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When nurses are also patients: Intimate partner violence and the health system as an enabler of women's health and agency in Johannesburg

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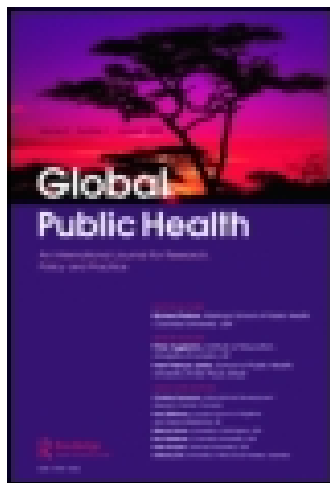
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When nurses are also patients: Intimate partner violence and the health system as an enabler of women's health and agency in Johannesburg

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While violence against women is a recognised global health problem, women's agency in marginalised settings is poorly understood, particularly in relation to health systems. We explored agency as a practical and theoretical construct through qualitative research among 20 nurses with direct or indirect experiences of intimate partner violence (IPV) in Johannesburg. Interviews conducted from August 2013 to March 2014 generated rich descriptions from respondents in five health facilities. Nurses' self-reported IPV matched national prevalence of 24–31%. Findings revealed the way in which agency is enacted by nurses, allowing them the economic means to leave abusive partnerships, yet disabling them from agency and health promotion in their workplace. At the same time, nurses expanded agentic possibilities for patients by enabling a national response to IPV within South African health clinics – one that is largely undocumented. We posit that nurses can serve as important agentic actors in public health systems in low- and middle-income country settings by assisting patients to address IPV, even in the absence of targeted training and guidelines. To ensure the health and well-being of women experiencing IPV, nurses should be supported by the health sector to respond skilfully to patients and to safely process their own experiences of violence.

Keywords: agency; intimate partner violence; health systems; South Africa; nursing

Introduction

What constitutes 'agency' for women who experience intimate partner violence (IPV) in marginalised settings? Is there a role for the health system to facilitate agency for women who experience intimate partner (or domestic) violence in low- and middle-income countries (LMICs)? And, what role do nurses play vis-à-vis agency, as both providers of health care and women who may experience IPV themselves? These are the questions that motivate this research.

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The gender and development literature has generally defined women's agency as the ability to understand and mobilise against social injustice, particularly when harm is inflicted on women directly, such as through IPV (Kabeer, 1999). IPV is defined as attempted or actual abuse – by a current or former partner – whether psychological, physical or sexual (World Health Organization [WHO], 2013). Agency that challenges such abuse has been regarded as a litmus test of women's empowerment (Parpart, Rai, & Staudt, 2002). This approach to agency assumes that development problems of poverty, illiteracy, unemployment and IPV are key factors defining women's agency and human development in particular contexts (Jewkes & Morrell, 2012). Indeed, the link between IPV, marginalisation and disempowerment has inspired important research on women's agency, including in women's health (Annandale & Hunt, 2000). While agency undertaken to address problems associated with human, social and economic development has been identified as essential for women's empowerment, the definition of agency by gender and development experts has focused on the capacity of individuals to resist patriarchal systems. Agency has thus largely been seen as a matter of choice and action, particularly of individuals (Madhok & Rai, 2012).

Yet, as Emirbayer and Mische (1998) emphasise, agency has received little attention as a theoretical problem in the social sciences, including the global public health literature. As they observe, 'agency ... has maintained an elusive, albeit resonant, vagueness; it has all too seldom inspired systematic analysis'. In spite of a laundry list of phrases associated with agency, such as 'self-hood, motivation, will, purposiveness, intentionality, choice, initiative, freedom, and creativity' (p. 962), a fuller theory of agency has only recently begun to emerge as feminists, particularly from the Global South, have begun to question established approaches to agency (Madhok, Phillips, & Wilson, 2013; Mahmood, 2001). This recent scholarship challenges long-held feminist assumptions that define agency as the struggle between patriarchy and subordinate women. To advance this critique, Mahmood (2001) redefines agency 'not as a synonym for resistance to relations of domination, but as a capacity for action that historically specific relations of subordination enable and create' (p. 203). Agency in these reformulations is not measured by its ability to challenge patriarchal power but rather by the capacity to act within patriarchal structures.

Gender and health research has echoed these points, emphasising the importance of situating agency within specific contexts. For instance, Jewkes and Morrell (2012), investigating sexuality, the limits of agency among South African teenage women and their HIV risk practices, found that women sought 'an accommodation with men's power whilst seeking to negotiate greater respect and non-violence within relations with men' (p. 1729). Such findings remind us that gender relations and practices are deeply embedded in sociocultural norms and practices (Wamoyi, Fenwick, Urassa, Zaba, & Stones, 2011). While this more nuanced, grounded interpretation of agency could be seen as failing to challenge patriarchal privileges, it permits more subtle understandings of agency in diverse contexts, which more accurately reflect women's varied experiences (Lee, 2009). This more particular, context-based approach to agency encourages a focus on the specific ways women in poorer-resource settings experience and address IPV. However, gaps in this theorisation remain.

Of relevance here is the notion of 'institutional agency'. This can be defined simply as institutions that enable or disable women's capacity to make choices that support their health, development and well-being (United Nations, 2012). Agency has been explored in terms of how law and banking institutions assist women to achieve a greater share in the production and ownership of household resources. However, to date, the literature on

women's agency in relation to public health systems and the social environments women inhabit is poorly developed, particularly in LMICs, requiring additional theoretical and empirical analysis to build on these more robust conceptions of agency (Campbell, 2013).

In response, this research locates women's agency within the context of a health system in the middle-income country of South Africa. Through qualitative research among health providers who are 'agents' of the health system, we explore agency as a practical and theoretical construct among nurses with direct or indirect experiences of IPV. We build on these reformulations of agency to understand how women in marginalised settings experience the public health system as a form of institutional agency within South Africa's particular social and cultural context.

IPV in South Africa

An estimated 24–31% of women in South Africa have experienced IPV (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). HIV prevalence in women is also high. National HIV prevalence in the annual antenatal care survey of South African women was 29.5% in 2012 (Republic of South Africa National Department of Health, 2012). South Africa's health profile thus makes interactions between HIV and IPV in women of reproductive age important to understand and address.

In 2013, international guidelines released by the WHO concluded there was insufficient evidence to recommend universal screening for IPV (WHO, 2013). Current health system responses that encourage health providers to address violence against women have evolved primarily in high-income countries, where health infrastructure is better resourced (Kim & Motsei, 2002). At present, clinical guidelines from the South African Department of Health (DoH) do not recommend universal screening for violence in patients during their encounters with the health system. Thus, health providers in South Africa are under no obligation to screen patients for abuse.

Little is known about health providers' direct experiences of IPV and how this might affect their own agency and the agency of female patients seeking care in the public health system (Jewkes, Abrahams, & Mvo, 1998). We briefly root nursing in its historic context to highlight the evolution of the profession as a key shaper of nurses' identity. This section also serves to highlight the rationale for selecting nurses as a professional cadre who are uniquely positioned to shed light on agency for women experiencing IPV in South Africa.

Nursing as an historical profession for black South African women

Historically, black nurses were trained in deeply patriarchal, gendered institutions, which reinforced Western colonial values and gender stereotypes emphasising domestic servitude and prayer (Sweet, 2004). A white hierarchy closely oversaw their training, reflecting colonial, and then apartheid, norms of power (Marks, 1994). At that time, black women had only two formal choices: education or nursing. In their communities, nurses were the most well-educated group of women, affording them greater socio-economic status and esteem (Jewkes et al., 1998). Creating a middle-class health cadre placed these nurses below doctors, yet gave them visible command over black South African patients (Van Der Merwe, 1999). The establishment of the nursing profession in South Africa thus created a corps of black South African women who are highly complex and well suited for explorations of agency. This is because nurses simultaneously hold characteristics of the patients they treat, hailing from the same communities, with similar identities and

historical experiences of apartheid. Yet they hold great authority over patients in health care settings across the country. Indeed, nurses largely run the public health system in South Africa.

Making similar assumptions about South African nurses as a study population, Kim and Motsei (2002) explored 38 primary health care nurses' attitudes and experiences of gender-based violence in the Eastern Cape. They did not question nurses about their direct experiences of violence, however, concluding: 'there is an urgent need to understand and address the lived experiences of the nurses, and the duality of their roles as professionals and as community members' (p. 1243). This research is located in that gap.

Study aim and research questions

We sought to understand the role of nurses in relation to IPV, including their actions and agency, as both IPV survivors and providers who observe and respond to violence. Research questions encompassed: What are the experiences of health providers vis-à-vis IPV in female patients (indirect) and in themselves (direct)? Given the absence of DoH guidelines, how do nurses respond to IPV? What are their demonstrations of agency in the public health system as a social institution?

Below we identify and locate these experiences and interactions within the culture of nursing in South Africa, exploring perceived aspects of the profession that enable or disable their agency related to IPV, while reflecting on the significance for re-theorising agency.

Design and methods

The study design was exploratory in nature, to investigate the relationship between health providers as women who may experience IPV and as women who may treat patients with experiences of IPV. The research took place in urban Johannesburg, Gauteng province. Gauteng has an estimated population of 10.5 million, with 42% classified as poor, 24% unemployed and 78% reliant on public health services (Gauteng Provincial Department of Health and Social Development (South Africa), 2009, 2011). Both IPV and HIV pose considerable health burdens in this province. Nationally, HIV prevalence is an estimated 12.2%, rising to an estimated 12.4% in Gauteng (Shisana et al., 2014).

Research sites were purposively selected to encompass a diverse representation of Johannesburg health facilities and included a total of five antenatal clinics, community health centres and hospitals. Ethics approval was granted by the University of the Witwatersrand Human Research Medical Ethics (South Africa; M130671) and the University of Massachusetts Boston (USA; 2013133). All participants gave informed written consent to be interviewed and recorded. All transcripts and other raw data were encrypted and stored in a password-protected computer managed by the lead author. Audio files of the interviews were immediately destroyed after transcriptions were completed. Pseudonyms were assigned to all participants to protect their anonymity.

Data collection and analysis

In-depth interviews were conducted from August 2013 to March 2014 with 20 nurses, who were purposively selected as a professional group. Convenience sampling was employed in health facilities to recruit participants. The first author and a trained qualitative researcher recruited, interviewed and collected data. A semi-structured interview guide engaged nurses in detailed conversations that included attitudes about

IPV, behaviours of patients with IPV, economic circumstances of nurses and patients, and prevalent sociocultural norms. Questions were designed to probe the full range of experiences about their direct (i.e., experienced by them) or indirect (i.e., observed in other people's lives) encounters with IPV. Interviews traversed the boundaries of the professional domain to the personal and back again.

Face-to-face interviews allowed us to collect rich narrative descriptions. Interviews, lasting 60 minutes on average, were recorded and transcribed in full. Transcriptions, self-reported information and social-demographic data comprised the primary data for analysis. Data were managed in Microsoft Word and Excel. Three authors coded broad themes based on concepts that emerged from participant interviews. Constant comparison of concepts was used to substantiate emergent themes among the group, which held a series of conference calls to enable reflection and agreement on final themes. Quotes presented are direct quotes by participants, with pseudonyms assigned to protect their anonymity.

Demographic characteristics of nurses

More than half (63%) of the nurses worked in antenatal care. The average age of participants was 44. With one exception, all of the nurses were black South African women. Thirty per cent of participants disclosed direct experiences of violence, while 100% disclosed indirect experiences of violence in their families or local communities.

Findings and discussion

In this section, we report these nurses' lived experiences. The first theme reveals how nurses enact agency in their private lives after experiencing IPV. The second theme relates to the ways in which nurses viewed IPV within the workplace, describing a culture where gossip and judgement were common, resulting in a distinct anxiety that impeded disclosures of abuse to colleagues, thus influencing their agentic actions (those that enlarge their ability to act in ways that enable them to make choices that generate the outcomes desired) and health-seeking behaviours. The third theme explores nurses' ability to recognise signs of abuse among patients and the ways in which they chose to proactively address IPV in their patient population, thereby expanding possibilities for women's agency.

Nurses facilitated agency in abusive relationships

A first theme was the ability of nurses who experienced IPV to leave their abusive partner, and those married, to seek divorce. Being able to leave an abusive relationship can be seen as one type of agentic behaviour. Though, as will be seen, this conceals aspects of agency as much as it reveals. Nurses described this fundamental action to leave their partners as being underpinned by their job and financial security. This theme emerged as a striking commonality among the six women with direct IPV experiences and a sharp contrast with female patients.

One nurse discussed the frequency of abuse among nurses, communicating that abuse has been attributed to their long working hours, but she believed this was not the case. She highlights the role of financial independence in women's agency:

It's not rare, it's very common [nurses being abused] so the easiest road is always to move out ... Before we used to think it's because of their long hours working shifts ... it might have contributed but everybody gets abused even if they are not working shifts ... how you deal with it depends whether you are independent or not. It's easier to move out [if you have financial independence] but if you don't have, you are trapped. (Thuli)

Another sister¹ articulated the role of their careers in offering nurses choices that other black South African women might not possess. She refers to their mothers who, under apartheid policies, did not have the same freedoms:

I remember when we were student nurses ... Our group was solid and we didn't drop out ... We knew that our careers will save us. We learnt that from our mothers' experience. When you don't have a job, it's hard. Where would I be? I'll be squashed at home with my sister and dependent on her mercy. (Thelma)

Similarly, Thuli characterised the ability of nurses to reject abuse and seek divorce due to their financial independence:

Women who are independent walk away easy but women who are not working ... they can't. It's more financial than anything. Women who are well employed and have money, they don't stay in those relationships for long. That's why a lot of nurses here are divorced. Why? Because they can look after themselves. They won't stay in that abusive relationship for long.

Through these quotes, it becomes evident that nurses in South Africa occupy a specific socio-economic position afforded by their education and profession that may allow them to take actions that demonstrate agency (leaving or divorce) that are largely unavailable to female patients of lower economic means who frequent the public health system. As the quote above indicates, nurses are aware of these differences.

Nurses' constrained agency and health-seeking behaviours in the workplace

The second theme relates to the inability of nurses to use agency within their workplace. Here, agency can be seen as a basket of choices informed by women's perceived comfort and freedom in whether and when to disclose IPV and to seek psycho-social and other available resources within their workplace. 'Help-seeking' can be seen as a function of agency and is often referred to as such in the domestic/IPV literature (see Liang, Goodman, Tummala-Narra, & Weintraub, 2005). 'Health-seeking' behaviours, more commonly used in the public health literature, are also functions of agency, connoting that health is not a once-off intervention or event (Shaikh & Hatcher, 2004).² Rather, health promotion and prevention is lifelong. The majority of nurses reported unmistakable unease over a lack of privacy and confidentiality at work. This disabled nurses' ability to use peer support, social workers or other resources offered through their employee assistance programmes (EAPs), which restricted their exercise of agency. Here, we capture the voices of six of the 20 respondents (30%) who experienced IPV in their own lives.

IPV stigma and disclosure

Nurses made specific references to IPV-associated stigma:

Mpho stated: 'Yeah, it [IPV] does have a stigma attached to it. No one would love to be known that she's been abused by her husband'. Sindiso indicated:

You know how nurses are ... we don't like talking about our private lives in the workplace. Because ... when you work with people you get to know them, and then you know what type of people they are. [judging you]

Sister Rose remarked that the shame of experiencing violence would preclude openness about engaging the subject within the workplace. She also expresses the desire to maintain a pretence of happiness, which could diminish agency:

I don't think people are open about it. Because ... I was in quite an abusive marriage and then I stayed ... for a very long time without telling anybody. [I]t's not something you just talk about because ... you want everybody to see that everything is happy ... you feel ashamed when you are directly involved.

In conversations about whether nurses talk about their experiences of partner abuse, a theme of self-censoring and 'saving' emotions was echoed:

You can never hear a nurse say I think [I] am feeling down ... I think [I] am over worried, when you are over worried, you need to talk to somebody but nurses will not do that. (Nondwe)

In a context where nurses expressed restricted agency in disclosing IPV and seeking psycho-social support, there was an occupational pressure that limited their help and health-seeking behaviours. This was the role of gossip. Specifically, nurses described a professional culture where gossip, blame and 'laughing' at others were perpetuated by the nurses themselves. Thelma spoke of the ways in which nurses are complicit in constructing this culture, diminishing other nurses instead of offering support:

We women ... are pulling each other down. We have a pull her down syndrome. People were laughing at another sister ... that she is divorced. That process [divorce] ... is so painful you cry. It's like your flesh leaving you[r] bones ... You cannot laugh at that, you cannot make it a joke. It's ... only when you experience it that you know how it feels. It is so painful. When it's you, it's tough. So women, we don't help one another. We pull each other down. We gossip about it. [IPV and resulting divorce]

Thuli indicated that disclosure of IPV had to be undertaken carefully; indeed, negotiated:

No you choose [who to talk to about IPV]. You go to people that you normally talk to. You won't talk to everybody. Even the managers you won't. You choose ... You look for your very closest friends. Sometimes it's not somebody who works here. Somebody, somewhere. You can even go to ... pray or the services on Sunday.

Mpho remarked on why nurses withhold their experience of abuse: that they could acknowledge it only after they had extricated themselves from a relationship that rendered them vulnerable and were able to 'come out the other side' to become 'strong':

They can't tell you [other nurses have experienced abuse too], they'll tell you after you come out of it – and they see you and then they say 'hey, you know I have a problem, even myself it was happening like this'. But all along they were laughing at you ... you become a laughingstock. Even they give you a name, 'that one who has been abused' name calling.

Seen in this light, the enabled agency of nurses due to their higher economic, educational and social status stood in marked contrast with their agency at work. The nursing culture

reproduced in that institutional setting prohibited fuller displays of agency. The overall picture becomes more complex, producing a knotty set of intricate influences of economics, cultural norms, social status and professional roles – among other factors – that inform expressions of agency in nurses.

Though nurses might not be able to openly communicate their own experiences of IPV, they could identify it in others. Sindiso explains this practice of ‘pretending’ that all is well, which could limit agentic behaviour:

Even if she’s pretending that everything is OK [referencing nurses that are abused at home but reluctant to disclose to co-workers]. ... there’s one day that you will pick up that ‘no, not everything is OK at home’.

She indicated that over time, nurses will ‘reveal’ abuse or violence by ‘talking through anger’:

[S]ometimes you find that she talks about her husband ... as if everything is OK. And then there is this one day where she will really express. Maybe she will be talking through anger, talking through whatever emotion ... Once in a while, maybe once a year.

Similarly, Jackie referred to the phenomenon of nurses evincing abuse by their attitudes and behaviours towards patients: ‘I can show it [abuse] ... by having a negative attitude towards my patients’. This indicates that nurses, though supporting health-seeking behaviour in patients, would not necessarily take these steps themselves. This is echoed in nurses’ failure to take advantage of psycho-social support, which illustrates that agency is limited for female nurses due to their particular occupational environment and culture.

Because of South Africa’s high HIV prevalence in women of reproductive age, clinical settings in Johannesburg are sufficiently populated with social workers, HIV counsellors and psychologists who provide a mental health support structure within the nurses’ occupational setting. These are colleagues and co-workers. A key question we explored was whether nurses would take advantage of resources within their own health facility, by accessing counselling or peer support, for example. Sister Rose observed:

They were doing some campaigns [in the health system related to IPV]. They came to the hospital to address the staff, and then they gave us the card [with information and resources]. ... at the time I really needed it, so then I made use of it ... I attended about three sessions with a psychologist. And my kids as well ... [but] I don’t think most of the people are making use of it.

Sister Rose was in the minority in utilising workplace resources. No other participant did so. Lindiwe emphasised their reluctance:

To tell you the truth they [nurses] won’t [seek resources where they work]. They would rather go private and see their private psychologist.

A breach of their privacy was a core concern:

Most of the staff members know [about the EAP]. But people are not willing to go there ... because the privacy thing. (Lindiwe)

One nurse explained that individuals feel anxious that disclosures of IPV would be used against them. She described coping strategies in this context:

We have the wellness programs going on. The system is manipulating that. They know your problems and they will do whatever [if you make a mistake] because of this [reporting IPV]. So people feel victimized because of the problems they put on the table ... people never make use of the wellness thing, no. They keep to themselves, they bottle up. Even if we have a problem, we're like 'okay let me just save it'. (Thuli)

By implication, their occupational setting was not seen as a resource for these nurses to exercise agency that would protect their health and well-being.

The health system as an enabler of institutional agency for women: ways in which nurses address violence in female patients

The third theme spoke to the dual role of nurses. On the one hand, they are women, with some nurses experiencing IPV and seeking to manage partner abuse in their own lives. On the other hand, they are providers of care with a professional ethos, who actively engage with violence in women they treat (as shall be seen). This offered a clear dichotomy between agency, enabled and constrained, vis-à-vis themselves and the health-seeking behaviours they employ, and their actions towards female patients who experience abuse. Nurses were in a position to support agentic possibilities for their patients. In the following narratives, the caring ethos traditionally associated with the nursing profession is manifest to a large degree in nurses' actions on behalf of patients. At the same time, nurses' identity as women who recognise, experience and understand violence against women is visible.

Nurses described their encounters and actions to address their patients' health, through talking or counselling; ascertaining and recording abuse (case finding); and referral and linkage to services (shelters, police, legal services). Sindiso noted:

Even if there are no physical signs, they just talk. Like when you're sitting with her, talking to her and then she just opens up.

Thuli stressed sharing personal experience with patients as a method for helping them work through their problems:

If you've found a solution to your problem you might share it with the patient [saying] 'Sometimes I've had the same problem, this is what I did'.

Talking as a vehicle for ascertaining and addressing abuse was a common refrain. Thelma observes:

She was crying bitterly, she just broke down and cried when I asked her, 'Why didn't you attend the clinic?' I said to her, 'there is something, let's talk'.

She described how she looked for signs of abuse:

From down there [primary health care] they sent her here. I said I cannot send her to medico-legal [specialised clinical forensic service]. Let me deal with her. What is the problem? Why the scars? They are fresh. What is happening? Who assaulted you? She didn't want to say.

You'll see from the signs. The person is not happy. BP [blood pressure] will be high. What is wrong? Why is your BP high? Sky rocketing!! [High BP caused by violence at home]

Sweeney explained how she would identify abuse by observing the male partner during labour and delivery:

Sometimes if I see a woman ... say to me I'm not hungry, for me it's like, maybe she's scared to ask for food or anything. I normally call in the partner just to see their reaction ... I will tell him, you know ... 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, then I would see that this one is abusive.

We discuss the consequences of the findings below.

Implications

What does this research mean for our understanding of agency in women who experience IPV in marginalised settings in LMICs and for 're-theorising agency'?

First, looking through the lens of nurses as a study population offers a window into the South African public health system as a form of institutional agency. It indicates that experiences of institutional agency differed substantially for these health providers and their female patients. Similarly, other individuals who play different roles in the institutional setting, and their experiences of agency within it, could vary quite dramatically, demonstrating a wide spectrum of agentic possibility. In this conception, health systems can be seen as enabling or disabling women's capacity to act in ways that allow them to make choices that produce desired outcomes that support their health and development. Of significance, then, is in grasping the crucial ways in which such institutions create the enabling environment for positively shaping agency that leads to optimal health outcomes and health behaviours over the long term, even as they deliver health care in the short term. Equally, the ways in which institutions replicate negative social behaviours that diminish agency become visible. This includes stigma and discrimination, whether related to IPV, HIV or sexual orientation. Institutional norms can simply reproduce negative norms in the wider society, as demonstrated. The institution thus offers possibilities for limiting or enhancing agency, or facilitating agency for one group but not another.

The pattern laid bare here was one of nurses with direct experiences of IPV possessing reduced agency within this institutional setting. In contrast, patients with IPV were in a position to exercise greater agency. Not because the South African Government's DoH created the conditions for the health system to be responsive to IPV, but in spite of it. Nurses' actions were voluntary. The overall diversity in experience in a single institution sheds light on the varied enablers and inhibitors of agency, including not only the multiple roles people play in the system but also factors that reproduce or challenge social and health inequalities. This both illuminates and raises questions about ensuring equity and fairness for the many actors who populate and have health encounters with the system. Better understanding of how to harness such systems to become more responsive to the needs and rights of the stewards and the users – to enable agency and health – is critical.

Second, this study offers insight into South African female nurses and their professional culture vis-à-vis agency, demonstrating how institutional culture is socially constructed. Nurses occupied a position that is highly agentic in particular ways yet restricted in others. They exercised greater agency in their abusive relationships,

uniformly attributing this to their financial independence and job security. This echoes other research findings that education and employment are fundamental factors for enhancing women's agency and reducing IPV (Abramsky et al., 2011). Yet, these nurses lacked full agency to harness workplace resources when experiencing abuse. The gossip and ridicule faced by those who had undergone abuse could be interpreted as stigmatising in ways that bind agency, a finding that perfectly mirrors HIV stigmatisation in these same clinical settings in South Africa (Sprague, 2009; Sprague, Chersich, & Black, 2011).

Lack of agency among nurses themselves underscores a workplace culture of stoicism, denying expressions of suffering. Our findings occur within a professional population already experiencing high stress – who may be facing IPV stigma from colleagues, while also seeking to uphold their professional caregiving duties (Van der Colff & Rothmann, 2009). Importantly, nurses recognised the ways in which this harmful culture was perpetuated, including re-enacting the stigma of IPV, through the processes of labelling, blaming and 'othering' (Link & Phelan, 2001). They acknowledged the ways they, themselves, reinforce or abide by this culture. That nurses contribute to the social construction of their professional and institutional culture also indicates that institutional agency is not fixed. It is socially constructed and therefore changeable.

A question emerges: who cares for nurses when they become patients? How are health providers sufficiently supported in their caregiving duties? Of particular importance for global public health are the untreated mental and physical health effects for nurses and other health providers experiencing IPV and other threats to their health. This warrants emphasis in a population already experiencing high stress – who may be facing ridicule from colleagues. It raises questions about the support and training of nurses and other health staff who are discharging their professional responsibilities under the pressure of HIV, TB and other disease outbreaks, such as Ebola.

This research places into stark relief the role that health systems can play in expanding or contracting agency related to IPV specifically, which is under-documented. The unsanctioned response in the health system in Johannesburg is enabling agency for women within a context where IPV is not recognised or addressed in national guidelines. In South Africa, this dearth of guidance to practitioners exists despite mounting evidence and recommendations (Joyner & Mash, 2012). It is this lack of an adequate national response to IPV that makes the health system, and the role of these nurses, all the more important. South African women seek resources from the public health system in a vacuum of functioning and responsive social institutions. Nurses indicated that they recognised this and were motivated to act. These respondents chose to address violence in female patients, despite the fact that IPV screening is deemed not feasible and not recommended – a policy of which nurses were well aware. When asked if they were too overloaded to do so, some admitted it was difficult and they lacked capacity but they uniformly expressed a desire for training to equip them with the skills to respond to IPV effectively.

The findings also raise questions that may have implications for national departments of health to train and support health providers in LMICs. Such training would be fully in line with WHO's (2013) guidelines, which call for a minimum standard that encompasses: training on how to ask about violence; a private setting for discussion between patient and provider; confidentiality for the patient; and with a referral system in place (p. 19). While nurses who encounter IPV in the South African public health system demonstrate elements of this minimum response, without support and leadership from the health department to guide them, they will not know how their actions align with recommended steps and measures of effectiveness, which also limits nurses' responses to IPV.

Study limitations and suggestions for future research

Rooting the study in an urban setting meant that nurses might have access to greater information, resources and support to address IPV in themselves or their patients, when compared to rural populations. We did not interview other cadres who may experience IPV and offer different accounts of agency and IPV responses in the public health system, which could be equally rich. Because no research incentives were provided, these participants might be distinct in their willingness to volunteer time to participate in interviews. Interview time with nurses was compressed because they were interviewed after their shifts, interruptions frequently occurred.

Further research should be conducted with different cadres of health professionals to understand their responses to IPV, existing guidelines and training, and direct experiences of IPV, including re-victimisation, especially in LMICs. It could probe factors that may facilitate or hinder IPV stigma and disclosure in the workplace. Further research on patients with IPV in LMICs is needed, particularly in rural regions. Systematic data collection of IPV trends would be important for provider pre- and in-service training and intervention, as well as national responses more generally. There is further need to understand how social norms, institutions and practices shape agency concerning health behaviours, including HIV–IPV interactions. Due to its sensitive nature, innovative research methods are needed to engage professional cadres and patients in IPV research, both in health and in community settings.

Conclusion

This research investigation asked whether there is a role for the health system to facilitate institutional agency for women in the LMICs who experience IPV, with South African nurses as survivors of IPV and providers of IPV care, serving as important agents in this system. While violence against women is a recognised global health and social problem, agency in relation to institutions, including health systems, is insufficiently documented and poorly understood (García-Moreno et al., 2006). This study sought to begin to address this gap, affording a glimpse into understanding IPV needs and responses in poorer-resource settings.

The research contributes to understanding how the health system can be viewed as an institutional form of agency in South Africa for patients and providers with IPV, one that is socially constructed. Through the actions of individuals, the system can enable agency for patients and providers. Equally, it can constrain agency in highly significant ways. This illuminated how individuals occupy multiple roles in the institution that allow for a more complex understanding of agency, mediated by education, employment, income, sociocultural and other factors.

This study adds to a small evidence base indicating that the health system itself can be viewed as a social or structural determinant of health, with nurses acting as health enablers for their female patients with experiences of IPV (Boxall & Leeder, 2006; Williams, 2003). This phenomenon may be more magnified in LMICs, where greater numbers of the population make use of public health systems. Health services are often free, and the power distance between patients and providers is generally less significant (Kim & Motsei, 2002). When services work as planned, the South African health system can be conceptualised as a transformative social system that allows individuals to link to care, information, support and resources, assisting them in managing and promoting their health in ways that enhance agency and human development over the life course (Freedman et al., 2005; Sprague, 2009).

Re-theorising agency requires attention to local definitions of gender, gender relations, femininities, masculinities and understandings of patriarchal power that not only reinforce but also create possibilities for greater gender equality (Madhok et al., 2013; Mahmood, 2001). In this reformulation, it becomes evident that public health systems, through a myriad of processes and mechanisms, can be sources of institutional agency for women who experience IPV. The intersection of institutional contexts and particular gender relations provides the framework for enhancing understanding of agency as a capacity for action in this case. Further re-theorising requires a better accounting of social systems and institutional structures that improve or limit health, including viewing both health systems and health providers as social determinants of health. It necessitates greater understanding of factors that may influence health and social inequities for groups and populations. In keeping with the South African Government's own vision of national and health system transformation, the health system could become a more effective, transformative social system for patients and providers. It is this vision of a health system that would enable agency and health for all.

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Notes

1. Nurses in South Africa are commonly referred to as 'sisters' regardless of rank. This has subtle yet important echoes of apartheid, where sisters and brothers were viewed as comrades and allies in the freedom struggle. Calling a nurse a sister also connotes a level of trust and friendship, which could serve to break down barriers between nurses and their patients.
2. On self-care and nurse agency, see Orem (1980).

References

- Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., ... Heise, L. (2011). What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health*, 11(1), 109. doi:10.1111/j.1360-s0443.2005.00994.x
- Annandale, E., & Hunt, K. (2000). Gender inequalities in health: Research at the crossroads. In E. Annandale & K. Hunt (Eds.), *Gender inequalities in health* (pp. 1–35). Buckingham: Open University Press.
- Boxall, A., & Leeder, S. (2006). The health system: What should our priorities be? *Health Promotion Journal of Australia*, 17, 200–205. doi:10.1071/HE06200
- Campbell, C. (2013). Intimate partner violence in marginalised settings: Re-theorising agency for global public health. *Global Public Health*, 8, 980–981. doi:10.1080/17441692.2013.842691
- Emirbayer, M., & Mische, A. (1998). What is agency? *American Journal of Sociology*, 103, 962–1023. doi:10.1086/231294
- Freedman, L. P., Waldman, R. J., de Pinho, H., Wirth, M. E., Chowdhury, A. M. R., & Rosenfield, A. (2005). Transforming health systems to improve the lives of women and children. *The Lancet*, 365, 997–1000. doi:10.1016/S0140-6736(05)71090-4

- García-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L., Watts, C. H., & WHO. Multi-country study on women's health and domestic violence against women study team. (2006). Prevalence of intimate partner violence: Findings from the WHO multi-country study on women's health and domestic violence. *The Lancet*, *368*, 1260–1269. doi:10.1016/S0140-6736(06)69523-8
- Gauteng Provincial Department of Health and Social Development (South Africa). (2009). *Annual performance plan*. Pretoria: Department of Health.
- Gauteng Provincial Department of Health and Social Development (South Africa). (2011). *Annual performance plan*. Pretoria: Department of Health.
- Jewkes, R., Abrahams, N., & Mvo, Z. (1998). Why do nurses abuse patients? Reflections from South African obstetric services. *Social Science & Medicine*, *47*, 1781–1795. doi:10.1016/S0277-9536(98)00240-8
- Jewkes, R., & Morrell, R. (2012). Sexuality and the limits of agency among South African teenage women: Theorising femininities and their connections to HIV risk practises. *Social Science & Medicine*, *74*, 1729–1737. doi:10.1016/j.socscimed.2011.05.020
- Joyner, K., & Mash, B. (2012). A comprehensive model for intimate partner violence in South African primary care: Action research. *BMC Health Services Research*, *12*, 399. doi:10.1186/1472-6963-12-399
- Kabeer, N. (1999). Resources, agency, achievements: Reflections on the measurement of women's empowerment. *Development and Change*, *30*, 435–464. doi:10.1111/1467-7660.00125
- Kim, J., & Motsei, M. (2002). "Women enjoy punishment": Attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Social Science & Medicine*, *54*, 1243–1254. doi:10.1016/S0277-9536(01)00093-4
- Lee, L.-L. (2009). Inventing familial agency from powerlessness: Ban Zhao's lessons for women. *Western Journal of Communication*, *73*, 47–66. doi:10.1080/10570310802636318
- Liang, B., Goodman, L., Tummala-Narra, P., & Weintraub, S. (2005). A theoretical framework for understanding help-seeking processes for survivors of intimate partner violence. *American Journal of Community Psychology*, *36*(12), 71–84. doi:10.1007/s10464-005-6233-6
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385. doi:10.1146/annurev.soc.27.1.363
- Madhok, S., Phillips, A., & Wilson, K. (2013). Introduction. In S. Madhok, A. Phillips, & K. Wilson (Eds.), *Gender, agency and coercion* (pp. 1–13). London: Palgrave Macmillan.
- Madhok, S., & Rai, S. M. (2012). Agency, injury, and transgressive politics in neoliberal times. *Signs*, *37*, 645–669. doi:10.1086/662939
- Mahmood, S. (2001). Feminist theory, embodiment, and the docile agent: Some reflections on the Egyptian Islamic revival. *Cultural Anthropology*, *16*, 202–236. doi:10.1525/can.2001.16.2.202
- Marks, S. (1994). *Divided sisterhood: Race, class and gender in the South African nursing profession*. New York, NY: St. Martin's Press.
- Orem, D. E. (1980). *Nursing: Concepts of practice* (2nd ed). New York, NY: McGraw-Hill.
- Parpart, J. L., Rai, S. M., & Staudt, K. A. (2002). *Rethinking empowerment: Gender and development in a global/local world*. London: Routledge.
- Republic of South Africa National Department of Health. (2012). *The 2012 national antenatal sentinel HIV & herpes simplex type 2 prevalence survey in South Africa*. Pretoria: National Department of Health.
- Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009). Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet*, *374*, 1011–1022. doi:10.1016/S0140-6736(09)60948-X
- Shaikh, B. T., & Hatcher, J. (2004). Health seeking behaviour and health service utilization in Pakistan: Challenging the policymakers. *Journal of Public Health*, *27*(1), 49–54. doi:10.1093/pubmed/fdh207
- Shisana, O., Rehle, T., Simbayi, L. C., Zuma, K., Jooste, S., Zungu, N., ... Onoya, D. (2014). *South African national HIV prevalence, incidence and behaviour survey, 2012*. Cape Town: Human Sciences Research Council.
- Sprague, C. (2009). *Cui bono?: A capabilities approach to understanding HIV prevention and treatment for pregnant women and children in South Africa* (Doctoral thesis). Johannesburg: University of the Witwatersrand, South Africa.
- Sprague, C., Chersich, M., & Black, V. (2011). Health system weaknesses constrain access to PMTCT and maternal HIV services in South Africa: A qualitative enquiry. *AIDS Research and Therapy*, *8* (1), 10–19. doi:10.1016/S0140-6736(10)60710-6

- Sweet, H. (2004). 'Wanted: 16 nurses of the better educated type': Provision of nurses to South Africa in the late nineteenth and early twentieth centuries. *Nursing Inquiry*, 11, 176–184. doi:[10.1111/j.1440-1800.2004.00228.x](https://doi.org/10.1111/j.1440-1800.2004.00228.x)
- United Nations. (2012). *World development report: Gender equality and development*. Washington, DC: International Bank for Reconstruction and Development/World Bank.
- Van der Colff, J. J., & Rothmann, S. (2009). Occupational stress, sense of coherence, coping, burnout and work engagement of registered nurses in South Africa. *SA Journal of Industrial Psychology*, 35(1), 1–10. doi:[10.4102/sajip.v35i1.423](https://doi.org/10.4102/sajip.v35i1.423)
- Van Der Merwe, A. S. (1999). The power of women as nurses in South Africa. *Journal of Advanced Nursing*, 30, 1272–1279. doi:[10.1046/j.1365-2648.1999.01226.x](https://doi.org/10.1046/j.1365-2648.1999.01226.x)
- Wamoyi, J., Fenwick, A., Urassa, M., Zaba, B., & Stones, W. (2011). "Women's bodies are shops": Beliefs about transactional sex and implications for understanding gender power and HIV prevention in Tanzania. *Archives of Sexual Behavior*, 40(1), 5–15. doi:[10.1007/s10508-010-9646-8](https://doi.org/10.1007/s10508-010-9646-8)
- Williams, G. H. (2003). The determinants of health: Structure, context and agency. *Sociology of Health & Illness*, 25(3), 131–154. doi:[10.1111/1467-9566.00344](https://doi.org/10.1111/1467-9566.00344)
- World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines*. Geneva: WHO.