

Willing but not able: Patient and provider receptiveness to addressing intimate partner violence in Johannesburg antenatal clinics

Abstract

**Background:** Intimate partner violence (IPV) during pregnancy is associated with maternal and infant health. However, in South Africa, where 20-35% of pregnant women report experiencing IPV, antenatal care rarely addresses violence. Little research has explored how clinic staff, community members, or pregnant women themselves view IPV.

**Methods:** We conducted formative, qualitative research with n=48 participants in urban Johannesburg. Focus group discussions with pregnant women (n=13) alongside qualitative interviews with health providers (n=10), managers and researchers (n=10), non-governmental organizations (n=6), community leaders (n=4), and pregnant abused women (n=5) explored the context of IPV and healthcare response. Data were analysed using a team approach to thematic coding in Nvivo10.

**Results:** We found that pregnant women in the urban Johannesburg setting experience multiple forms of IPV, but tend not to disclose violence to antenatal care providers. Providers are alert to physical injuries or severe outcomes from IPV, but miss subtler cues, such as emotional distress or signs of poor mental health. Providers are uncertain how to respond to IPV, and noted few existing tools, training, or referral systems. Nevertheless, providers were supportive of addressing IPV, as they noted this as a common condition in this setting. Providers and managers considered the safety and wellbeing of mother and infant to be a strong rationale for identification of IPV. Pregnant women were receptive to being asked about violence in a kind and confidential way. Understaffing, insufficient training, and poorly-developed referral systems were noted as important health system problems to address in future interventions.

**Conclusion:** South African patients and providers are receptive to identification of and response to IPV in antenatal care, but require tools and training to be able to safely address violence in the health care setting. Future interventions should consider the urban South African antenatal clinic a supportive, if under-resourced, entry point for improving the health of pregnant women experiencing violence.



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Background

The global prevalence of intimate partner violence (IPV) during pregnancy is estimated to be 2% to 13.5% among ever-pregnant women (Devries et al., 2010). In sub-Saharan Africa, meta-analysis suggests IPV in pregnancy is as high as 15% (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). Violence during and in the time leading up to pregnancy is known to be associated with adverse health outcomes (Taillieu & Brownridge, 2010). Pregnant women exposed to IPV are more likely to miscarry or have pre-term delivery, induced abortions, and stillbirths (Martin et al., 2006; Okenwa, Lawoko, & Jansson, 2011; Pallitto et al., 2013; Stockl et al., 2012). IPV among pregnant women is associated with a marked increase in stress, depression, and anxiety (Ludermir, Lewis, Valongueiro, de Araujo, & Araya, 2010; Martin et al., 2006; Rodriguez et al., 2008) and with lack of fertility control (Miller et al., 2010; Pallitto & O'Campo, 2004). Infants of women reporting IPV in pregnancy are, in turn, more likely to experience low birth weight, illness, under-nutrition, and mortality (Hill, Pallitto, McCleary-Sills, & Garcia Moreno, in press; Karamagi, Tumwine, Tylleskar, & Heggenhougen, 2007; Sarkar, 2008; Stockl et al., 2013; Valladares, Ellsberg, Pena, Hogberg, & Persson, 2002; Yount, DiGirolamo, & Ramakrishnan, 2011).

Pregnancy is an important time for health providers to address IPV because during this phase, pregnant women have repeated interactions with the healthcare system (Bacchus, Mezey, Bewley, & Haworth, 2004; Stockl et al., 2012). In addition, this time in a woman's life may provide a window of opportunity to address IPV, since pregnancy is a transition period and may be a time of increased receptivity to healthy changes and interventions (Hatch, 2005). This is especially true since women's desire to protect their children's wellbeing can influence their decisions to leave violent relationships (Davis, 2002; Meyer, 2010, 2011).

There is a great need to address IPV in antenatal care settings. In South Africa, an estimated 20 to 35% of pregnant women report past-year experience of physical or sexual violence from a partner (Dunkle et al., 2004; Groves, Kagee, Maman, Moodley, & Rouse, 2012; Hoque, Hoque, & Kader, 2009). Despite this high prevalence, there are few studies showing the efficacy of antenatal IPV interventions in Sub-Saharan Africa. One qualitative study in Zimbabwe highlighted health worker challenges of responding to IPV in antenatal care, including both practical concerns (eg. infrastructure, workloads) and socio-cultural dynamics (eg. taboos, and a patriarchal culture that normalizes IPV) (Shamu, Abrahams, Temmerman, & Zarowsky, 2013). In Kenya, a feasibility study in antenatal care and other clinical settings found that health providers are willing and able to implement IPV screening if given appropriate training and support (Undie, Maternowska, Mak'anyengo, & Askew, 2014). Elsewhere, promising health sector interventions have been developed, but either fail to include pregnant women, as was the case in a South African primary healthcare intervention (Joyner & Mash, 2012), or lack the evaluative rigour necessary to assess their effectiveness, as was the case in a Kenyan antenatal intervention (Turan et al., 2013).

To date, most health setting intervention studies related to IPV have been implemented in high resource countries. One recent review noted that of 17 primary healthcare IPV interventions, only two took place in resource-constrained countries (Bair-Merritt et al., 2014). Another review identified 19 studies on IPV referrals in health settings, of which none were located outside of the United States or England (Kirst et al., 2012). Despite a strong legal framework to address IPV ("Domestic Violence Act," 1998; Republic of South Africa, 2007), South Africa's Domestic Violence Act is poorly implemented and has little oversight (Seedat, Van Niekerk, Jewkes, Suffla, & Ratele, 2009). To date, the South African Department of Health has not provided guidelines for IPV health service provision, and has not developed clinical tools or standardised trainings for IPV assessment and care at the health systems level – all seen as crucial components of a health sector response to IPV (WHO, 2013).

One of the main challenges in implementing health sector-based interventions for IPV may be that providers, policy-makers or pregnant women themselves hold views that are resistant to addressing violence in health settings. However, little is known about views around IPV in the South African health setting. To address this gap, we conducted qualitative formative research to establish the context of IPV in pregnancy and to explore the receptiveness of patients and providers to addressing it. The goal of this study was to provide formative information for developing a health sector intervention in urban antenatal care in South Africa. We aimed to explore the views of patients, health providers, and community members around assessing and addressing IPV in this setting.

## Methods

We assessed the acceptability and feasibility of incorporating a response to intimate partner violence in antenatal clinics by conducting qualitative research among patients and providers in antenatal clinics in urban Johannesburg.

### *Participants*

We conducted in-depth interviews (IDIs) and focus group discussions (FGDs) with a range of stakeholders with potential to take part in, deliver, or scale-up an intervention for pregnant women at risk of partner violence (n=48). Because the qualitative research was formative in nature, our sampling strategy was to purposively recruit a variety of participants, not necessarily to obtain representative views from any single group. Table 1 describes the participant group, data collection approach, and total number of participants.

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*Pregnant women seeking antenatal care* were recruited for FGDs from selected antenatal clinics. The researchers gave information about the study to groups of women who waited in queue for a clinic appointment. They invited interested pregnant women to participate and women

were asked to indicate their interest during the information giving session. *Pregnant women experiencing IPV* (n=5) were convenience sampled from participating clinics from women who were waiting for routine antenatal services. All women introduced to the study were asked to approach the research team privately to indicate their interest in taking part in IDIs and to self-report whether they had experienced physical or sexual violence. The interviews took place in a private room at the clinics while the pregnant women were still waiting to be seen by clinic staff.

*Health care providers* included doctors, nurses, and lay counselors (n=10) who worked in antenatal clinics. We purposively selected a sample from each cadre of health worker, but nurses made up the largest group (n=6). *Health managers and researchers* (n=10) were recruited using a snowball sampling approach. These participants included governmental managers and academic researchers who had conducted similar violence-related research. These participants were introduced to the study via email and invited to participate in a phone or in-person interview. *NGOs* were purposively sampled from among the original list of possible Johannesburg referral sites, and were purposively recruited to represent a wide range of geographic and organizational roles. This group (n=6) included managers of shelters, community-based organisations, and counseling services. *Community leaders* were recruited using a convenience sampling method (n=4) and represented pastors, a Community Advisory Board member, a youth representative, and a traditional healer, selected because of their influential role in shaping opinions in the community.

### *Procedures*

All FGDs were conducted in a private room in the clinic. FGDs were led by specially trained moderators, who were the same sex as participants and fluent in multiple local languages (Sotho, Zulu and Tswana). Semi-structured discussion guides explored several topics (Table 1; Topics). Discussions were audio-recorded after obtaining participants' permission and signing an informed consent form. The discussions lasted for about 1 hour and 30 minutes, and took place during

clinic working hours. Participants were reimbursed R50 (US \$6) for transportation and offered refreshments.

Because of the group nature of focus groups, additional confidentiality measures were needed. During the informed consent process, researchers explained that questions about women's individual experiences of violence or HIV would not be asked, but rather the discussion would address the issue as observed in the community. They explained that if a woman disclosed in the group setting that the researchers could not guarantee confidentiality. If an individual participating in the focus group demonstrated a need for additional assistance related to her personal experience of violence, she was referred privately to a local counseling resource. In addition, all participants were offered referrals to other organizations that could assist them. Positionality of researchers was a potential problem in the case of women patients, since researchers may have been viewed as relatively more powerful. This was addressed by training research staff to be humble, empathetic, and to prioritise the voice of respondents over their own training or expertise. The same concerns around positionality were not present with health provider, health manager or NGO participants, since these respondents often had similar backgrounds to our team's researchers.

#### *Data management and analysis*

All data were transcribed verbatim in the language in which they were conducted by professional transcriptionists and, as necessary, translated from the local language (Sotho, Zulu, Tswana) into English by professional translators. To ensure accurate translation, each transcript was reviewed by the researcher who conducted the IDI or FGD, and queries were resolved through discussions among the authors. Researchers then added a brief report including personal reflections on how the IDI or FGD proceeded, observations, and notes about key themes. All identifying information about the participant or clinic setting were removed and transcripts were saved by a file name

with no personal details. Any names included in this report are pseudonyms, and have been provided for illustrative purposes.

Data were managed in QSR Nvivo 10, qualitative analysis software. Members of the research team collaboratively built an analytical framework by drawing upon the study research questions and emerging issues of interest. First, a ‘start list’ of possible themes was brainstormed by the team based on an initial review of 8 transcripts (Miles & Huberman, 1994). New ideas were added and combined, whenever possible, to capture main themes emerging from the transcripts. Next, the start list was compared to original formative study research questions, to ensure that no major themes were missing. This final framework of thematic codes was imported into Nvivo along with code definitions. Two researchers applied the thematic codes to each transcript using the technique of ‘double-coding’.

Next, the research team held a series of meetings to collectively develop ‘fine codes’ using an inductive approach of deriving meaning from the data itself rather than imposing pre-formed ideas (Hutchison, Johnston, & Breckon, 2010). Fine codes were developed by printing out a full set of excerpts related to each code, and engaging in peer debriefing about the sub-themes emerging from the data. The fine codes were constantly compared to the broad code definition – ensuring that finer themes related to the question of interest. This process was crucial for analytical rigor as it allowed the opportunity for seeking out disconfirming evidence (Miles & Huberman, 1994), and for adding to the preliminary ‘audit trail’ of decisions made by the research team (Lincoln & Guba, 1985).

Lastly, the reports were shared and critiqued by at least one other member of the team, making the writing process itself an additional way to check that research findings highlighted the reality of the transcripts, rather than simply one researcher’s view of the data (Richardson, 2000). This step involved synthesizing the data from various stakeholder groups, a form of “triangulation” that adds to the validity of qualitative research (Guion, 2002). The quotes



presented here are representative in nature, and disconfirming quotes were sought for each sub-theme, as these existed within the data.

### *Ethical considerations*

All participation in this formative research was sought on the basis of informed consent and good clinical practice guidelines. Ethics approval was obtained by the World Health Organization (WHO RPC471) and University of the Witwatersrand (HREC M110832). In keeping with the ethical considerations of researching IPV in pregnancy, all research was conducted based on the WHO guidance on ethical and safety considerations in researching Violence Against Women (WHO, 2001). Special precautions were taken due to the sensitive study topic of IPV. Rather than using the term “violence”, study staff was trained to describe the research as “social barriers to use of health services”. In cases of severe violence, researchers were trained to accompany the participant to the local referral office. This did not happen during the course of the research, but was an important precaution for this type of study.

## Results

### *Awareness of IPV*

Pregnant women who access antenatal care services reported various forms of violence from intimate partners. Pregnant women identified physical violence, which included beating, kicking, stabbing, hitting with an object, strangling and killing. One NGO service provider described a client who experienced blows to the abdomen during pregnancy:

*When she got pregnant he used to kick her in the stomach. But really kick her so that she landed in hospital. Brutal violence! And it did increase, although I don't know if he wanted the children. I don't really know what put that [violence] in his head. –NGO 4*

One pregnant woman described a friend who was locked up in a house during her pregnancy:

*In the end she got mixed up with another guy, so she fell pregnant. And he locked her up in the house for like two months. He stayed there, physically he hit her... and he put the music loud on. –*

Pregnant woman, FGD 2

Physical wounds or scars were often described by health workers as their first indication that a woman was experiencing violence:

*There's one that I saw with scars, and then when I asked, she refused, she said no it's the table, it was not that. –Health care provider 8*

Pregnant women reported psychological violence as another type of IPV, including yelling, insulting, belittling, neglect, controlling behaviours, and threats. One woman described the psychological abuse that her sister experienced during pregnancy, stating that the impact of the emotional violence seemed even worse than physical IPV:

*He was always shouting. You know, for me it's better if a person hits me, but the shouting..., because to shout or insult, you always remember about those things for a long time, you know. She felt so embarrassed, because each and every time he is insulting or shouting, he put all of those names: "You are pregnant because you were slut." –Pregnant woman, FGD 2*

In some cases, the psychological abuse escalated into outright physical violence:

*He started telling me things, hurting me emotionally, telling me that I'm a fool, and stupid, I'm an idiot. And then he let his cousin beat me up, that's when it started. –Pregnant woman 1*

This quote highlights how IPV intersects with other forms of violence against women, such as extended family violence.

For several pregnant women, the fear of physical violence or homicide led to immense psychological distress. One pregnant woman in a focus group described how her husband often drank and expressed her own constant fear that he might return home drunk and turn the gun on her:

*Because sometimes to live with a fear, sometimes I used to fear because he owns a gun he's going to kill me. –Pregnant woman, FGD 1*

One health worker described seeing increased cases of psychological and emotional abuse, as men tried to assert control without having visible repercussions of inflicting physical violence:

*When they speak, you know that there is some violence going on there but there is nothing you can do. And they become teary and things like that. You never know [what's happening]...cause men are very clever - they don't usually hit a woman these days. Especially pregnant woman, [they don't hit them] on the face and things like that. And what I have realized is [the problem] is not physical as much as it is emotional.* –Health care provider 3

Another type of violence pregnant women reported was sexual. Pregnant women felt that it was difficult for them to negotiate condom use in their relationships, and would be forced to take part in unprotected sex:

*So the man forced her to sleep with her without a condom though she was told that she must use the condom. And that man said, "No, why have we been sleeping without a condom, but because today you went to the clinic, you're telling me we've got to use a condom?" Which is wrong. You're killing yourself! They ended up separating. The lady said, "No, I can't live with this man, because he is forcing me to sleep with him without a condom."* –Pregnant woman, FGD 1

Other pregnant women indicated that they were coerced into having sex with their partners even if they did not give consent;

*He says to me, "You go to bed now, you must sleep [with me]." But then I don't want [to have sex]. I say "I don't want." For me also, I've been made to sleep with him. I say to him, "You're shouting and you're not going to force me." It's hard.* –Pregnant woman, FGD 4

Another pregnant women described being sexually exploited by her partner to supplement financial and household needs.

Adverse pregnancy outcomes, like miscarriage, complications of pregnancy, fetal loss, and maternal deaths were highlighted by health providers. For example, one health provider described how an abused patient lost her fetus through physical blows to the abdomen, but noted

that many of the patients experiencing IPV may never come to the attention of health workers at all:

*In one case I remember where a woman had sustained abdominal trauma, the fetus died, so those are the really serious cases, where an admission is required. But again, I think those are the tip of the iceberg cases. I suspect that there is a huge number of women who don't have serious consequences of domestic violence, they simply either don't complain or even if they do, I suspect that we don't listen to them. –Health manager / researcher 1*

This quote relates not only to the consequences of violence, it also highlights the fact that women rarely seek healthcare for the abuse itself and its direct consequences. Such a finding supports an urgent need for IPV identification and care during other routine pregnancy clinic visits in this setting.

#### *Receptiveness to intervention*

We explored how receptive patients and health workers were to the idea of an intervention addressing IPV in pregnant women accessing antenatal services in their clinics. Reluctance to disclose IPV was seen as common in this setting. In the current system, many women experiencing abuse choose not to disclose it. Reluctance to disclose is associated with fear that partners might retaliate and losing financial support if the abusive partner is arrested:

*And as you know, most of the time people who are being abused sometimes they keep silent, because they are afraid their abusers are the people who are providing financially, they are afraid to talk or report to the relevant departments. - Health care provider 7*

Some health workers perceived that antenatal patients would be reluctant to disclose experience of IPV unless health workers were properly trained and saw them multiple times to build rapport:

*They are very reluctant to speak about it. With experience, you can really probe and you can really tell - especially when you've gotten to know the client. They will not say it at first, but as you get to know clients, then they are able to tell you. But it will take a lot of [clinic] visits and things like that. Some of them you can just pick it up but they will deny it. – Health care provider 3*

Health workers at clinics indicated that some of the pregnant women in antenatal care have visible signs of physical abuse but are reluctant to explain the actual causes of injury, which indicates that if providers were trained properly they could inquire more appropriately:

*It wasn't easy because in the first place, they didn't want to tell [about the violence], but you could see. The other lady told us she fell, but you could see where the mark was. It was not falling. So we discussed with the doctor that this is not just the falling. We probed and probed till she told us the truth that she was in a domestic violent relationship. – Health care provider 5*

In this example, the health worker was untrained around identifying violence in participants, and reported using an aggressive technique of continually probing the woman until she disclosed IPV.

Interestingly, pregnant women themselves were very receptive to the idea of being asked about IPV, but had clear suggestions around how health providers should approach the asking. Pregnant women explained that nurses who know about their clients' lives would be better able to treat them:

*While treating you, if she's got counseling skills, the nurse can also ask nicely, "What happened? How did this come to be like this?" And you'll be more open and easier to treat because she will know what really happened. - Pregnant woman, FGD 1*

Several pregnant participants described how the provider approach was a crucial aspect of asking about violence. They stated that kindness and confidentiality are essential components of responding to IPV in the antenatal setting:

*If you are friendly people are able to be honest and speak to you about their problems...If a person is warm like the way you talk to me right now they will find a way to talk about their problems. – Pregnant woman 2*

Several pregnant women expressed that a key message around IPV should be safety of the mother and child:

*What I know you must say is: "What's happening to your life is important for your safety and the safety of your child." That's the only thing. – Pregnant woman, FGD 3*

Health care providers felt that addressing IPV during pregnancy would be a useful intervention because it is a condition that they see often, and presently have few skills to address. Health workers believed that this form of intervention would provide women access to IPV care and support through the health care system, in this case targeting women who attend antenatal clinics:

*I think it's a good thing. You know it also gives us a chance to be supportive and to advise the women on issues of empowerment, also give them information.* – Health care provider 3

Part of the receptivity towards an intervention is that health workers perceived that additional support would be beneficial to their patients:

*Yes I think it's feasible, even though you know the staff would say "It's extra work." But I think it would be beneficial to the women, because it will be also giving information and helping them if they experience something like that. And [telling them] where to go.* – Health care provider 4

Several issues that made health workers resistant to the intervention were raised: fear for personal safety, health workers experiencing IPV themselves, inadequate training, staff shortages, and perceptions that clients would be reluctant to open up about violence. One participant expressed a fear that asking pregnant women about IPV may cause their partners to visit the clinic in anger and hurt the health workers asking the questions:

*Maybe the challenges will be if sometimes the patient that you are busy talking then tells you about problems and you don't know how to counsel properly and maybe also you end up, you know the partner becoming violent even to you as a person. Because maybe we will be giving suggestions to this woman on what to do, then the partner ends up coming to the clinic looking for you.* - Health care provider 4

Another participant described that asking about violence may be difficult for health workers who are themselves in a violent relationship:

*I can't answer for everybody, but just violence to me I don't think I can say other people have a negative attitude about it, unless if maybe the person experiencing the same thing. - Health care provider 1*

### *Clinic considerations for IPV interventions*

The current health sector response tends to offer help only when violence results in physical injuries or trauma. One policy maker described the fact that it is generally the physical scars that alert a health provider to ask questions about IPV, although many other cases likely exist in this setting:

*I think we don't look for it enough. We don't ask the right questions, because if you ask you'd be amazed. I just don't think we look for it, but there are cases. About a year ago I saw a teenager, 17 year old, who was with a much older partner, the second pregnancy and I think to let me check, she had marks on her body, and so obviously been physically assaulted. But I think if we don't see the physical scars we don't ask. -Health manager / researcher 2*

Presently, there are few existing policies or tools that address IPV in the facilities. One health worker explained that on the antenatal green card (which provides a checklist for providers dealing with antenatal patients), violence goes unmentioned:

*No, even on the ANC green card there is nothing stated about violence. -Health care provider 2*

Several health workers described being unsure how to respond effectively to IPV as they have undergone little training. One health worker suggested that training would help the clinic identify violence and better understand what the patients are going through:

*I: Ok, do you think there is a need for staff to get training on violence against woman?*

*P: I think so. I think so cause maybe sometimes we miss things that if we have more training we will pick it up. I believe if we have more experience, some of the things that other people go through then we will have an idea of what's going on. -Health care provider 3*

Although an IPV intervention was seen as a worthwhile addition to antenatal care, some providers expressed concerns that it may be challenging due to constant staff shortages and rotations. In the context of increasing workloads, some health care workers would prefer not to ask about IPV signs, since a disclosure of violence may lead to spending significantly more time with a patient:

*When you have a queue in any kind of antenatal care setting, and then the nurse asks the question ... if you open up this space you might end up having to sit with this patient to spend 20 or 30 minutes instead of 8 minutes. And so, what is that going to mean for me to be able to get through my workload? And so, there is reluctance on the part of nurses.* –Health manager / researcher 5

Staff burnout and work overload were similarly described as barriers in providing good service to patients experiencing IPV. For example providers explained that because of work overload they don't have time to get in depth information from patients regarding their IPV issues.

*You find staff saying they are already taking more that they can manage and in some cases it's true, they are. There's an element of burnout, there's an element of not feeling rewarded and appreciated on their side, so it's like, if I don't feel appreciated and I'm not rewarded for the work that I do. how am I going to provide a good service.* –Health manager / researcher 2

Providers mentioned not being able to do everything because of shortage of staff and having to attend to long queues:

*You know if we had more staff we would have time to listen to people, and understand what they are going through but now we are looking at the queues we want to finish and that's the problem.*  
– Health care provider 2

Policy makers were wary of the implications of adding new workload to the antenatal clinic setting, which is already under pressure in terms of time and resources:

*Time and resources are limited. You're not necessarily going to get the continuity in terms of staff members. I don't think the way the clinics are run, and the scarce resources, I'm not sure whether we're going to achieve this. So you need to ask yourself, what would it take to establish it and how sustainable it's going to be?* –Health manager / researcher 3



Several stakeholders encouraged that the intervention be sustainable beyond a trial itself:

*It needs to be sustainable; it needs to be owned and located somewhere within the public health system, so that it can continue beyond this particular study, or this particular intervention. And as we know, given the lack of capacity of the health system, this is going to be a challenge. –Health manager / researcher 8*

### *Towards a feasible, sustainable intervention*

In order to design an effective and sustainable intervention, we asked participants for their advice on the intervention structure. Included in this were questions about the best ways to train health workers to deliver the intervention. We found that participants valued clinics dedicating time to this issue, and providers having skills such as empathy and openness.

Both patients and health workers encouraged us not to add more time to patient queues, but to find ways to utilize the time that patients are already waiting for their routine services. It may be possible to weave in IPV screening during the booking visit, when several steps occur at the same clinic visit.

Several health workers and patients suggested that we ask about IPV multiple times throughout the pregnancy. One pregnant woman explained that asking several times will help women to open up, especially if health workers explain that these questions are for the safety of the baby and the woman themselves:

*Interviewer: Do you think we should do it only once? Or is it something that you think we should repeat during your period of antenatal care?*

*Participant: They must do it repeatedly. There are women who are so secretive, who don't want anyone to know what is happening in their lives. –Pregnant woman, FGD 3*

An important component of a successful intervention is training health workers to deliver the intervention. The health workers we spoke to described several gaps that should be addressed in training. They needed training to learn how best to identify violence and to strengthen

interpersonal skills, tools and job aids for use in the clinic setting, and strong referral systems to ensure they helped clients. One health worker explained that the benefit of training would be gaining the skills and tools required to speak openly about IPV - an issue that they see often in the clinic, but generally avoid:

*Interviewer: Do you think if we provide training here, it will be beneficial for your colleagues too?*

*Health worker: Very much! Because most of the time, where it's very sensitive, we try to avoid it though we can see it. It [violence] is treated as if it's not there, because you'll always feel like you're infringing, you're getting into a person's private life. But if we have tools, we can talk about it. – Health care provider 8*

Providing health workers support and debriefing over time was identified as a priority to ensure the intervention success. This is because health workers themselves are going through many of the same challenges as patients, and need an opportunity to reflect and process the difficulties:

*The health workers are affected by the same things. So whether it's HIV or gender-based violence, maybe the starting point is to talk to the healthcare workers and sensitise them about it. But then how do you get them to talk about their own problem? It's true what you say, in that, you know, "I don't want to talk about that because it's just so close to home." –Health manager / researcher 2*

To increase the ability of health workers to respond to cases of IPV, several participants suggested that we identify good referral sites with a direct point of contact. This is partly because “normal” referrals (often, simply giving women a slip of paper) are inadequate to ensure that IPV cases receive the attention they require:

*And yes, you say, there are options available. But then maybe also making the referrals easier and facilitating those referrals. Not only to say "here's their name and a contact number," ... but to say, "Okay, I'm going to phone somebody, do you want me to do that? Do you want the help? Here's a place you can go to." I don't think just giving contact details is enough. –Health manager / researcher 2*

Participants mentioned an absence of proper referral systems for IPV survivors from the health facility to other organisations. For example, while there are existing services at larger hospitals, many services closer to the community are unavailable outside of normal office hours:

*So we have been referred to other communities so that presents a challenge because if anything happen at any time of the night and you need those services done, then you refer to the big hospital ... so if the services could be brought to the community it would help quite a bit. -NGO 3*

## Discussion

We found that pregnant women in urban Johannesburg experience multiple forms of intimate partner violence but tend not to disclose IPV to antenatal care providers. Health care providers, recognize IPV as prevalent in their patient populations, but are uncertain how best to inquire and respond. Providers tend to overlook subtle cues around IPV and assist only in cases of severe physical injuries, thus missing a large majority of women who present with other signs and symptoms of violence. IPV interventions in the antenatal clinic setting will require tailoring to address challenges in current staffing and skills, as well as time shortage and long queues.

Pregnant women who lived with violence and those without IPV in their own lives expressed support for being asked about violence in antenatal care. This aligns with research from resource-rich settings suggesting that many pregnant and postpartum women are supportive of health providers inquiring about IPV (Eisenman et al., 2009; Ramsay, Richardson, Carter, Davidson, & Feder, 2002; Stockl et al., 2013; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). In South Africa, research suggests patients are receptive to being asked about IPV in HIV counseling settings (Christofides & Jewkes, 2010) and ambulatory care (Joyner & Mash, 2012), but little research has explored views of patients around IPV inquiry within antenatal services. Our findings confirm that pregnant women would be supportive of health care providers identifying and responding to violence during antenatal care.

IPV in this particular urban, sub-Saharan African context seems to include multiple forms of violence, many of which are rather severe. Examples included kicking a pregnant woman's belly, fetal death due to abdominal blows, locking a woman up, threatening to use a gun, and forced sex. Importantly, some violence escalated from intimate partner-only to family violence, as in the case of the woman whose cousin beat her up. This confirms that clinic interventions may need to be accompanied by community work in order to counter prevalent norms of violence.

Health care providers were receptive to the idea of receiving training on IPV, despite practical challenges in a resource-constrained health setting. Similar to findings elsewhere (O'Reilly, Beale, & Gillies, 2010; Roelens, Verstraelen, Van Egmond, & Temmerman, 2006), we found that inadequate time with patients may hinder IPV inquiry and subsequent intervention. The time constraints faced by providers may make it particularly challenging to ask patients "repeatedly" about their violent relationships. Yet, as patients noted in our sample, women may need repeated inquiry to gain comfort with a provider and disclose around this sensitive topic (Edin, Dahlgren, Lalos, & Högberg, 2010; Lutz, 2005).

In our sample, provider fears included those around provider safety if, for example, a perpetrator turned rage towards the clinic staff. In other studies, health providers held fears around possible repercussions of asking about violence (Rodriguez, Bauer, McLoughlin, & Grumbach, 1999; Waalen et al., 2000). A distinct provider concern was that women would not disclose due to the normalization of violence in this setting. However, this constraint did not seem to dissuade providers from intervening, which differs from findings from other settings in sub-Saharan Africa where providers express ambivalence around intervening in IPV due to beliefs that violence is an acceptable means of punishing women who transgress cultural norms (Lawoko et al., 2013; Shamu et al., 2013). Rather than ambivalence or an unwillingness to take up the screening role, the main reason cited by health care providers in urban Johannesburg were that they required more guidance and training around addressing IPV (Sprague, Hatcher, Woollett, & Black, 2015). Indeed, having a dedicated protocol for screening improves provider ability to

identify IPV (Waalén et al., 2000) and lack of training is often a barrier to IPV screening (Beynon, Gutmanis, Tutty, Wathen, & MacMillan, 2012). Robust training and ongoing support of providers seems a necessary aspect of implementing any IPV intervention in the health setting (Colombini, Mayhew, & Watts, 2008; Stöckl, 2014). Yet, it is striking that South African providers have virtually no access to training or clinical tools for responding to violence in the antenatal setting.

Participants offered several concrete suggestions for designing an IPV intervention in antenatal care. Referrals to existing services should be strengthened, so that women receive more than simply the name of a support service and phone number. Other studies suggest that referrals from health care can increase women's access to social services (Wathen & MacMillan, 2003). Findings from this research support setting a systems-based approach to referrals from the clinic (Decker et al., 2012; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011; Ramachandran, Covarrubias, Watson, & Decker, 2013). Others have found that comprehensive services, including danger assessments, safety plans, mental health services, and active referrals to other community resources, lead to increased identification by providers (McCaw, Berman, Syme, & Hunkeler, 2001). The capacity and accessibility of existing referral services must be assessed in determining the appropriateness of a referral system.

Pregnant women emphasized that the interpersonal approach by health care providers is crucial to encourage IPV disclosure. For example, providers should be empathetic and kind when discussing the issue, and should refrain from judgment. This aligns with qualitative research elsewhere, where pregnant, abused women desire empathy and respect from health providers, but have no expectation that these professionals should "somehow fix their situation" (Lutz, 2005). Others have noted that even brief discussions with clinicians who approach patients in a concerned and non-judgmental way can lead to a life-changing opportunity for women to reconsider the violence (Chang et al., 2005; Rhodes & Levinson, 2003). This is partly because naming the experience as abuse and connecting with health workers can reduce isolation and

allow women to create new narratives of their experience (Herman-Lewis, 1992; Joyner & Mash, 2011; Spangaro, Zwi, & Poulos, 2011). In some instances, health workers in our research recounted cases of “pushing women” to disclose violence. Existing guidelines suggest that such a forceful approach should be avoided in lieu of more empathetic and women-centered approach, as it violates women’s autonomy (WHO, 2013). Our research showed that women find it less important *who* delivers the intervention than *how skillfully* a health worker conducts it. This finding suggests that training for health providers should focus on skills around empathy, non-judgmental listening, and offering concrete support.

The findings of this formative research should be examined in light of several design limitations. Firstly, logistical constraints led to small sample sizes of each participant group. While analysis suggested that we began to reach saturation through FGDs with pregnant women, the IDIs with pregnant women experiencing IPV were not sufficient to reach thematic saturation (Morse, 1993). Recruitment of the latter group posed a challenge because abused women were asked to volunteer for in-depth interviews following a brief information session and may have preferred a personal invitation in a more private setting. Secondly, as with any research, and qualitative research in particular, the perspective of individual researchers was brought to the data analysis process. Although we tried to limit a skewed version of the data analysis using team analytical and writing approaches, it is possible that personal perspectives altered the final interpretation of findings. Thirdly, we did not collect detailed demographic information about each participant group, which may limit the interpretation of the findings. The study setting was urban Johannesburg, and thus findings may not be applicable to other settings within South Africa, such as rural areas where clinic services and patient perspectives may differ.

### *Conclusion*

While promising IPV interventions have been developed for antenatal care in resource-rich settings (McFarlane, Soeken, & Wiist, 2000; Parker, McFarlane, Soeken, Silva, & Reel, 1999; Tiwari et al., 2005), scholars have noted the urgent need to develop and evaluate such IPV programs in sub-Saharan Africa (O'Reilly et al., 2010; Stockl, Watts, & Kilonzo Mwambo, 2010). Our findings suggest that a well-designed intervention to address IPV in Johannesburg antenatal care clinics would meet with high receptivity among both patients and providers. These formative data suggested several key prerequisites to implementing an IPV intervention in antenatal care. Firstly, we learned that providing high-quality training and mentorship of key health professionals necessary and valued skills around IPV response. A focus on skillful, empathetic inquiry about IPV would ensure providers display the interpersonal techniques that promote safe IPV disclosure. Secondly, additional dedicated staff may be required to address provider concerns around time constraints in a busy antenatal clinic. Thirdly, patients do want to be asked about violence and this conversation can be framed around staying safe in pregnancy – a key priority for a majority of patients who deeply care for the health of their children. Lastly, building a systems-based referral network from the antenatal clinic would ensure onwards services related to IPV. A carefully designed health systems response to address IPV in antenatal care will be a crucial step in achieving sustainable impact on maternal and child health in South Africa.

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Table 1. Data Collection Methods

<b>Participant Group</b>	<b>Group Size</b>	<b>Method</b>	<b>Sampling</b>	<b>Example Participants</b>	<b>Topics</b>
Pregnant women at ANC	(n=13)	Focus group discussions	Convenience	-	Types of IPV in pregnancy; Patterns of help seeking and available community resources for violence and HIV; Barriers to disclosing IPV; Receptivity to an antenatal intervention.
Pregnant abused women	(n=5)	Semi-structured interviews	Convenience	-	Existing needs and concerns of abused women; Patterns of help seeking and available community resources for violence and HIV; Receptivity to an antenatal intervention
Health managers and researchers	(n=10)	Semi-structured interviews	Purposive	Department of Health managers, Academic experts	Types of IPV in pregnancy; Current health sector response to IPV; Potential integration with HIV activities, including PMTCT
Health care providers	(n=8)	Semi-structured interviews	Purposive	Doctors, nurses, lay counselors in antenatal clinics	Types of IPV in pregnancy; Knowledge and practice responding to IPV; Receptivity of health workers to antenatal intervention; Existing capacity in clinic
Non-Governmental Orgs	(n=6)	Semi-structured interviews	Purposive	Shelters, Police, Counseling services	Psycho-social, legal and other needs of abused women; Referral options for women living with IPV
Community leaders	(n=4)	Semi-structured interviews	Convenience	Pastors, Neighbourhood representatives, Traditional healer	Community factors that support or prevent women from seeking IPV assistance during pregnancy