The husband disappeared for a week. The patients says “I’m trying to phone him he’s not even picking up the phone. I’m there with the kids, there’s no food, I don’t have money.”

The lived reality of abandonment, referenced in our previous studies, was observed by Lily (Sprague, 2009). She stated women with HIV typically experience violence in their intimate partnerships, and suggested that abandonment followed HIV disclosure:

> Most of them in violence are women who are HIV positive, the majority of them. It’s difficult to disclose and when they disclose the other partners, they leave them, pack their things and go.

In this environment, Kagiso remarked that the patient has an expectation that because she has come to the health system, she will receive care or information including for partner abuse and the nurse meets that expectation:
[The patient] is already here. So if you are already here . . . if you are in a health center you want all your problems to be sorted. What I’ve noticed . . . it is up to their decision (female patients), but they go home having information and less stressful . . . you will be knowing that yeah really these are signs and symptoms and then you are able to help that person.

One sister expressed her view that nurses were obligated to address IPV in their patients because women lacked other channels and institutional remedies for abuse:

You cannot have someone [a nurse] who doesn’t like talking to abused women. It’s our problem now in the present situation. (Lily)

Against a background where injuries—emotional and physical—were apparent, nurses described their actions as “intervening” to prevent or address risk of or actual harm. In conjunction with concerns over women’s health, respondents further illuminated the “why” of their actions by revealing direct experiences of partner abuse.

Theme 3: Direct Experience of Partner Abuse Shapes Nurses’ IPV-Related Attitudes and Behaviors

Direct abuse by nurses emerged as influencing nurses’ IPV-related responses to a great extent. Two nurses shared their own experiences, the mental health consequences, and how it informed their attitudes and responses toward IPV in their patients. Lily observed,

When you were in an abused [an abusive situation], you have a better chance to say something to somebody who is going through that rough time.

Lily reflected further on her ability to assist others to address violence in their lives but not in her own, referencing her failure to seek mental health services, though she knew she needed support:

Funny, I was able to help them [patients experiencing IPV] but I couldn’t do it to myself . . . We are slow to grasp . . . We don’t consult psychologist . . . We stay with the stress [of violence] until it kills us. Even we learned women [disclosing she was abused by her husband and divorced him after 25 years of abuse].

Embedded in Lily’s account, apart from admitting her own experience of extended partner violence, is the recognition that if “learned women” cannot
seek help, what about women who are not as well educated, who lack independent means?

Similarly, Tumelo captured the isolation, depth of pain, and associated depression she experienced when undergoing IPV, expressing how she also “sat on” or suppressed her emotions, considering suicide as an option:

It was so difficult. I would sit on the pain. I sit and keep quiet with it. My only option was to think of killing myself. I was depressed a lot. I was admitted [to hospital] for depression.

In conversations with nurses, the role of the police, and nurse perspectives on their willingness to address IPV came to the fore, providing additional motivation for providers to respond.

**Theme 4: Weak Police Response to IPV Places Pressure on Nurses to Respond**

Nurses repeatedly mentioned the failure of the police in matters of domestic violence as problematic. By implication, women would go to the health system where they could feel more confident about receiving some assistance. Inaction by the police was cited as a rationale for nurses to act—to fill a yawning gap created by police authorities. Noncedo indicated that police actions were both delayed and wanting:

Women need to be protected by the police but people would call the police and [the] police would come after three hours when somebody is already been beaten. (Noncedo)

She continued, highlighting the tendency of police to instruct women to return to abusive homes and take up their roles as compliant wives:

Women go to report to the police and they [police] tell them [the women] “Go back [home], it’s a family issue, and talk about it.” They tell them “please be obedient to your man.” (Noncedo)

Sister Sarah remarked on the lack of importance with which government and police services seemed to consider IPV:

I think the fact that there is not a lot being done shows that it [violence against women] isn’t being taken seriously . . . I don’t think they [the police] see it as very important. They don’t take it seriously, and I feel like . . . they should . . .
It is not seen as a priority . . . The police think that they are above the law . . . training would really help. Training them on intimate partner violence and how they should respond.

One nurse noted that violence survivors are made to feel “stupid” when they reported partner abuse to the police, which may further victimize women, making them less likely to seek protection orders and report abuse:

[The government should] strengthen the laws to hold perpetrators accountable, it sends out the wrong message if they are released. Then the women can feel empowered to report the violence. Otherwise they don’t see the point. I don’t know if the police also perpetrate violence because when you report it they just laugh. I don’t know how the government should address this—because they make you look stupid and make you feel as if you are fighting a losing battle [when you report IPV]. (Khotso)

Additional victimization of women by police services in South Africa and re-victimization (occurring when women retold their experience of abuse to police or others and re-experienced trauma) were reported. This was identified across interviews as typical and worrying, leading nurses to again express concern over the health effects of patients who remained in abusive partnerships, while providing another motivational factor for health professionals to step into the breach.

Discussion

In this exploratory study, we did not enter the research setting with a hypothesis or set of assumptions. Rather, we sought to capture what naturally emerged from the data generated. In probing the “how” of provider responses, we sought to map, capture, and identify patterns in respondents’ actions and behaviors. These consistent accounts gave rise to a clear phenomenon taking place in these public health facilities, that is, how Johannesburg nurses without DoH guidance identify and address violence perpetrated by the intimate partners of their female patients. Findings suggested that there was a generally standard health provider response to violence in female patients occurring in Johannesburg that was quite well organized and followed a largely uniform pattern.

In employing “talking” to engage patients, probing to ascertain abuse, referral to social workers (more scarce and difficult to access in the public health sector), and treatment of any injuries, nurses marshaled their many years of training, experience, and knowledge to address violence in women
patients. Yet only 5 were trained in IPV treatment, and nurses were unsup-ported in this role. They lacked the requisite policy guidance, protocols, and IPV training specifically. Strikingly, all 25 respondents communicated a desire for training to better respond. Only 1 nurse in the sample expressed irritation at having to address violence in female patients. Three separate interviewers conducted interviews, and this willingness emerged across the accounts. We were surprised by this, given nurses’ demands. Interviewers had to wait to interview nurses at the end of their long shifts and return frequently to try to conduct interviews, due to the unrelenting work pace in the public health system.

In addition to considering nurse responses to IPV in patients, this research aimed to do more than describe the phenomenon, it sought to interpret nurse motivations and generate an explanation underlying what emerged from the empirical data on nurses’ behaviors, that is, why did nurses take active steps to treat violence in women? What motivated their actions in this regard? Together, the “how and the why” offered a more complete picture of what was taking place in health facilities. Health provider motivations, as the quotations indicate, were based on a combined, complex rationale that included these factors: (a) significant fear for the patients’ health and welfare, and nurses’ sense of professional obligation to respond; (b) patients’ expectations that if they go to the health system, they will receive care, treatment, and support for IPV; (c) nurses’ experiences of direct partner abuse; and (d) a recognized deficit in the response to IPV by the South African Police Services. All of these rationales informed the motivations underlying nurses’ attitudes and behaviors.

In terms of risks to patients’ health, nurses engaged with female patients in Johannesburg who were more likely to be unemployed, economically dependent, HIV positive or at risk of acquiring HIV, and less likely to afford social welfare organizations or services (shelters, for example). Nurses were aware that social welfare organizations in South Africa were few in number (compared to high-income countries such as the United States). In sharp contrast, the health system was known. It was recognized and familiar to women, especially poorer women, with nurses indicating it was likely to be a first port of call. Nurses recognized that it would be “acceptable” for a woman to go to the hospital and could reasonably be done without raising questions or objections by an abusive partner. Also, but for the transport fare, it would be free. Nurses, as indicated, saw visible signs of injury and threat of harm in their patients, triggering a sense of professional duty.

Nurses’ actions were also grounded in a context where police services were viewed as ineffectual: where police were part of blaming or re-victim-izing women, sending them back to abusive partners. Nurses recognized the
threats to women’s health and well-being, given these realities. Through their narratives, nurses were indicating strongly that in light of these ineffective state responses to violence against women, their roles in engaging the problem and meeting women’s needs became magnified and more urgent.

Against that backdrop, the theme of patient expectation and nurse response came into sharper focus. Nurses’ attitudes toward violence against women and IPV were shaped by their full understanding of the problem and the scale of IPV in South African women. Nurses expressed a recognition of the potentially deep and long-lasting health implications of IPV. They did not see themselves as “standing apart” from this problem, whether they had experienced IPV in their own lives or at a distance. They saw their communities, their social fabric, their country as interlaced with such violence.

In this research, nurse actions were placed within the complex context of the South African public health system: a stressed, reforming health system, yet also a dynamic, “live,” and fluid system, one that has relied on the innovation and responsiveness of real people, who identified themselves as “givers of care” and “providers of health” with the more expansive meaning attached to those oft-used terms. This is a system where considerable innovation has historically occurred, for example, in relation to rolling out HIV prevention, treatment, care, and support services on the back of this same reforming public health system (Sprague, 2009; WHO, 2003). The same was true of the early HIV epidemic in South Africa. Although deemed by the DoH and the state as too costly to treat until 2004, clinicians and nurses had begun to treat and support patients with HIV in 1999 (Heywood, 2003; WHO, 2003).

In the case of IPV, like HIV, to an uncanny extent, these nurses have also effectively placed themselves at the heart of the IPV response. The respondents were not turning away or dismissing patients who sought services. On the contrary, although unsupported, they were routinely attending to the physical and psychosocial needs of their female patients, which they perceived as fully in line with their professional obligations.

**Study Limitations and Agenda for Future Research**

These participants may not be representative of all South African nurses. Our sample of five public health facilities was small, and research relied on self-reports that may amplify issues of immediate concern during the interview. In addition, the study was located in urban Johannesburg, not in rural, poorly resourced areas where providers might have less time to address IPV in female patients. In addition, we did not interview patients, nor did we interview doctors, social workers, or HIV counselors who might have different
experiences, accounts, and responses of IPV among female patients in the health system.

However, these actions and motivations were cited by participants across health facilities that spanned geographic locations from northern to southern and central Johannesburg. Because we purposively sampled nurses who were willing to volunteer for our study without reimbursement, it is probable that our sample is comprised of nurses who might be more willing to engage with IPV. To explore the responses of “average” nurses, future studies should sample a random portion of nurses from varied facilities. Based on our team’s previous research (Hatcher et al., 2013), we anticipate the possibility that providers might, in some cases, be hesitant to address violence, due to competing responsibilities, confusion around what is expected of them, and overwork. However, Joyner and Mash (2012) gauged primary care provider willingness to address IPV in Cape Town, finding that practitioners would be willing to conduct violence screening if given the necessary tools and training to do so (Naidoo et al., 2013).

Nurses in our study maintained the greatest degree of contact with patients and are widely viewed as comprising the backbone of South African health care (Kim & Motsei, 2002). The vast majority of South African nurses are Black and share some similar social-demographic characteristics with female patients, though not all. In our qualitative study in urban Johannesburg, nurses acted out of professional obligation, and patients actively sought care from nurses. We envisage IPV responses by nurses and health care professionals may be roughly similar across the country—although more representative work would be required to confirm this hypothesis. Social workers and psychologists in South Africa are severely under-represented in the South African public health system (Coovadia et al., 2009; Lund, Kleintjes, Kakuma, & Flisher, 2010). In the future, trained nurses should work alongside mental health professionals to offer counseling and psychosocial support for IPV. This research demonstrated that there has been a health system response unfolding in the country by these, and likely other, nurses—and possibly other health personnel—who have viewed IPV as a public health threat warranting their consistent and concerted attention, even if un sanctioned by the DoH.

In LMIC settings, research could be conducted to see whether similar patterns prevail, in terms of how health providers address IPV or not, and what motivates them to act or refrain from acting. Research with different types of health professionals could be conducted to investigate whether responses to IPV vary by health cadre and may be gendered. Research is needed on whether training of health providers in LMICs and the development of IPV protocols and guidelines is occurring. More systematic data on IPV trends in LMIC health systems are also needed.
Conclusion

In this third wave of a global response to IPV, the role of health systems and health providers has increasingly been recognized. South Africa’s legal framework, its progressive Constitution and DVA, have been fully in line with international norms that prohibit IPV. The South African government has established clear obligations for the police, legal, and justice departments to address IPV, yet there has been no corresponding obligation for the public health system broadly, and no guidelines or protocols to direct health providers to date (Government of South Africa, 1996, 1998). Evidence demonstrated that South African women who experienced IPV sought health care with more frequency than nonabused women (Gass et al., 2010). Despite indications of provider willingness to screen, it had not been established whether nurses and other health professionals had already begun to actively address IPV in female patients in the South African health system, generating the rationale for this study.

Qualitative research with 25 nurses in five public health facilities in Johannesburg found nurses across the five different hospitals, clinics, and wards actioned similar interventions, including routine “engagement”—through talking, counseling, probing—as well as case finding, treatment of injuries, and referral of women, primarily to social workers on-site, in facilities where social workers were available. Through the responses of nurses and social workers, the public health system in Johannesburg has been serving as an important venue to address IPV, promote, and protect the health of South African women. Yet nurses were not supported or guided by the DoH. Given the absence of guidelines and that nurses were going beyond their required duties, nurses’ attitudes toward IPV will continue to impact whether and how women are treated for IPV in the South African public health system. The South African response has policy and practice implications for other countries.

Policy and Practice Recommendations

WHO has led efforts to rely on the evidence base to make more systematic clinical and policy recommendations for addressing IPV, globally (Garcia-Moreno et al., 2015). In 2013, WHO released new clinical and policy guidelines (WHO, 2013b). Universal screening for violence against women in the low- and middle-income countries was not recommended, due to lack of evidence and insufficient resources. In developing countries, such as South Africa, there is a dearth of published data about the existing responses of health providers to high levels of IPV (Kim & Motsei, 2002). Accordingly,
assumptions have been made that human and financial capacity is too limited to address IPV in poorer-resource settings, where health provider actions are poorly documented and understood (WHO, 2013b). This research indicates that those assumptions may be incorrect due to the factors documented here and potentially others in different settings. In actual fact, policies or practices guiding responses to IPV in LMICs, whether against women or men, may be under-documented and fail to feature in published studies in international journals, the majority of which are housed in high-income countries. They might also be ad hoc. Studies such as this one underscore the need for additional research and documentation of LMIC efforts to address IPV, including data-capturing of statistics on violence by health systems, together with data analysis and utilization, to inform such responses. Alongside data systems and research, these findings highlight the need for comprehensive guidelines to be developed by national authorities, in consultation with health personnel and other stakeholders. This fully aligns with WHO 2013 recommendations setting forth minimum requirements for health providers—in all countries—to be trained to ask patients about violence, including the addition of training in IPV and sexual assault to basic professional education curricula and as part of continuing education for providers who are the most likely to come into contact with women (WHO, 2013b).

Health providers who undergo training also require monitoring, evaluation, and feedback on performance, such that individuals can learn and develop their skill sets, as these health providers requested. Health systems should align with WHO recommendations by offering private settings for discussions between patients and providers to take place that are confidential. Referral systems to refer patients to lay counselors, social workers, psychologists, or other mental health professionals, and social service providers should also be in place (WHO, 2013b).

Technical support for LMICs to produce protocols, clinical guidelines, and training programs may be required, and should be prioritized by international health and funding agencies, given the ill health burden associated with IPV (WHO, 2013a, 2013b). These interventions, as well as ongoing research and data collection, remain essential to govern and locate health provider actions to address violence in patients firmly within the framework of a public health response. Such steps would enable a more robust, effective response to IPV, while meeting the mental and physical health needs of those who experience IPV.

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1. Reports of psychological abuse were not collected.

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