'They can't report abuse, they can't move out. They are at the mercy of these men': exploring connections between intimate partner violence, gender and HIV in South African clinical settings

Courtenay Sprague
University of Massachusetts Boston, courtenay.sprague@umb.edu

'They can't report abuse, they can't move out. They are at the mercy of these men': exploring connections between intimate partner violence, gender and HIV in South African clinical settings

Courtenay Sprague, Abigail M. Hatcher, Nataly Woollett, Theresa Sommers & Vivian Black

Published online: 27 Oct 2015.

Submit your article to this journal 🖉

View related articles 🖉

View Crossmark data 🖉

Routledge
Taylor & Francis Group

'They can't report abuse, they can't move out. They are at the mercy of these men': exploring connections between intimate partner violence, gender and HIV in South African clinical settings

Courtenay Sprague[a,b,c], Abigail M. Hatcher[c,d], Nataly Woollett[c], Theresa Sommers[a] and Vivian Black[c]

[a]Department of Conflict Resolution, Human Security & Global Governance, McCormack Graduate School of Policy and Global Studies, University of Massachusetts Boston, Boston, USA; [b]Department of Nursing, College of Nursing and Health Sciences, University of Massachusetts Boston, Boston, USA; [c]Wits Reproductive Health and HIV Institute, Faculty of Health Sciences, University of the Witwatersrand, Hillbrow Johannesburg, South Africa; [d]Bixby Center for Global Reproductive Health, University of California San Francisco, San Francisco, USA

ABSTRACT

This qualitative study captured South African female health provider perspectives of intimate partner violence in female patients, gender norms and consequences for patients' health. Findings indicated female patients' health behaviours were predicated on sociocultural norms of submission to men's authority and economic dependence on their partners. Respondents described how men's preferences and health decision-making in clinics affected their patients' health. Adverse gender norms and gender inequalities affected women's opportunities to be healthy, contributing to HIV risk and undermining effective HIV management in this context. Some providers, seeking to deliver a standard of quality healthcare to their female patients, demonstrated a willingness to challenge patriarchal gender relations. Findings enhance understanding of how socially-sanctioned gender norms, intimate partner violence and HIV are synergistic, also reaffirming the need for integrated HIV-intimate partner violence responses in multi-sector national strategic plans. Health providers' intimate knowledge of the lived experiences of female patients with intimate partner violence and/or HIV deepens understanding of how adverse gender norms generate health risks for women in ways that may inform policy and clinical practice in South Africa and other high-HIV prevalence settings.

Introduction

While maternal mortality has declined by 45% since 1990, maternal deaths have remained disproportionately high in sub-Saharan Africa (World Health Organization [WHO] 2014). HIV has been a leading cause of maternal mortality in sub-Saharan Africa, with upwards of 15% HIV prevalence in women of reproductive age in eight southern African countries (Hogan

et al. 2010; WHO 2014). In South Africa, HIV has contributed to an estimated 40% of maternal and child mortality (Black, Brooke, and Chersich 2009; South Africa Every Death Counts Writing Group 2008). HIV prevalence is 23–43% in South African women of reproductive age (18–44 years) and has remained elevated over the last decade (Shisana et al. 2014).

Intimate partner violence also poses a primary challenge to women's health. Globally, 30% of women, and in Africa, 37% of women, have experienced intimate partner violence – defined as psychological, sexual or physical harm, whether attempted or completed, by a current or previous partner (WHO 2013). Intimate partner violence has been an important correlate of HIV risk, particularly for South African women (Dunkle and Decker 2013; Maman et al. 2002). An estimated 31–55% of women have experienced intimate partner violence in South Africa (Dunkle et al. 2004; Gass et al. 2010). The negative health consequences of such violence have been well established. These span extensive injuries, chronic pain, increased risks of sexually transmitted infections, including HIV, severe mental health consequences, suicide and homicide (Abrahams et al. 2009; Ellsberg et al. 2008).

HIV-intimate partner violence linkages

Systematic reviews have found intimate partner violence to be a risk factor for HIV (Campbell, Baty, and Ghandour 2008; Li et al. 2014). This is because violence, including forced sex, can lead to micro-tears in women's vaginal tissue and abrasions that substantially increase women's risk of HIV acquisition (Blair, Paxton, and Kamb 2012). The evidence on these correlates is mixed, however. United States studies, where HIV prevalence is < 1%, have consistently indicated no greater risk for intimate partner violence in women with HIV (McDonnell, Gielen, and O'Campo 2003; McDonnell et al. 2005). In contrast, four studies in sub-Saharan Africa demonstrated a significantly higher risk of intimate partner violence for women who were HIV-positive (Campbell, Baty, and Ghandour 2008).

Maman et al. (2002) compared reported intimate partner violence between HIV-positive and HIV-negative women less than 30 years of age in Dar es Salaam, finding that intimate partner violence was 10 times higher in women with HIV compared to HIV-negative women. Fonck et al. (2005) found that HIV-positive women in Nairobi had a twofold increase in partner violence over their lifetimes. Dunkle et al. (2004) found South African women with experiences of partner abuse who attended antenatal care clinics in Southwestern Townships (Soweto) had a higher risk of acquiring HIV, even when considering their own risk behaviours (e.g., number of male partners, non-primary male partners, transactional sex, substance use and lack of condom use). Strong evidence of links between HIV and intimate partner violence were reported by Jewkes, Dunkle, Nduna et al. (2006), who found that HIV disclosure may lead to partner violence and that partner abuse may lead to HIV transmission in their study with South African women in the peri-rural Eastern Cape province. Hatcher et al. (2014; see also Shamu et al. 2014; Mulrenan et al. 2015) investigated HIV-intimate partner violence interactions among pregnant South African women, finding that HIV diagnoses triggered relationship conflicts, resulting in increased risk of partner violence – pointing to a bi-directional relationship between HIV and partner violence, with distinct pathways linking them directly and indirectly.

Social-cultural gender norms facilitating intimate partner violence and HIV

Gender norms, or the beliefs and actions that define relations between men and women, influence intimate partner violence risk and HIV risk (Gibbs et al. 2015; Jewkes, Dunkle, Koss et al. 2006; Jewkes, Nduna et al. 2006; Jewkes, Sikweyiya, and Morrell 2011). Evidence from South Africa has indicated that men's higher socioeconomic status may lead to a sense of male sexual 'entitlement', whereby forced sex is facilitated by women's economic dependence on their partners (Boonzaier 2005; Strebel et al. 2006).

Relationship power, control and infidelity by male partners have been identified as factors enabling domestic violence and HIV acquisition in women (Dunkle et al. 2004; Walker and Gilbert 2002). Kalichman et al. (2005) wrote that women experiencing partner violence were 'often unable to negotiate life-saving strategies in HIV prevention' (304). Conversely, recent studies have found changing gender roles created tension in relationships, particularly when men's power was perceived as threatened by women's employment or earnings (Jewkes and Morrell 2012; de Lange, Mitchell, and Bhana 2012; Pettifor et al. 2012).

Health providers have long been in a position to influence health beliefs and behaviours through structured daily encounters with patients. Nurses have played a leading role in healthcare delivery in South Africa and are in a position to influence the healthcare and health behaviours of their patients, including abused women (Marks 1994; see also Annandale and Hunt 2000). Indeed, research indicates that women who experience intimate partner violence in South Africa (like other settings) seek healthcare from the public health system more frequently than women who have not been abused (Gass et al. 2010; WHO 2013). Perhaps because no clinical guidelines on intimate partner violence have been developed in South Africa to date, there has been little published research on health provider perceptions of intimate partner violence in their female patients in this high-HIV prevalence setting (Joyner and Mash 2012; Kim and Motsei 2002). This includes risks or consequences of partner abuse for patients' health, HIV-intimate partner violence interactions and how providers have perceived gender norms vis-à-vis partner abuse (Sprague et al. 2015). This gap in the literature provided the study rationale. Such research adds to the evidence base of prevention interventions. It enhances our understanding of the role of public health systems and social processes in shaping gender relations and intimate partner violence-HIV responses, which may be used to inform policy and clinical practice in South Africa and other countries, as relevant (Cluver et al. 2014; Hargreaves and Boler 2006; Pronyk et al. 2006).

Study aim and questions

The present study aimed to engage health provider perspectives of intimate partner violence in their female patients, perceptions of gender norms and potential consequences for patients' health. Exploratory research questions included: (1) What do healthcare providers view as sociocultural or behavioural factors associated with, or underlying, intimate partner violence in female patients and (2) How do providers describe and interpret sociocultural norms, behaviours, gender roles and potential consequences for patients' health, including HIV?

Setting and methods

A significant number of the 10.5 million people in Johannesburg are classified as poor (42%), with high levels of unemployment (23%), reliance on public health services (78%) and an estimated HIV prevalence of 12.4% (Gauteng Provincial Department of Health 2011; Statistics South Africa 2014).

Sites and sampling procedures

This was a qualitative study employing in-depth interviews (IDIs) to solicit health provider views. In-depth interviews have been viewed as highly appropriate for sensitive research subject matter, including in clinical settings, where validity depends on gaining participants' trust (Bickman and Rog 1998; Elbogen 2002). Ethics approval was granted by University of the Witwatersrand (M130671) and University of Massachusetts Boston (2,013,133).

In-depth interviews with 28 healthcare providers were conducted from August 2013 to March 2014 in five public health facilities in Johannesburg. Memos were kept to capture observations. Research facilities and sites were purposively selected to offer a diverse economic and geographic representation of public clinics and hospitals – from north to south across the city and surrounding suburbs. Two clinics were selected because they served the needs of women exclusively. One served a community living in a densely-populated slum area, thus offering care to poorer patients. In contrast, another was a tertiary facility located in the wealthy northern suburbs. One hospital served patients south of the city. Clinical settings were chosen for their differences in size, pace, organisation and service delivery, including: one hospital, two clinics, one academic teaching hospital and a maternal-child health centre.

We used snowball sampling to identify research participants (health providers in this study), in each facility. They were selected purposively as a cadre due to their location in health clinics where they treated the physical effects of intimate partner violence and HIV in patients, and because of their familiarity with social-cultural practices and social norms affecting women's health. Indeed, most providers came from the same communities, though they had secure employment, unlike patients. Of 28 female respondents, 5 had received training in intimate partner violence through a pilot intervention.

Access to clinics occurred via a doctor, who introduced the researchers and explained the study purpose and recruitment procedures to head nurses in each facility. The first author led recruitment and data collection, with continuous liaison between researchers and head nurses in each ward to recruit participants. Interviews were digitally-recorded and transcribed in full by the research team. Three of the interviews took place in isiZulu and were transcribed into English by the interviewer; the remainder took place in English. Four participants declined voice recording, thus researchers took extensive notes and typed them immediately following interviews. Interviews averaged one hour in duration, though some exceeded 90 minutes. Three trained female qualitative researchers, including the first author, conducted the interviews. These were extensive face-to-face IDIs, where emphasis was placed on flexibility to allow health providers to share their experiences freely (Robson 1993). A semi-structured guide had four main sections and followed a uniform format. The guide probed: (1) nature, type and patterns of intimate partner violence in patients, (2) social, cultural and behavioural factors perceived as underlying intimate partner violence in

patients, (3) health consequences for patients, including HIV, and (4) attitudes and actions of providers towards intimate partner violence in patients.

The primary data captured were the narratives, memos and providers' sociodemographic data. Data were managed and coded in both Microsoft Word and Excel in an encrypted, password-protected computer. We analysed and interpreted data through content analysis (Creswell 2013). Key members of the team identified dominant themes independently from the narratives, which were checked by a third. Two members then coded broad themes using a coding structure emerging from the transcripts. Major themes identified across respondent accounts were verified by one member for consistency and accuracy. All members of the team discussed, agreed and approved final findings.

Findings

The majority of respondents were Black nurses aged in their 40s working in antenatal care wards (Table 1). Eight (29%) disclosed personal experiences of intimate partner violence, reflecting national prevalence estimates (Gass et al. 2010). Disguised names were assigned to ensure anonymity. The trained participants are identified with (T). In the discussion section, we consider whether trained nurses exhibited substantial differences in attitudes, knowledge or likelihood to address intimate partner violence, compared to untrained participants.

Culture supports gender hierarchies and facilitates the normalisation of partner abuse

The first goal of the research was to explore those factors providers viewed as facilitating intimate partner violence in their patients. A shared dominant perception emerged across the sample of participants, namely that adverse gender norms associated with culture allowed for intimate partner violence in female patients to be socially accepted and normalised. This first theme offered a view of the interconnected dimensions of gender relations and the social sanction of partner abuse.

Table 1. Participant characteristics.

Participants ($n = 28$)	N (%)
Ward	
Antenatal care	19 (68)
Termination of pregnancy	5
Maternity	1
Obstetrics and gynecology	3
Race	
Black	27 (96)
White	1
Role	
Nurse	24 (86)
Management	2
Clinical social worker	1
Physician	1
Average age (estimated)	43
Disclosed direct experience of intimate partner violence	8 (29)
Disclosed indirect experience of intimate partner violence	28 (100)

Depicting gender hierarchies, nurse Nelly (T) indicated men are seen as 'favoured' over women, which she attributed to culture: 'When you look at a culture, our culture, it favours men, it will always put men up there … and then put women under the men.'

Culture as a rationale for partner violence was affirmed by Gugu (T). She identified the role of socialisation in enabling punishment of women and the cultural practice of *lobola*, in which the groom offers payment to the bride's family. This was seen as conferring 'ownership':

> It is culture. The man is treated as superior …. Most power is given to the man. He is socialised he has a right to punish the woman. It is also because our parents have accepted *lobola* that leads to violence. The person feels he owns you.

Gugu (T) emphasised the socialisation of women to be obedient wives who accept abuse:

> When you go home and complain [about intimate partner violence] they [parents] say 'ah you are married'. They think you must go back to your husband. The women feel they have nowhere to [run] … so they sit and accept the abuse. So it is also about [how] women are socialized … they must respect men, how to be obedient in marriages.

Gugu (T) also stressed the acceptability of beating a woman, in relation to expected 'gender roles', for example cooking:

> They feel it is normal [beating a woman partner]. It is acceptable … they [women] think the man has a right to beat them if they didn't cook in time or undertake their gender roles.

Respondents sketched an increasingly clear picture of the lower-social-status of women. Abuse was seen as an instrument men routinely employed to attain a desired outcome.

Traditional gender relations together with economic hardship make women vulnerable to abuse

The second resounding theme across respondent accounts was economic hardship, rendering women vulnerable to partner abuse. Economic dependence has been associated with research on intimate partner violence in different contexts (Benson and Litton Fox 2004; McDonnell et al. 2005). The fresh angle captured here was the connection communicated between economic dependence and direct and indirect effects on women's health in a context of high-HIV prevalence. In the statements presented, gender norms, unemployment and economic dependence were viewed as strongly limiting women's health behaviours.

Queen stressed: 'Many women [partners] are dependent. They can't report abuse, they can't move out …. They don't have means.'

Precious articulated these same links, while speaking to the complexity of extracting women from abusive relationships permanently:

> It's not easy for them because they are at the mercy of these men. Unemployment is so rife. So she is at the mercy of the men. It's very hard to tell them just to move away from their relationship because they depend on it. And I don't have the social grants for them. Domestic violence is a very complicated thing, because those people they never move out. They move out and go back to the men …. That man was their only hope [for economic survival].

Significantly, Funi communicated that social norms were changing:

> They [men] are the controlling bodies in our society and in our homes. So now once that is taken away from them [referring to women working and supporting the family, men not having financial control], they start behaving strangely [referring to abuse].

Ntombi (T) remarked that financial independence could be protective:

> [If] she is financially independent, I believe a certain level of violence can be eliminated or minimized …. Education empowers you to be able to stand for your rights …. I've never come across educated women who are abused.

Associations that service providers made between culturally-endorsed gender hierarchies and economic factors enabling abuse were emerging. Reference was also made to shifting gender relations and perceived influences of education and employment for women as mediators (see Pettifor et al. 2012). Health risks for women experiencing recurrent physical and emotional abuse were largely in the background. These moved to the foreground in subsequent themes.

Men's sexual preferences and resulting practices and norms create tangible risks to women's health

A second goal of the research was to explore how service providers describe and interpret sociocultural norms, behaviours, gender roles and potential consequences for patients' health, including HIV. This third dominant theme communicated strongly among the health providers served to underline how the gender norms previously described pressured women to meet men's sexual preferences in ways that undermine women's health. Provider statements elucidated men's influence on women's health behaviours: women were expected to adhere to men's sexual desires, introducing HIV and other health risks.

Dikeledi indicated demands for sex where women's compliance was expected:

> Men are superior. So, if I [the man] do 1, 2, 3 … I can demand sex the way I want it. I can demand whatever I want, the way I want it. So they [women] take it as their norm [submitting to abuse].

Queen explained the cultural norm around 'dry sex' (see Scorgie et al. 2009). She narrated how men dictate to women that their natural sexual response is undesirable, leading women to try various remedies to keep themselves 'dry' to please their partners:

> The partners will always say to them, 'you are wet, you are cold' so the women will want anything they can put in the vagina to keep it dry …. [O]ne lady's … partner said 'you are wet, go and wash'. If you think of [the] sexual act, when you get excited, what happens?

Similarly, Hettie (T) communicated that sex was largely determined by men: 'Hmm, [men are] controlling, they want sex by force, even if the partners do not agree on sex.'

The implication was that if women disagreed, they would face abuse and/or lose their partners and what little economic security they had, potentially resulting in abandonment.

In complying with social convention, women were denying, not only their sexual desires, but their health needs. Moreover, in some cases, women were submitting to practices that compromised their health and welfare. Theme four, below, highlights additional health dimensions for women with HIV.

HIV and intimate partner violence are interconnected

HIV-positive women require access to uninterrupted combination antiretroviral therapy for optimal health and survival (United Nations Joint Programme on HIV/AIDS 2014). In the fourth major theme, providers consistently pointed to a lived reality in which HIV and intimate partner violence were intertwined and relational. They saw patients blamed for

introducing HIV into the family and women's fears in disclosing HIV potentially affecting both adherence and exposure to intimate partner violence when they disclosed to partners. HIV was described as prompting intimate partner violence.

Gugu (T) observed:

> The only thing that would stir their violence is [HIV] disclosure. Because women are blamed for spreading HIV. This was seen as inciting the partner to commit violence against female patients.

Margaret (T) remarked that women were viewed as introducing HIV into the household:

> Women … discovering they are HIV-positive are also emotionally abused … it's interpreted they are the one that brought HIV home, so they also bear the brunt [of partner abuse].

Nonkululeko discussed the need for HIV disclosure to ensure medication adherence. These consultations enabled nurses to identify patients experiencing abuse:

> After you have done the HIV test, you'll find the patient is not willing to disclose the status. When you advise 'it's important … to disclose to your partner …' she will give you reasons: 'I cannot because my husband will react in this way [violently]'. Then in that way, you can see there is a problem [of abuse].

References to partner violence were punctuated throughout provider accounts of HIV-positive patients. Precious observed:

> We see a lot of them [abused women]. Especially when the HIV issue came into the picture. We test the woman … most of the time we encourage them – to … disclose their status to their partners at home for the treatment to be effective.

Precious emphasised the reaction on the part of a male partner following HIV disclosure:

> [T]hey leave the clinic and go home [and] tell their partner. Their partner gets so angry … [one man] took the treatment and threw it away. So she came to us with black eyes … she had no clothes. He'd actually torn everything in the house. That's the violence we're dealing with and it's very difficult. Where do you start? Are you going to arrest that man? Where do you get him?

Here, men's actions were seen as inhibiting or harming women's health-promoting behaviours. A range of effects would result when women's health needs were denied. Yet the nature of those exact effects often remain obscured. Theme five, below, illuminated these more readily.

Men's decision-making has negative effects on women's sexual and reproductive health

Provider narratives uniformly indicated how the premise of men's superiority and control was extended to health decision-making in clinical settings where women were undergoing medical procedures, diagnostic testing or counselling.

Fikile discussed men's preferences related to condom use and women's inability to negotiate decisions directly affecting their health, including birth control:

> For me if you can … be pregnant this year, and then next year again you are pregnant, and then when we talk about birth control [she's] saying 'I'm still going to ask my husband'.

Fikile referenced a different husband's decision-making vis-à-vis birth control:

> [She] has just given birth … we are asking [her] about birth control [in future] …. She's telling us 'I'm still going to ask my husband'. And we are … worried … [because she delivered] a dead baby. We tell her, 'Now you have to make the decision whether you want birth control or not.' [She says] 'No, my husband won't allow it'!

Thabisa referred to the woman's need for a surgical delivery and the husband's prohibition of the procedure: '[The] patient was supposed to go for a Caesarean section because the baby was not proceeding … then the partner said: "no, my wife is not going to go there.'

She highlighted the fear evident in the woman's inability to take decisions for her own health:

> So you would see the wife was afraid of the husband … she doesn't make any decision on her own. Even if it's for the benefit of the baby or her – she still waits for the husband. So, if she could have died, then she would have died waiting.

In these narratives, the husbands were portrayed as the dominant decision-makers, wielding considerable power through coercion.

Female health providers intervene to challenge gender norms and assist patients experiencing intimate partner violence

The final dominant theme shared by participants allowed for a focus on providers as positioned subjects in the study. The narratives depicted a broad array of firm, direct actions taken by female providers to ascertain or address intimate partner violence or HIV and protect patients' health.

Queen advised her HIV-positive patient to use condoms:

> I said to her you don't owe nobody [an] explanation …. Don't be afraid of other people who don't know their status. … If you[r] partner says he can't [use a condom], he should know that you are going to use a condom because you are a positive. Use a condom to protect yourself!

Ntobisa's (T) patient, beaten by her husband and pregnant, was considering termination of pregnancy when Ntobisa interceded:I found her outside [the clinic]. She was still thinking about whether to book [termination of pregnancy procedure] but because I found her crying I could see that this is my client, I must intervene … I asked her if she would like a shelter.

Tandiwe's experience of intimate partner violence in her own marriage informed her understanding and guidance:

> Usually I advise them [patients experiencing partner violence], why don't you go to police? At least do something. Because one day, [he says] 'I will kill you, I will kill you' – [he] will end up killing you. So I usually advise them with police [matters], and will refer them to the social worker.

Lebo indicated how she communicated a patient's health needs to the partner, identifying abusers at the same time:

> Once a person says to me 'I'm not hungry', [I think] maybe she's scared to ask for food … I normally call in the partner just to see their reaction. I will tell him … 'she's in labour, she's hungry, she needs 1, 2, 3 and you must bring it now'. Then the way he would react back, I would see this one is abusive.

Discussion

Respondents perceived factors underlying intimate partner violence to be attributed to dominant sociocultural norms and economic factors in society, including the socialisation of girls towards marriage and cultural practices such as *lobola* (research questions with corresponding findings and potential mediators are shown in Table 2). All nurses, both trained and untrained, identified women's economic dependence on men as a central factor underlying partner abuse, with men's roles as 'providers' remaining central to their masculine identity.

Table 2. Research questions with corresponding findings and potential mediators.

Research question 1: What do providers view as sociocultural or behavioural factors associated with, or underlying, intimate partner violence in female patients?

Theme	Perceived factors stated as enabling intimate partner violence and health effects	Potential mediating influences
Culture supports gender hierarchies, facilitating the normalisation of partner abuse	Culturally-condoned ideas of gender hierarchies, practices (*lobola*), enforcing traditional gender roles (cooking), lower social status of women; social sanction of intimate partner violence	–*
Traditional gender relations, together with economic hardship, make women vulnerable to abuse	Dependent women are 'trapped'; lack of employment undermines women's autonomy; facilitates acceptance of abuse	Financial independence; employment; financial assistance (through government programs); education (stated and observed)

Research question 2: How do providers describe and interpret sociocultural norms, behaviours, gender roles and potential consequences for patients' health, including HIV?

Theme	Interpretation of how gender norms affect health and HIV	Potential mediating influences
Men's sexual preferences and resulting practices and norms create tangible risks to women's health	Timing, frequency of sex determined by men; women cannot say 'no'; dry sex increases HIV risk; unwanted pregnancy and HIV may result; stress and risk of self-harm to women	–
HIV and intimate partner violence are interconnected	Women blamed for bringing HIV into households; disclosure precipitates intimate partner violence; fear of intimate partner violence and abandonment may affect HIV disclosure and adherence	–
Men's decision-making has negative effects on women's sexual and reproductive health	Women lack autonomy over pregnancy intentions, medical procedures, condom use negotiation for pregnancy and/or HIV prevention	–
Female health providers intervene to challenge gender norms and assist patients experiencing intimate partner violence	Condom instruction; examine for intimate partner violence; determine health risks and needs; detect symptoms; counsel; refer	Health providers act to protect and advance women's health (stated and observed)

*Note: Signifies no mediating influences were stated or observed.

From provider statements, this was seen as a potential mediating influence, supported by the published literature (Boonzaier 2005; Pronyk et al. 2006).

Health providers described a complex relationship between HIV and intimate partner violence (Maman et al. 2000; Hatcher et al. 2014). Acts of threatened and completed abuse were seen as inhibiting or preventing women from HIV disclosure, ART adherence and social support, also found in US studies (Gielen et al. 2000). Providers described instances when men made decisions related to surgical procedures, contraception and condom use. Women's behaviours appeared predicated on social norms of female submission. Respondents referenced verbal threats, physical coercion, force and taunts used by men to maintain women's subservience around these key health decisions.

We found that health behaviour and decision-making were influenced by gender hierarchies rather than the health concerns of patients, aligning with research from other settings (Browner 1979; Moore 2010). Similar to recent South African literature (Gilbert and Selikow 2011; Jewkes, Sikweyiya, and Morrell 2011), gender inequalities came into sharp relief in

these clinical settings, seeming to profoundly shape women's health, particularly in women of reproductive age.

Changing the focus to the providers was revealing. Juxtaposing the 23 participants lacking prior training in intimate partner violence with the five trained nurses demonstrated that all had well-developed attitudes about intimate partner violence in patients and a degree of willingness to become engaged in intimate partner violence-related problems facing them, regardless of training. Two trends emerged. First, the trained nurses appeared capable of articulating the links between sociocultural norms surrounding gender and intimate partner violence, suggesting that training may increase provider ability to assess and understand partner violence. However, due to a small sample of five trainees, further formal evaluation would be needed to confirm this. Second, the eight participants with direct experience of intimate partner violence were particularly sensitised to it, with high knowledge and likelihood to address abuse in their patients. This suggests that, at a minimum, trained providers and those with direct experience may be more likely to address intimate partner violence in female patients.

All providers had in common an understanding of the cultural practices cited, and many identified with adverse gender norms. This indicated an accommodation, acceptance, resistance and rejection, which might be plotted as points along a spectrum of socially accepted gender norms, with the notion that individuals might move along the continuum. Providers could be seen as understanding and questioning gender relations, while at the same time seeking to deliver a 'standard' of quality healthcare to their patients. Health providers may thus be seen here as posing a potential mediating influence in shifting gender hierarchies related to health decision-making. In South African health systems, then, gender inequality might be further challenged by female health providers, thus potentially assisting in reconstructing accepted notions of gender.

In terms of limitations, the study relied on participant narratives. Studies of intimate partner violence have been found to be particularly influenced by interviewer effects (Jewkes 2002). At the same time, IDIs have been recognised as a highly important technique in research on partner violence because they allow for in-depth, intimate conversations (WHO 2001). Additionally, this research only sought female provider views, yet research on men's perspectives (patients and providers) could offer a more robust picture of gender relations, also indicating whether providers' willingness to challenge sociocultural norms might be associated with gender (Connell and Messerschmidt 2005; Odimegwu, Pallikadavath, and Adedini 2013). Future research could be conducted to see whether providers trained in engaging intimate partner violence would be more willing to contest gender hierarchies compared to a control group. The study relied on participants from urban clinics, which may have distinct characteristics from clinics in more rural settings. Additionally, we did not calculate inter-rater reliability of coding, which may limit the way that certain themes were identified in the data.

This research contributes to published literature in which gender is considered a social determinant of health (see Phillips 2005). Soliciting health providers' knowledge of the lived experiences of female patients with intimate partner violence deepens our understanding of ways adverse gender norms generate health risks for women, and ways in which potential mediating influences may offer leverage in changing gender relations. Research elsewhere has connected intimate partner violence to impecunious female partners (Lichtenstein 2005) but few sub-Saharan African studies have investigated provider perceptions of gender, lack

of economic independence, HIV, intimate partner violence and risks of ill health together (Kim and Motsei 2002). While other studies have focused on attitudes and pregnancy intentions, including those of men and those with HIV (Cooper et al. 2009; Moore 2010), gender inequalities, reproduced in public health settings here, rendered the links between social norms, processes and women's health more visible.

Such gender inequalities may continue to constrain access to treatment and management of HIV more than a decade after a hard-won national HIV treatment programme was introduced in the public health system. Provider perspectives inform understanding of women's freedom and opportunities to be healthy in a newly-democratic South Africa lauded for its commitment to the right to health for all (Government of South Africa 2013).

Conclusion

Findings suggest that the South African health system is a social institution in which gender inequalities persist to the detriment of women's health, particularly with respect to HIV risk and management. Health providers demonstrated a willingness to play a mediating role in influencing gender hierarchies vis-à-vis health decision-making. Intimate partner violence represents one manifestation of gender inequality, and despite its high prevalence in South Africa, conclusive data are sorely lacking (Government of South Africa 2013). National-level data from the Demographic and Health Surveys, and related evidence of links between HIV and intimate partner violence, must be recognised and incorporated into future policies and programmes in South Africa and other high-HIV prevalence countries. This includes National Strategic Plans on HIV and AIDS, which guide country responses (Crone, Gibbs, and Willan 2012; Government of South Africa 2012; Piot et al. 2015). Training health providers to recognise and address linkages between HIV and intimate partner violence, as well as underlying factors, may better protect women's health in South Africa and elsewhere.

Acknowledgments

Disclosure statement

References

Abrahams, N., R. Jewkes, L. J. Martin, S. Mathews, L. Vetten, and C. Lombard. 2009. "Mortality of Women from Intimate Partner Violence in South Africa: A National Epidemiological Study." *Violence and Victims* 24: 546–556.

Annandale, E., and K. Hunt. 2000. *Gender Inequalities in Health*. Buckingham: Open University.

Benson, M., and G. Litton Fox. 2004. *When Violence Hits Home: How Economics and Neighborhood Play a Role*. Rockville (MD): National Institute of Justice, US Dept of Justice. https://www.ncjrs.gov/pdffiles1/nij/205004.pdf

Bickman, L., and D. Rog, eds. 1998. *Handbook of Applied Social Research Methods*. Thousand Oaks, CA: SAGE.

Black, V., S. Brooke, and M. F. Chersich. 2009. "Impact of HIV Treatment on Maternal Mortality at a Tertiary Center in South Africa: A Five Year Audit." *Obstetrics & Gynecology* 114: 292–299.

Blair, J., L. Paxton, and M. L. Kamb. 2012. "HIV and AIDS in Women." In *Women and Health*, edited by M. Goldman, R. Troisi and K. Rexrode, 505–522. Boston, MA: Academic Press.

Boonzaier, F. 2005. "Women Abuse in South Africa: A Brief Contextual Analysis." *Feminism and Psychology* 15 (1): 99–103.

Browner, C. 1979. "Abortion Decision Making: Some Findings from Colombia." *Studies in Family Planning* 10 (3): 96–106.

Campbell, J., M. Baty, and R. Ghandour. 2008. "The Intersection of Intimate Partner Violence against Women and HIV/AIDS: A Review." *International Journal of Injury Control and Safety Promotion* 15 (4): 221–231.

Cluver, L., F. M. Orkin, M. Boyes, F. Gardner, and J. Nikelo. 2014. "Cash plus Care: Social Protection Cumulatively Mitigates HIV-Risk Behaviour among Adolescents in South Africa." *AIDS* 28: S389–S397.

Connell, R. W., and J. W. Messerschmidt. 2005. "Hegemonic Masculinity: Rethinking the Concept." *Gender and Society* 19: 829–859.

Cooper, D., J. Moodley, V. Zweigenthal, L. G. Bekker, I. Shah, and L. Myer. 2009. "Fertility Intentions and Reproductive Health Care Needs of People Living with HIV in Cape Town, South Africa: Implications for Integrating Reproductive Health and HIV Care Services." *AIDS & Behavior* 13 (Suppl 1): 38–46.

Creswell, J. W. 2013. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. Thousand Oaks, CA: Sage.

Crone, E. T., A. Gibbs, and S. Willan. 2012. *From Talk to Action: Review of Women, Girls, and Gender Equality in NSPs in Southern and Eastern Africa*. Durban: Health Economics and HIV Research Division, University of KwaZulu-Natal and ATHENA. http://www.salamandertrust.net/resources/heard-and-athena-gender-report.pdf

Dunkle, K., and M. Decker. 2013. "Gender-Based Violence and HIV: Reviewing the Evidence for Links and Causal Pathways in the General Population and High-Risk Groups." *American Journal of Reproductive Immunology* 69 (suppl 1): 20–26.

Dunkle, K., R. Jewkes, H. C. Brown, G. Gray, J. McIntyre, and S. D. Harlow. 2004. "Gender-Based Violence, Relationship Power, and Risk of HIV Infection in Women Attending Antenatal Clinics in South Africa." *The Lancet* 363: 1415–1421.

Elbogen, E. 2002. "The Process of Violence Risk Assessment: A Review of Descriptive Research." *Aggression and Violent Behavior* 7 (6): 591–604.

Ellsberg M., H. A. Jansen, L. Heise, C. H. Watts, C. García-Moreno, and WHO Multi-country Study on Women's Health and Domestic Violence Against Women Study Team. 2008. "Intimate Partner Violence and Women's Physical and Mental Health in the WHO Multi-Country Study on Women's Health and Domestic Violence: An Observational Study." *Lancet* 371 (9619): 1165–1172.

Fonck, K., E. Leye, N. Kidula, J. Ndinya-Achola, and M. Temmerman. 2005. "Increased Risk of HIV in Women Experiencing Physical Partner Violence in Nairobi, Kenya." *AIDS & Behavior* 9 (3): 335–339.

Gass, J., D. Stein, D. R. Williams, and S. Seedat. 2010. "Intimate Partner Violence, Health Behaviours and Chronic Physical Illness among South African Women." *South African Medical Journal* 100: 582–585.

Gauteng Provincial Department of Health. 2011. *Annual Performance Plan*. Pretoria: Author.

Gibbs, A., R. Jewkes, Y. Sikweyiya, and S. Willan. 2015. "Reconstructing Masculinity? A Qualitative Evaluation of the Stepping Stones and Creating Futures Interventions in Urban Informal Settlements in South Africa." *Culture, Health & Sexuality* 17 (2): 208–222.

Gielen, A., K. McDonnell, J. Burke, and P. O'Campo. 2000. "Women's Lives after an HIV-Positive Diagnosis: Disclosure and Violence." *Maternal and Child Health Journal* 4 (2): 111–120.

Gilbert, L., and T. Selikow. 2011. "The Epidemic in This Country Has the Face of a Woman: Gender and HIV/AIDS in South Africa." *African Journal of AIDS Research* 10: 325–334.

Government of South Africa. 2012. *National Strategic Plan on HIV, STIs and TB 2012–2016*. Pretoria: National Department of Health.

Government of South Africa. 2013. *MDG Country Report*. Pretoria: Author.

Hargreaves, J., and T. Boler. 2006. *Girl Power: The Impact of Girls' Education on HIV and Sexual Behaviour*. London: ActionAid International.

Hatcher, A. M., N. Woollett, C. Pallitto, K. Mokoatle, H. Stöck, C. MacPhail, S. Delany-Moretlwe, and C.

García-Moreno. 2014. "Bidirectional Links between HIV and Intimate Partner Violence in Pregnancy: Implications for Prevention of Mother-to-Child Transmission." *Journal of the International AIDS Society* 17: 19233.

Hogan, M., K. Foreman, M. Naghavi, S. Y. Ahn, M. Wang, S. M. Makela, A. D. Lopez, R. Lozano, and C. J. L. Murray. 2010. "Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis towards Progress on Millennium Development Goal 5." *The Lancet* 375: 1609–1623.

Jewkes, R. 2002. "Intimate Partner Violence: Causes and Prevention." *The Lancet* 359: 1423–1429.

Jewkes, R., and R. Morrell. 2012. "Sexuality and the Limits of Agency among South African Teenage Women: Theorising Femininities and Their Connections to HIV Risk Practices." *Social Science & Medicine* 74: 1729–1737.

Jewkes, R., M. Dunkle, J. Nduna, N. Levin, N. Jama, M. Khuzwayo, A. P. Koss, and N. Duvvury. 2006. "Factors Associated with HIV Sero-Status in Young Rural South African Women: Connections between Intimate Partner Violence and HIV." *International Journal of Epidemiology* 35: 1461–1468. doi: http://dx.doi.org/10.1093/ije/dyl218

Jewkes, R., K. Dunkle, P. Koss, J. B. Levin, M. Nduna, N. Jama, and Y. Sikweyiya. 2006. "Rape Perpetration by Young, Rural South African Men: Prevalence, Patterns and Risk Factors." *Social Science & Medicine* 63: 2949–2961.

Jewkes, R., M. Nduna, J. Levin, N. Jama, K. Dunkle, N. Khuzwayo, M. Koss, A. Puren, K. Wood, and N. Duvvury. 2006. "A Cluster Randomized-Controlled Trial to Determine the Effectiveness of Stepping Stones in Preventing HIV Infections and Promoting Safer Sexual Behaviour amongst Youth in the Rural Eastern Cape, South Africa: Trial Design, Methods and Baseline Findings." *Tropical Medicine & International Health* 11(1): 3–16. [PubMed: 16398750]

Jewkes, R., Y. Sikweyiya, and R. Morrell. 2011. "Gender Inequitable Masculinity and Sexual Entitlement in Rape Perpetration South Africa: Findings of a Cross-Sectional Study." *PLoS ONE* 6 (12): e29590.

Joyner, K., and B. Mash. 2012. "A Comprehensive Model for Intimate Partner Violence in South African Primary Care: Action Research." *BMC Health Services Research* 12 (1): 1–10.

Kalichman, S. C., L. C. Simbayi, M. Kaufman, D. Cain, C. Cherry, S. Jooste, and V. Mathiti. 2005. "Gender Attitudes, Sexual Violence, and HIV/AIDS Risks among Men and Women in Cape Town, South Africa." *Journal of Sex Research* 42 (4): 299–305.

Kim, J., and M. Motsei. 2002. "'Women Enjoy Punishment': Attitudes and Experiences of Gender-Based Violence among PHC Nurses in Rural South Africa." *Social Science & Medicine* 54: 1243–1254.

de Lange, N., C. Mitchell, and D. Bhana. 2012. "Voices of Women Teachers about Gender Inequalities and Gender-Based Violence in Rural South Africa." *Gender and Education* 24 (5): 499–514.

Li, Y., C. M. Marshall, H. C. Rees, A. Nunez, E. Ezeanolue, and J. Ehiri. 2014. "Intimate Partner Violence and HIV Infection among Women: A Systematic Review and Meta-Analysis." *Journal of the International AIDS Society* 17: 1–12. doi: http://dx.doi.org/10.7448/IAS.17.1.18845

Lichtenstein, B. 2005. "Domestic Violence, Sexual Ownership, and HIV Risk in the American Deep South." *Social Science & Medicine* 60: 701–714.

Maman, S., J. C. Campbell, M. Sweat, and A. C. Gielen. 2000. "The Intersections of HIV and Violence: Directions for Future Research and Interventions." *Social Science & Medicine* 50 (4): 459–478.

Maman, S., J. K. Mbwambo, N. M. Hogan, G. P. Kilonzo, J. C. Campbell, E. Weiss, and M. Sweat. 2002. "HIV-Positive Women Report More Lifetime Partner Violence: Findings from a Voluntary Counseling and Testing Clinic in Dar Es Salaam, Tanzania." *American Journal of Public Health* 92 (8): 1331–1337.

Marks, S. 1994. *Divided Sisterhood*. New York: St. Martin's Press.

McDonnell, K. A., A. C. Gielen, and P. O'Campo. 2003. "Does HIV Status Make a Difference in the Experience of Lifetime Abuse? Descriptions of Lifetime Abuse and Its Context among Low-Income Urban Women." *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 80 (3): 494–509.

McDonnell, K. A., A. C. Gielen, P. O'Campo, and J. G. Burke. 2005. "Abuse, HIV Status and Health-Related Quality of Life among a Sample of HIV Positive and HIV Negative Low Income Women." *Quality of Life Research* 14 (4): 945–957.

Moore, A. 2010. "Male Reproductive Control of Women Who Have Experienced IPV in the United States." *Social Science & Medicine* 70: 1737–1744.

Mulrenan, C., M. Colombini, N. Howard, J. Kikuvi, and S. H. Mayhew. 2015. "Exploring Risk of Experiencing Intimate Partner Violence after HIV Infection: A Qualitative Study among Women with HIV Attending Postnatal Services in Swaziland." *BMJ Open* 5 (5): e006907.

Odimegwu, C., S. Pallikadavath, and S. Adedini. 2013. "The Cost of Being a Man: Social and Health Consequences of Igbo Masculinity." *Culture, Health & Sexuality* 15 (2): 219–234.

Pettifor, A., C. Macphail, A. Anderson, and S. Maman. 2012. "'If I Buy the Kellogg's Then He Should [Buy] the Milk': Young Women's Perspectives on Relationship Dynamics, Gender Power and HIV Risk in Johannesburg, South Africa." *Culture, Health & Sexuality* 14 (5): 477–490.

Phillips, C. 2005. "Defining and Measuring Gender: A Social Determinant of Health Whose Time Has Come." *International Journal for Equity in Health* 4: 11. doi: http://dx.doi.org/10.1186/1475-9276-4-11

Piot, P., S. A. Karim, R. Hecht, H. Legido-Quigley, K. Buse, J. Stover, S. Resch, et al. 2015. "Defeating AIDS-Advancing Global Health." *The Lancet* 386: 171–218.

Pronyk, P. M., J. R. Hargreaves, J. C. Kim, L. A. Morison, G. Phetla, C. Watts, J. Busza, and J. D. H. Porter. 2006. "Effect of a Structural Intervention for the Prevention of Intimate-Partner Violence and HIV in Rural South Africa." *The Lancet* 368: 1973–1983.

Robson, C. 1993. *Real World Research: A Resource for Social Scientists and Practitioner- Researchers*. Oxford: Blackwell.

Scorgie, F., B. Kunene, J. A. Smit, N. Manzini, M. F. Chersich, and E. M. Preston-Whyte. 2009. "In Search of Sexual Pleasure and Fidelity: Vaginal Practices in KwaZulu-Natal, South Africa." *Culture, Health & Sexuality* 11 (3): 267–283.

Shamu, S., C. Zarowsky, T. Shefer, M. Temmerman, and N. Abrahams. 2014. "Intimate Partner Violence after Disclosure of HIV Test Results among Pregnant Women in Harare, Zimbabwe." *PLoS ONE* 9 (10): e109447.

Shisana, O., T. Rehle, L. C. Simbayi, K. Zuma, S. Jooste, N. Zungu, D. Labadarios, and D. Onoya. 2014. *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town: HSRC.

South Africa Every Death Counts Writing Group. 2008. "Every Death Counts: Use of Mortality Audit Data for Decision Making to save the Lives of Mothers, Babies, and Children in South Africa." *Lancet* 371: 1294–1304.

Sprague, C., N. Woollett, J. Parpart, A. Hatcher, T. Sommers, S. Brown, and V. Black. 2015. "When Nurses Are Also Patients: IPV and the Health System as an Enabler of Women's Health and Institutional Agency in Johannesburg." *Global Public Health* 1 (1): 1–15.

Statistics South Africa. 2014. *Mid-Year Unemployment Estimates*. Pretoria: Author.

Strebel, A., M. Crawford, T. Shefer, A. Cloete, N. Dwadwa-Henda, M. Kaufman, L. K. Simbayi, K. Magome, and S. Kalichman. 2006. "Social Constructions of Gender Roles, Gender-Based Violence and HIV/AIDS in Two Communities of the Western Cape, South Africa." *SAHARA-J: Journal of Social Aspects of HIV/AIDS* 3 (3): 516–528.

United Nations Joint Programme on HIV/AIDS. 2014. *The Gap Report*. Geneva: Author.

Walker, L., and L. Gilbert. 2002. "HIV/AIDS: South African Women at Risk." *African Journal of AIDS Research* 1 (1): 75–85.

WHO (World Health Organisation). 2001. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*. Geneva: Author.

WHO (World Health Organisation). 2013. *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Geneva: Author.

WHO (World Health Organisation). 2014. *Trends in Maternal Mortality 1990 to 2013*. Author: WHO.