# Quality of Care for Intimate Partner Violence in South African Primary Care: A Qualitative Study


## Abstract

Intimate partner violence (IPV) makes a substantial contribution to the burden of disease in South Africa. This article explores the current quality of care for IPV in public sector primary care facilities within the Western Cape. Only 10% of women attending primary care, while suffering from IPV, were recognized. Case studies, based on in-depth interviews and medical records, were used to reflect on the quality of care received amongst the women who were recognized. Care tended to be superficial, fragmented, poorly co-ordinated and lacking in continuity. The recognition, management, and appropriate documentation of IPV should be prioritized within the training of primary care providers. It may be necessary to appoint IPV champions within primary care to ensure comprehensive care for survivors of IPV.



## Key Words

Domestic violence, primary health care, South Africa, quality of care, qualitative study

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## Introduction

Internationally, abuse against women by intimate partners (intimate partner violence, IPV) is a massive public health problem. In South Africa more women are killed by their current or ex-intimate male partner than in any other country with a rate of 8.8 per 100000 women (Abrahams et al., 2009). Apart from femicide, fatal outcomes of IPV include suicide, maternal mortality, abortion, stillbirth and AIDS.

Indeed the health consequences of IPV add up to a substantial burden of disease for public health systems internationally (Garcia-Moreno & Watts, 2011). Physical consequences include unwanted pregnancies, burns, fractures, chronic illness and pain syndromes, problems with hearing and sight, arthritis, seizures, headaches, sexually transmitted infections and HIV. Mental consequences include depression, anxiety, post- traumatic stress, eating and substance disorders (Campbell, 2002). IPV in pregnancy can seriously harm both mother and fetus. In India IPV has been linked with fetal, infant, and maternal death, low birth weight infants, and developmental abnormalities (Jejeebhoy, 1998; Ganatra, Coyaji, & Rao, 1998). Strong links exist between IPV and risk of HIV infection (Jewkes, Dunkle, Nduna, & Shai, 2010), which is particularly relevant since South Africa has the largest number of people living with HIV/AIDS (UNAIDS, 2009).

Despite the relevance of IPV to our burden of disease with its consequent impact on all South African communities, health providers tend to resist identifying and managing IPV as a health issue (Joyner & Mash, 2012a). In South Africa first contact care is mostly offered by primary care nurses with the support of doctors. Baldwin-Ragaven (2010) testifies to the proliferation of peer-reviewed articles measuring the problem and documenting the consequences of our

failure to act, commenting: “For any other disease process as costly in financial and human measures we would demand answers, find cures, and disseminate evidence about interventions. What is it about IPV?” There is a clear moral argument that health providers should attend to the problematic impact of IPV on health and family systems. Women experiencing IPV present to all health care settings, usually without naming the problem as IPV.

Intimate partner violence is a complex phenomenon, where layers of emotional, spiritual and financial abuse are intertwined with varying degrees of physical and sexual violence. Therefore, while the term “intimate partner violence” may bring to mind a violent physical assault, subtlety is often a key strategy, particularly in psychological abuse (Johnson, 2008). Thus prevalence figures that only reflect physical violence do not actually measure IPV, but merely the physical component thereof.

This article works with an understanding of IPV as words and behaviours that undermine and diminish the humanity of the other intimate partner. Intimate partner refers to a current or former dating, married or cohabiting relationship or even a would-be rejected lover (Mathews et al., 2004). Michael Johnson’s typology of domestic violence delineates four contrasting forms: intimate terrorism, violent resistance, mutual violent control and situational couple violence (2008, p. 5). Intimate terrorism or coercive control describes use of violence by one partner to control the other; violent resistance describes the resister’s response to the effort of their partner to gain control; mutual violent control refers to use of violence by each partner to control the other; while in situational couple violence either couple can be violent due to escalating conflict, but not to exert control.

Central to this range of violence and control is emotional abuse, which is clearly pervasive and usually concurrent with sexual and physical violence (Jewkes, 2010). Emotional abuse has various forms, but its consequences almost always include diminished social support, low self-esteem, and anxiety states. It has been found to be a primary contributor to postnatal depression (Ludemir, Lewis, Valongueiro, de Arújo, & Araya, 2010).

A Cape Town study found that sexual violence was common in intimate relations and was associated with the use of violence to solve problems, having more than one current partner, alcohol abuse, and verbally abusing a partner (Abrahams, Jewkes, Hoffman, & Laubsher, 2004). Internationally, studies connect abuse with unwanted pregnancies, especially in adolescent females (Campbell, 1998). Violence of all kinds significantly impedes women's ability to use contraceptives or condoms to prevent sexually transmitted infections, including HIV/AIDS, unsafe abortions and pregnancy (Adongo et al., 1997; Bawah, Akweongo, Simmons, & Phillips, 1999). In a national sample from Colombia, women's adjusted odds of having had an unintended pregnancy were significantly elevated if they had experienced sexual or physical abuse (Pallitto & O'Campo, 2004). The need to include screening and treatment for IPV in reproductive health services, to promote male involvement in fertility control programs, and to improve the political and social response is highlighted.

Recent IPV prevalence studies in sub-Saharan Africa have focused on pregnancy (Groves, Kagee, Maman, Moodley, & Rouse, 2012; Eaton et al., 2012; Ntaganira, Muula, Siziya, Stoskopf, & Rudatsikira, 2009). A systematic review on IPV in pregnancy in Africa found it to be one of highest reported globally (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). Sexual risk taking, HIV infection, alcohol and drug use, and violence were major risk factors. Shamu et al. (2011) urge for interventions in pregnant women as part of

antenatal care. They recommend that such screening programs address prevention of HIV and IPV simultaneously, as both relate to issues of women empowerment.

A South African study found that pregnant teenagers were significantly more likely to have been forced into sexual initiation and were beaten more frequently (Jewkes, Vundule, Maforah, & Jordaan, 2001). Multiple modelling revealed that both forced sexual initiation and unwillingness to confront an unfaithful partner are strongly associated with pregnancy and with each other. In Durban, almost 25% of women experienced some type of IPV during their current pregnancy, with psychological abuse the most common (Groves et al., 2012). The odds of emotional distress were significantly higher for each additional episode of psychological abuse and also for each additional episode of sexual violence during pregnancy. Reflecting these issues, a study conducted in Cape Town shebeens found that men with pregnant partners recorded the highest rates of assaulting intimate partners, forcing sexual intercourse on a partner, and being forced by their partner to have sex (Eaton et al., 2012). Men with pregnant partners were also more likely to report searching in bars for a new intimate partner. Alcohol abuse among pregnant women is reported as alarmingly high, and appears to be closely linked to IPV in pregnancy.

South Africa's Domestic Violence Act No 116 of 1998, includes a definition of domestic violence so comprehensive that it is recognized to be a legislative standard bearer internationally. It recognizes physical, sexual, emotional and psychological, verbal and economic abuse as well as intimidation, stalking, damage to property and trespassing between any two people who are in a domestic relationship. Yet a shortcoming at legislative and policy levels is the failure to outline any specific responsibilities for the health sector. This deficiency has been exacerbated by inadequate healthcare provider training and under-resourced implementation of the Act.

The dismissal of IPV as a social or legal issue, and therefore not requiring comprehensive health care, seems to underlie a poor quality of healthcare for women affected by IPV. The failure to attend to psychosocial issues, within health services that are mainly orientated towards biomedical problems, is arguably exacerbated by a victim-blaming discourse prevalent among providers (Petersen, 2000). A victim-blaming discourse provides solutions for individuals and then blames them when they fail to comply, whilst not understanding their perspective or key contextual factors. Few studies, globally or locally, have focused on quality of care for IPV. This article explores the current quality of care for IPV in South African primary health care.

## Methods

### Study design

The results presented here were drawn from a larger study that implemented, modified and evaluated a screening and management protocol for IPV in the primary care sector (Martin & Jacobs, 2003; Joyner, 2009). In the larger study, women suffering from IPV were identified by primary care providers (nurses or doctors), who were asked to screen all women 18 years and older during a four to eight week period using a simple open question that invited disclosure. These women were offered a referral to the study nurse for an initial consultation. This consisted of an in-depth biopsychosocial and forensic consultation of between 60 and 90 minutes (Joyner & Mash, 2012b). The consultation was followed a month later by a semi-structured interview, which focused on their experience of the management protocol.

The study reported here is based on an examination of the medical records of these women for any evidence of prior recognition or management of abuse by the primary care providers during the previous two years. Qualitative information arising from the consultation with the

study nurse or follow-up interview, which related to prior attempts to obtain help at the health centre, was also included.

**Setting**

Primary care in South Africa is predominantly offered by nurses, many of whom are trained clinical nurse practitioners. Nurses are supported by visiting doctors in offering care via a network of small mobile and fixed clinics. In larger urban areas care is also offered at community health centres (CHC). These usually have a multidisciplinary team that includes nurses, doctors, a pharmacist, a social worker, lay counsellors and a psychiatric nurse. CHCs also usually have a dedicated area for emergencies and trauma. Primary care services refer to district hospitals that are staffed by generalist medical officers. As only about 15% of the population is insured, the majority rely on these public sector health care services.

Two urban and one rural community health centre, as well as two smaller rural clinics in the Western Cape, were purposefully selected as study sites for the larger study according to the following criteria: having a psychiatric nurse; availability of a private room for the research assistant; and sufficiently comprehensive service to support the protocol being implemented (e.g. X-rays, HIV testing and counseling) (Martin & Jacobs, 2003).

All facilities had high workloads and served low socio-economic English, Afrikaans and Xhosa speaking communities. Urban sites were in Cape Town and rural sites were 120-200km away in farming areas within the Cape Winelands District.

**Selection of women**

In the screening phase of the larger study 168 women were identified as survivors of IPV who had been attending the health centres during the past two years. Out of these 168, only 11 (9.6%) had been previously recognised as having a problem of IPV. This article reports on the quality of care received by these 11 women.

**Data collection**

The management protocol required a structured record of the consultation and the follow up interview utilised a semi-structured questionnaire. The authors recruited and trained two nurse practitioners to help provide the intervention. These study nurses, and the principal author, obtained consent and built rapport before proceeding with comprehensive assessment and management (Joyner & Mash, 2011). The two instruments provided qualitative data on the situation at home and previous encounters with their primary care providers. Each document contained sections where the patient's story was captured verbatim or paraphrased in a narrative style.

Additional information on the care received was obtained by inspecting their medical records for the previous 24 months. The International Classification of Primary Care was used to code all reasons for encounter and diagnoses made (WONCA International Classification Committee, 1998; Joyner & Mash, 2012a). Qualitative data relating to the recognition or management of abuse was included in the analysis.

**Data analysis**

Data on the specific elements of the management/care plans recorded by clinicians in the medical notes were categorized and quantified. Data from the medical records, initial consultation and follow up interviews were combined to give case studies of each woman's experience of IPV, health seeking behaviour and experience of health care. A thematic content analysis focusing on the quality of care was then performed on the case studies according to the framework method (Ritchie & Spencer, 1993).

**Ethical considerations**

Guided by the Global Programme on Evidence for Health Policy (World Health Organization, 1999) , the safety of respondents and the research team was paramount and underpinned all project decisions. The Health Research Ethics Committee of Stellenbosch University approved the investigation. The anonymity of the participants was protected by use of codes

instead of names as identifiers. Written informed consent was obtained and each participant's right to privacy and confidentiality was safeguarded.

## Findings

### Profile of the Women

Table 1 provides an overview of the age, context and nature of the abuse experienced by the 11 women.

The mean age was 41 years, and average number of children was three. All but one were cohabiting with the abusive partner. Drawing on Johnson's typology (2008), nine of the eleven women were in situations of intimate terrorism / coercive control. Violent resistance better described another, and mutual violent control was also evident in one case. Emotional abuse was the only form of abuse that was experienced by all eleven women.

The 11 patients presented an average of 11.7 times at the health centres over a 24 month period. The range varied between a minimum of four and a maximum of 27 visits. At some point their experience of IPV was referred to in all of their medical folders. The management of IPV in the 11 patients identified by health care providers is summarized in Table 2.

Insert Table 1 followed by Table 2.

Management mostly involved referral to other professionals or services. The most common elements of the management plan were referral to a social worker or prescription of psychiatric medication. Overall social issues were addressed in 8 patients, legal issues in 2 patients, psychological issues in 7 patients and clinical issues in 2 patients. Social issues were addressed through mobilization of social support and planning for emergency situations, while psychological issues were addressed through referral for counseling or prescription of psychiatric medication. The clinical component included family planning and general

medical care. The number of different components to the management plan ranged from 0 to 5 with an average of 3.

**Recognition of IPV without action**

Even when primary care providers, such as emergency staff and clinical nurse practitioners, acknowledged the abuse underlying injuries, their care remained focused on the injuries and did not address the abuse itself. For example the first entry regarding IPV in Vuyi's medical record revealed an injury that merited "advice about the disability grant application procedure" from the healthcare provider. "Injury due to domestic violence" ends the brief entry. There was no offer of assistance or referral. The next relevant entry appeared seven months later on an Accident and Emergency form: "…patient allegedly fell and injured right arm yesterday." A crepe bandage, anti-inflammatory and analgesic medications were prescribed, but no action taken in terms of the underlying abuse.

Similarly when Olive survived attempted murder at the hand of her knife-wielding husband on her kitchen floor, the attending doctor's notes were purely clinical, with not one reference to her mental state, nor any indication of her potential emotional needs.

**Biomedical care overlooks IPV**

Carolyn presented the most times, 27 in all, over two years. For a long while her medical record depicted a passive patient who had "no complaints", yet her blood pressure remained uncontrolled. Over time, her record revealed that she often sent a relative to fetch her medicine or simply did not attend her monthly appointment. It was only when she complained to the facility manager about a provider's attitude that she was referred to our study. On interview, we found that she was in urgent need of assessment for anxiety and depression. She admitted one of her husband's abusive tactics was to throw away her chronic medication. It also became clear that she had been enduring vicious verbal, sexual, physical

and financial abuse during the previous two years; and yet had not felt safe enough to share these serious problems with her health providers.

Sylvie had been seen by a primary care provider fourteen times over two years and had received medical care for tension headaches, neck pain, back pain, abdominal pain, genital pain, breast pain, intermenstrual bleeding, insomnia, dizziness and reproductive health needs. Eventually she was referred to the psychiatric nurse who noted a history of physical and sexual abuse from her cohabiting ex-husband. Sylvie was referred to our study where we discovered that she and their five children were living in severely abusive circumstances.

**Recognition of mental health problems**

Seven of the eleven women were known psychiatric patients, referred to the study by their psychiatric nurses. Five came from one site, where the psychiatric nurse was as proactive as he could be in a scarcely resourced context. He provided a detailed description of all social and environmental stressors on Axis 4 of each patient's DSM-IV diagnosis. It was clear that each woman felt comfortable enough to be honest with him. For example, Daphne admitted to drinking alcohol to cope with her nerves and to calm them. Apart from acknowledging her difficulties and providing a sounding board, he continued medication, included them in a psychosocial support group and made good use of local resources. His approach was exceptional in that he obtained a psychosocial history and addressed issues of abuse and safety in a co-ordinated way. This was not evident in the other cases.

Candy's story began with an attempted overdose of 16 paracetamol tablets whereupon she was referred to the psychiatric nurse at the health centre. The multi-axial diagnosis specified, "... husband – psychological abuse ..." on Axis 4 and an Axis 1 diagnosis of major depressive disorder with anxiety. Antidepressants were prescribed. Two months later, the psychiatric nurse noted, "…husband still violent and abusing," and planned to continue medication and refer the patient to both a psychologist and marriage counsellor.

Candy's medical record revealed that she had presented with insomnia and depressed mood and the psychiatric nurse noted that her husband expected sexual activities from her that she abhorred. She, "…wants to visit her sick sister but her husband forbids her… manipulates her +++ and breaks her down emotionally".

The psychiatric nurse's management plan reads: "1)medication 2)social worker for advice re ?divorce 3)follow-up". He referred her to a community-based organisation, which arranged a place of safety for her.

When Candy presented to our study, her mental state clearly reflected the oppressive difficulties of her circumstances. In the previous week she had been booked off work by her doctor due to injuries sustained. Her husband followed her everywhere. She said she had been in many shelters, but because she missed her children she had always returned home. She claimed he was a good father although their daughters were scared of him. She seemed to have made no progress with getting a protection order.

Although Candy scored as low risk on our safety assessment scale, the relentlessly severe verbal abuse had still triggered a suicide attempt. On follow up she revealed that she was feeling "weak and scared to make decisions". Candy's disabling fear of the abuser was palpable. Health providers need to grasp the underlying power and control issues that are central to the violence of intimate terrorism (coercive control) ( Johnson, 2008). Candy provides an example of someone paralyzed by fear and disempowered by sexist social and economic factors that constrain her capacity to find another way out of her situation. Arguably, it is precisely this type of hopeless scenario and internalization of IPV as culturally normative that deters providers from engaging with patients about their IPV issues in the first place.

By contrast the rural psychiatric nurse only recorded that Carolyn was oriented and not psychotic. It appeared that in her psychiatric service, the concept of mental illness had been restricted to managing chronic psychosis, and she was mainly interested in excluding the

presence of psychosis. It was only when Carolyn was explicitly required to respond to the issue of IPV, because of her dissatisfaction with the social worker, that she focused on IPV.

In the case of the seventh psychiatric patient, Nomsa, even though she was regularly attended to by medical officers, nurses and mental health personnel, no one had recorded the diagnosis of agoraphobia in her folder. On interview she explained that she feared social gatherings and crowds of people and sometimes felt as if the walls suffocated her and her head would burst. Yet her medical folder revealed no effort to assist her with this disabling anxiety condition, other than the problematic prescription of lorazepam. The highly addictive nature of this short-acting benzodiazepine highlights another fault line in contemporary primary care which aspires to be biopsychosocial in approach, but is functionally biomedical.

Of the four patients who presented for general health complaints, all were found by respective study nurses to need further assessment and treatment for anxiety and depressive disorders, and three were found to be in need of assessment for post-traumatic stress disorder. No reference is made to any of this anywhere in their folders. No attempt seems to have been made to open a conversation that would enable discussion of these difficult psychosocial areas.

Yet when Vuyi answered about how useful she had found our intervention, she said, “After I’ve met her I was so relieved. When I was talking I was feeling very hurt and bad about what my husband has done to me, but after that day I felt different.” In response to what had changed, if anything, “Yes, the following week I came for check-up and I dressed up nicely. I used to not want to wear clothes, I felt so dull ... Now I always have a hope that things can be right for me – ideas about the future - before it was just darkness.”

Here Vuyi refers to her experience of the interview with the study nurse. It seems to indicate that as little as an hour of with an effective IPV champion’s time can make a vast different to the mental state of the woman concerned.

**Quality of counseling**

It would appear that counseling was largely non-empathic and at times rather directive and judgemental in nature. Psychologists, social workers, clinical nurse practitioners and psychiatric nurses alike provided examples of directive responses, which lacked an empathic understanding of the patient's situation and perspective.

For example, a psychologist at an urban site recorded the advice given to Nomsa as follows, "… explained that she needs to be pro-active, she needs to break cycle of abuse. Advised her to contact the National Institute of Crime Prevention and Rehabilitation of Offenders. She needs to protect herself and children. If husband will not stop drinking and abuse, then she needs to make the choice."

Here all the responsibility for the solution is put onto her while simultaneously dismissing potential contextual factors, which may constrain her agency. In this case poverty made travel difficult, and she did not have her husband's permission to speak to the neighbours or anyone else, so how could she risk making a trip further afield? She suffered from agoraphobia, which is a disabling anxiety condition, and so coping with the outside world would be difficult. For all these reasons, the counseling she received was essentially unhelpful.

Later, with a deteriorating mental state, she presented to the triage nurse, who was responsible for assessing the reasons for encounter and deciding on who should see the patient. "Sleep disturbance and nausea" is noted and she was referred to the clinical nurse practitioner for further medication. The nurse also states that, "social problems were looked at and counseled". No indication is given of what that may have comprised, but the next time this patient presented to the health service it was as a result of her fourth suicide attempt.

On interview we discovered that Nomsa was scared her partner will kill her. Even though she had presented 11 times to the health centre and frequently discussed these difficulties, her

reproductive health was neglected and she had become pregnant with her fifth child. This seems to have been a trigger for the last suicide attempt.

This patient received far more attention than most, and yet the biomedical frame of the service meant that she was forced to rely on fragmented referrals linked by a notable lack of empathy and insight. This failure to think comprehensively and to accurately assess the severity of her problem was a common theme in the case studies.

Another case in a rural clinic exposed the cold, perfunctory nature of the social worker's approach, and how it focused on legislative procedures rather than emotional availability. Carolyn was so dissatisfied with the untherapeutic nature of the encounter that she refused to see this social worker again. The social worker's notes were as follows:

> "Woman seen about home circumstances. She was requesting advice about divorce. I explained that I can't give advice but rather guidance with regard to therapeutic intervention. Further I explained that I am not a lawyer and that she should preferably go for legal advice.
>
> Woman threatened to kill herself. She feels helpless and is looking for answers.
>
> Action plan:
>
> - refer for protection order
> - undertake to phone Legal Aid
> - discuss suicidal ideation with doctor
> - follow-up telephonically."

These notes reveal a management plan that appears reasonable, but failed to build a therapeutic relationship or to recognize the mental health problems that would make dealing with the courts difficult. At this point she was referred to our study where it transpired that she had been in an extremely abusive marriage for over 30 years and that she was in urgent need of help for anxiety and depressive disorders.

**Continuity and co-ordination of care**

There was no consistent follow up of patients by a specific health provider who could ensure ongoing continuity and co-ordination of plans. For example, even though a healthcare provider noted that Nomsa reported that her husband became violent under the influence of alcohol, that she was scared he will kill her, little progress was made. Referral was made to the Family and Marriage Society of South Africa (a local social service organization), "regarding her contemplation of divorce and the relationship problem and also the contravention of the marital contract. To see social worker in due course." However there was no further evidence of her seeing a social worker. Indeed the last management plan recorded in her folder seven months after she was originally referred, was for "urgent social work referral."

In the case of Daphne, the psychiatric nurse noted many social problems, primarily marriage problems which had worsened since the death of her mother. However the subsequent psychiatrist's assessment made no reference to relationship issues or relevant management and follow-up despite the fact that her husband was extremely verbally abusive and had threatened to kill her with his gun. Perhaps the psychiatrist was concerned to protect confidentiality, but such omissions beleaguer continuity of care and effective team work which is so critical if primary care services are to function efficiently.

**Record keeping**

Continuity of care was further undermined by poor record keeping. Copies of referral letters were frequently not included. For example, Nomsa was seen by a nurse and the matter discussed with a doctor: "Contacted Saartjie Baartman Centre (local shelter for domestic violence) for alternative placement ... client not keen to divorce husband. Letter written to court as per client's request. Patient to be seen soon."

No copy of the letter was included in her folder.

**Comprehensive versus fragmented care**

Women suffered from a lack of a comprehensive approach with different providers each looking at one aspect of the problem. This implies that a generalist is needed who is willing to make a comprehensive assessment and at least co-ordinate care across the full range of issues while offering empathic understanding and continuity. The culture of vertical programmes, such as for psychiatric, reproductive health or HIV, contradicts the delivery of comprehensive and integrated care. IPV needs a generalist who is willing to provide a comprehensive response.

**Discussion**

This study demonstrates that the quality of care in the district health system of the Western Cape, offered to the small percentage of women who are recognized as having a problem with IPV, is fragmented and inadequate. Documentation in the medical record tends to be scanty and superficial, reflecting similar findings elsewhere (Colombini, Watts, & Mayhew, 2008). This is problematic in the light of substantial evidence that IPV is linked to multiple immediate and long-term health consequences, including physical disability and death (Krug, Dahlberg, Zwi, & Lozano, 2002).

A decade into post-apartheid South Africa, Andrews and Pillay's assessment of progress in the health care system, highlighted a failure to mainstream gender issues within the health sector. They suggested that this reflected ineptitude at addressing and resolving problems that require an integrated approach, exacerbated by a lack of collaboration and co-ordination within the Department of Health (Andrews & Pillay, 2005). Such a fragmented approach is unlikely to help.

Evidently, prior to our intervention, most health providers, both doctors and nurses, had failed to obtain a psychosocial history, or to ask about a history of sexual or physical abuse, or to

address issues of safety. Even if a woman does not choose to pursue interventions, a clinician's support is an act that may, in the long run, contribute to her being able to change her situation (Hegarty, Taft, & Feder, 2008).

South African primary care nurses are fundamentally responsible for the service provided; yet their training and subsequent practice has remained biomedical and task oriented. Clinical nurse practitioners struggle to provide a holistic and patient-centred approach – with significant implications for the provision of IPV care. For example, a recent morbidity survey of South African primary care demonstrated that psychological and social problems are rarely diagnozed or recognized (Mash et al., 2012). The training of clinical nurse practitioners should focus more on developing a biopsychosocial approach that can at least recognize the presence of psychological and social problems and initiate a response.

Current chronic care policy in the Western Cape initiates the concept of 'champions' who provide continuity of leadership for chronic care and practice. The IPV champion would also take responsibility for co-ordinating care between all the role players and ensuring that the organization keeps focus on maintaining and strengthening the service. This model could work for IPV care if the 'IPV champions' are selected according to specific characteristics and qualities that create a therapeutic environment. Policy must specify that this person should be capable of handling the demands of emotional labour as well as consistently exhibiting empathy and good listening skills; respect for client confidentiality and autonomy; a collaborative approach to problem-solving; effective multi-disciplinary team work; and good networking skills to foster intersectoral collaboration. Thus the champion could be any member of staff at the community health centre who is interested and able to work with IPV in this way.

Scant documentation of issues pertaining to a patient's abuse is an international phenomenon (Buel, 2002). Yet medical records often comprise the sole documentation of patient's injuries. Given their forensic significance, medical records should contain all key facts

(Gerbert. Moe, & Caspers, 2000; Joyner & Mash, 2010). In our sample of medical records of IPV survivors, the only mention of IPV-related injuries is of the most reductionist kind. Minimalistic entries may represent the cursory manner in which the patient was handled or the overloaded nature of the health provider's caseload, which leaves little time to make comprehensive notes.

Structural changes to documentation that make recording of IPV mandatory have a far higher success rate with changing health provider behaviour than training and education alone (Harwell et al., 1988; Olson et al., 1996). A comprehensive approach to IPV should be formalized within health systems and training so that continuity and coordination of care can be improved. Not only is this a key feature of quality care, it also has significant ethical implications. In the case of Nomsa for example, a better coordinated, proactive approach could have prevented her fifth (unwanted) pregnancy. The growing evidence of the high risk of unwanted pregnancies in abusive relationships suggests that serious efforts should be made to integrate reproductive health with IPV care (Palitto & O'Campo, 2004). Violence often results from sexual health problems and reproductive issues. For example, covert contraceptive use renders some women vulnerable to IPV (Njovana & Watts, 1996); women's refusal of sex is frequently cited as a justification for violence (Jewkes, Penn-Kekana, Levin, Ratsaka, & Schreiber, 1999); fear of violence in the home and consequent ostracism is an important reason why pregnant women refuse an HIV test or do not return for the results (Krug et al., 2002). In South African antenatal care, IPV is significantly associated with HIV seropositivity (Dunkle et al., 2004).

Table 2 demonstrates that the majority of women were referred to specialists such as psychologists, social workers, or psychiatric nurses. Clearly, no one sees each woman comprehensively, but prefer to deal with only a piece of the problem. The primary care provider, who is the generalist, is either too busy or lacks the competencies required to coordinate comprehensive care. Consequently the woman is treated in a fragmented fashion.

Elsewhere we recommend that following identification and the provision of appropriate clinical care, the woman should be referred to an IPV champion (Joyner & Mash, 2012b). The IPV champion, if properly selected and trained, may be better able to complete a comprehensive biopsychosocial and forensic assessment and care plan, provide ongoing care and refer to community-based support groups.

Services by health care providers that give patients a sense that they are being cared for has been termed emotional labour. This relates to the element of work that is involved in being sympathetic, empathic and respectful. If emotional labour is unrecognized in health care systems it may be that it does not easily fit the biomedical organizational culture (Small, 1995). Further, care and emotion are concepts that have strong cultural associations within the private realm of love and feelings, rather than the public world of work. Caring individuals and a safe environment have been found to be most beneficial in assisting women who live with IPV, "It's not so much what people do to help, but how they do it." (Stenius & Veysey, 2005, p. 1155).

A recent study of primary care doctors in Cape Town found high levels of burnout characterized by emotional exhaustion and depersonalization that would make it difficult for them to provide the necessary emotional labour (Rossouw, 2011) Similarly, the organizational culture in primary care facilities is characterized by poor communication, blame, control, and manipulation and can therefore also be seen as potentially abusive (Mash, Govender, Isaacs, de Sá, & Schlemmer, in press). These issues may also be vitally connected to the failure of primary care nurses to recognize anxiety and depression (Mash et al., 2012).

Unsurprisingly therefore, the counseling offered by various health providers seems to be predominantly directive and judgemental and more characteristic of an "inhibitive helper response" (Limandri, 1987). Many providers internalize and consequently perpetuate in their practice the misguided *separation assumption* of the dominant discourse on IPV. This is the assumption that separation from the partner will resolve her problems and is the only solution.

This fails to acknowledge the autonomy of the women, the complexity of relationships and the variety of choices or goals that may be reasonable in a specific context. By contrast, a "facilitative helper response" would acknowledge the seriousness of abuse and that the women are not to blame for it. Active and compassionate listening should be combined with assisting the woman to assess her internal strengths and to consider the full range of available options (Limandri, 1987). Limandri developed these categories during her pioneering qualitative work with abused women. Motivational interviewing terms this a guiding style (Rollnick, Miller, & Butler, 2008).

Vuyi provides a florid example of how pervasively abuse impacted on her mental health, with ongoing effects even after the relationship had ended. Indeed, findings confirm psychiatric disorders to be a persistent and disabling consequence of IPV; particularly depression, post-traumatic stress disorder, chronic anxiety and substance misuse (Rees et al., 2011). In an investigation into the strength of association between adult mental health disorders and childhood sexual abuse, sexual assault in adulthood or domestic violence; the latter showed the strongest associations with most mental health measures (Coid et al., 2003). These findings support the importance of all mental health clinicians and primary care providers actively seeking evidence for IPV and treating survivors proactively for mental health problems.

A cross-sectional investigation of 1293 young rural South African women (Jina et al., 2012) found that emotionally abused young women are more at risk of suicide than those experiencing no abuse. The combined experience of emotional with physical and/or sexual abuse was strongly associated with poor mental health outcomes.

Patients' entrapment tends to overwhelm health providers, preventing them from assisting such an IPV survivor. Yet empathic, constructive attention from the study nurse impacted positively on their mental health (Joyner, 2009). Women experiencing IPV want recognition

and ongoing support from health care providers, without pressure for a specific course of action (Joyner & Mash, 2011).

The re-engineering of primary care, and training of community health workers and nurses in community-based teams responsible for households, needs be predicated within a conceptual framework that prioritizes the problem of South Africa's gender-based violence epidemic. A genuinely biopsychosocial and forensic approach should be implemented within primary care as a matter of urgency.

**Limitations**

Given the hidden nature of IPV and lack of standardized care guidelines it was not possible to conduct an audit of the quality of care as one might do for other chronic diseases. Findings were based on a small number of case studies and it is not possible to generalize to other primary care settings from a qualitative study based on a number of purposefully selected health centres. Nevertheless we would expect that the findings are reasonably applicable to similar settings in the Western Cape. As the health services in the Western Cape are generally better resourced than other provinces we would anticipate that care may be worse elsewhere.

**Implications and recommendations**

1. Primary care providers need to be trained and enabled to offer a more comprehensive biopsychosocial and forensic approach to IPV. This means that nationally, IPV-related knowledge and skills should become a compulsory component of all nursing, medical and community health workers' curricula.
2. Primary care providers need to offer a more empathic and patient-centred approach to their interactions. These competencies should be embedded in the training of these three groups.

3. There is a need for a generalist at the heart of caring for women with IPV. This person should be able to provide holistic, ongoing care and to co-ordinate other services. Primary providers should have all these attributes, but their training does not seem to have provided them with these vital generalist skills.
4. Attention should be given to improving documentation of IPV within patients' medical records, so as to provide women with evidence of abuse sustained should they require it in the future.
5. Consideration should be given to making active case finding part of the structured medical record in specific settings e.g. family planning, antenatal and postnatal care.

**Conclusion**

The study suggests that most women living with IPV who attend primary care facilities are not recognized. Amongst the few that are identified, care tends to be superficial, fragmented, poorly co-ordinated and lacking in continuity. The recognition, management, and appropriate documentation of IPV should be prioritized within the training of primary care providers. It may be necessary to appoint IPV champions within primary care to ensure comprehensive care for survivors of IPV.

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**Table 1: Profile of the study population**

| **Patient's pseudonym** | **Age** | **Context** | **Nature of abuse** |
|---|---|---|---|
| Vuyi | 43 | Married with one son. Husband abuses alcohol. | Physical, emotional and financial abuse, including attempted femicide. After they married, he started attacking her with metal weapons all over her body while inebriated. He also hit and |

| | | | |
|---|---|---|---|
| | | | kicked her, insulted her and controlled all financial decisions including refusing her permission to work. When she found a job he burnt her clothes, official documents and even set light to her shack (home) while she and her son were inside it. Intimate terrorism/coercive control |
| Nomsa | 39 | Married with four children and subsequently pregnant. History of psychotic depression and 3 suicide attempts. Husband abuses alcohol. | Physical, emotional and financial abuse, including threatened femicide. For example, “verbal abuse is worse – he uses strong words, always blaming me. That makes me feel worthless, stupid …I hate myself most of the time”. Also, her husband does not allow her to meet people, not even neighbours. No friends, no work. Intimate terrorism/ coercive control |

| | | | |
|---|---|---|---|
| Candy | 49 | Married with two teenage daughters. Major depressive disorder with suicide attempts. | Emotional, social, sexual and physical abuse, including use of a weapon. For example her husband expects sexual activities from her that she abhors. Intimate terrorism/coercive control |
| Sylvie | 39 | Breadwinner for family with 5 children. Currently also supporting ex-husband who lives with them. He is addicted to metamphetamine. | Physical, emotional, financial and sexual abuse, including use of a weapon. For example he becomes extremely verbally abusive if she refuses him sex. Sometimes he wants it three times a night. He also has tramped on and kicked her with safety boots to gain her compliance. Intimate terrorism/coercive control |

| | | | |
|---|---|---|---|
| Carolyn | 51 | Mother of four sons currently cohabiting with ex-husband. | Physical, sexual and emotional abuse. For example he chopped a piece of her finger off and her 10 year old son commented that the dog had eaten it.<br>Intimate terrorism/coercive control |
| Meryl | 27 | Married with one foster son. History of epilepsy and depression with psychotic features. Husband abuses alcohol, also has a girlfriend and is unemployed. | Emotional, financial and sexual abuse.<br>For example he sometimes wants to have sex three to four times per day, "my whole vagina is sore – inside, outside it is sore. Even if I have my period he wants sex. No foreplay, he just shoves it in and goes on and then leaves me lying there. I feel nothing." He threatens to kill her if she won't have sex with him. " … patient wants to kill her husband but admits to no specific plan."<br>Intimate terrorism/coercive control<br>Violent resistance |

| | | | |
|---|---|---|---|
| Daphne | 34 | Married with two children and has a problem with alcohol. | Emotional, sexual and physical abuse, including death threats. He has threatened to kill her with his gun. She also becomes aggressive when inebriated. Mutual violent control |
| Olive | 46 | Married with three children. | Physical, sexual, financial and emotional abuse, which culminated in attempted murder. Intimate terrorism/coercive control |
| Thobeka | 39 | Mother of three and married for eight years. Lives with epilepsy and alcohol dependence. Husband's family are also hostile and complicit with abuse. | Emotional, financial, verbal and physical abuse. For example, husband unfaithful, withholds money and controls all financial decisions, restricts her contact with family and friends, pushes her around and insults her. Intimate terrorism/ coercive control |

| | | | |
|---|---|---|---|
| Shamiz | 44 | Married according to traditional Muslim rites, with five children. Chronic depression. | Emotional and social abuse. For example insults, shouting, restricting contact with family and friends, controlling her activities. Intimate terrorism/ coercive control |
| Jackie | 40 | Mother of four children who live with their fathers. Now with abusive boyfriend. History of epilepsy, substance abuse, depression and anxiety. | Physical, emotional, sexual and financial abuse. He assaults her physically and psychologically. Intimate terrorism/ coercive control |

**Table 2: Management of patients (N=11)**

| **Management plan** | **N** |
|---|---|
| **Social issues** | |
| Referral to social worker | 7 |
| Referral to shelter | 2 |
| Referral to Family and Marriage Society of South Africa | 1 |
| Administrative procedure e.g. social grant, referral letter | 3 |
| **Legal issues** | |
| Referral to Domestic Violence Court for Protection Order | 2 |
| Referral to police | 1 |

| | |
|---|---|
| **Psychological issues** | |
| Referral to psychiatric nurse | 1 |
| Referral to psychologist/psychiatrist/ psychotherapeutic group | 3 |
| Admission to psychiatric hospital | 1 |
| Referral to marriage counselor | 1 |
| Prescription of psychiatric medication | 7 |
| **Clinical issues** | |
| Referral to medical officer | 1 |
| Suture and dressing | 1 |
| Medication prescribed e.g. analgesics | 1 |