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Enhancing Agency for Health Providers and Pregnant Women Experiencing Intimate Partner Violence in South Africa

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Abstract

Global policy frameworks call for strengthening the role of health systems to address intimate partner violence (IPV) and support women's agency, yet the evidence of health system responses remains slender in low-and-middle-income-countries (LMICs). In South Africa, 25–35% of pregnant women experience IPV, posing long-term health risks. We utilised agency as a theoretical construct, applying qualitative methods to investigate health professionals' experiences of a randomised controlled trial intervention to address IPV in pregnant women in five antenatal clinics (ANC) in Johannesburg (2011–2016). In-depth interviews (n=16) were supplemented by participant observation, debriefing and field notes. Health providers viewed the intervention as *enhancing health promotion agency* and *advancing help-seeking agency* for IPV-exposed patients. Intervention nurses reported their own *self-efficacy improved*, and their *relational and collective agency expanded*. Ongoing supervision, mentorship and feedback were essential to establish the knowledge and skill-building necessary for providers to improve self-efficacy in intervention delivery. Integrating mental health services into primary ANC services is recommended. Findings offer insight into the untapped potential for LMIC health settings to become transformative, gender-responsive social systems, for patients and health professionals, in ways that advance women's agency, health, human rights and SDGs.

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Keywords

Intimate partner violence; agency; health systems; implementation science; randomised controlled trials; low-and-middle-income countries; South Africa

Background

Intimate partner violence (IPV) is defined as behavior by a current or previous partner that causes psychological, physical or sexual harm (WHO, 2013a). IPV prevalence is an estimated 30% for women, globally; and even greater for women in sub-Saharan Africa: up to 57% (WHO, 2013a). Experience of IPV in pregnancy is associated with significant negative health consequences, including women's increased risk of miscarriage, premature delivery, stillbirths, abortion, low birth weight infants, chronic pain, as well as HIV acquisition, poorer HIV testing uptake and lower adherence (Campbell, 2002; Hatcher, Stockl, Christofides, Woollett, Pallitto, & Garcia Moreno, 2016). Though neglected in national policies of low-and-middle-income countries (LMICs), IPV during pregnancy also adversely affects women's mental health. Negative mental health effects encompass anxiety, post-traumatic stress disorder, depression and low self-esteem (Sugg, 2015). Additionally, mental health sequelae may persist over the life course and become intergenerational (Glover, 2015; Wachs, Black, & Engle, 2009; Woollett & Thomson, 2016).

Today, global policy frameworks, notably Sustainable Development Goal (SDG), 5 (gender equality) and 3 (health and wellbeing), are supportive of addressing violence against women and women's mental health (WHO, 2019). While there is growing recognition that interventions to address IPV may be helpful for women, especially in prenatal or antenatal care (ANC) settings (WHO, 2016; WHO, 2013b), the evidence of health system and health provider responses to IPV remains slim and poorly understood (Virkki, 2015), especially in LMIC contexts characterised by poorer health and physical infrastructures, health provider shortages, overburdened staff and systems (Mills, 2014).

In 2013, WHO issued clinical and policy guidelines to direct health providers on how to respond to IPV-exposed patients in health settings. This guidance recommended a minimum threshold level of training for health providers: if absent WHO does not encourage the health sector to engage with IPV (2013b). In South Africa there is currently no training nor national guidelines to govern how health professionals should address IPV in the health system—though 25%–35% of women experience physical or sexual violence in pregnancy (Gass, Stein, William & Seedat, 2010; Hoque, Hoque, & Kader, 2009). Therefore, to align with current WHO guidelines, the South African health system would need to either upskill entire cadres of health professionals or ignore IPV altogether.

The national South African public health sector, staffed by an estimated 30% of the country's doctors, remains the exclusive provider of care for more than 40 million people who are uninsured and constitute 84% of the population (Mayosi, Lawn, van Niekerk, Bradshaw, Abdool Karim, & Coovadia, 2012). This sector is challenged by a legacy of maldistribution of staffing and skills that has compromised its ability to deliver key programmes, particularly for HIV, tuberculosis, child health, mental health and maternal

health (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). Given that health professionals are key implementers of IPV-related interventions in such constrained environments, it is crucial to understand how they perceive such interventions. It is equally important to investigate potential changes in agency among health providers themselves or among their patients. Indeed, the institutional agency within broader health systems in resource-limited settings (Lund, Kleintjes, Kakuma, Flisher, 2010) has been under-studied but holds potential for understanding structural levers to advance women's health (Hay, McDougal, Percival, Henry, Klugman, 2019; Campbell & Mannell, 2016; Freedman, Waldman, de Pinho, Wirth, & Rosenfield, 2005).

Against that background, this study seeks to contribute to scholarship calling for interventions to better meet demands for real world implementation that overcome the 'science to service gap'—to build theory and translate research knowledge into practice (Onken, Carroll, Shoham, Cuthbert, & Riddle, 2014)—particularly in LMICs. We drew upon agency as a theoretical construct to investigate potential changes expressed by health professionals for themselves and in relation to patient care. We also examine the implications of these changes for the institutional agency of the primary health care clinic.

Nurses in South African historical context

The cadre who implemented the intervention in Johannesburg—nurses—have the most direct contact with patients in the South African public health system (see Box 1). Indeed, across income settings, nurses remain the backbone of health services' delivery (Okello & Gilson, 2015). South African nurses are a complex group who maintain elements of both social status and marginalization (Honikman, Field & Cooper, 2019). Nurses have higher educational attainment, employment security and higher socio-economic status compared to their patients (owing to nurses' professional job security and standing). Yet the vast majority of nurses are black South African women who hail from the same communities as the women they treat (Coovadia et al., 2009; Marks, 1994). Nurses thus have a shared understanding of the social-cultural norms that influence the agency of their women patients who experience IPV. Our previous research and colleagues have indicated that nurses in South Africa can be regarded as agents of change; and that primary healthcare clinics can be viewed as key locations of intervention for women who experience IPV within broader social systems (Sprague, Woollett, Parpart, Hatcher, Sommers, Brown & Black, 2016; Kim & Motsei, 2016; Freedman, Waldman, de Pinho, Wirth, & Rosenfield, 2005). At the same time, nurses own agency can be magnified or diminished within these same clinical settings, based on context-specific and even situational factors—lending a complexity and import to understanding their agency.

Agency: context and definitions

In recent years, rich scholarship on agency has evolved in response to the grave social problem of IPV. A developing corpus especially from the LMICs has challenged long-held feminist assumptions that define agency as the struggle between patriarchy and women who are subordinate (Madhok, Phillips, & Wilson, 2013). The agency literature, previously under-theorised in relation to women in marginalised or extreme settings, had conveyed IPV as a personal problem dependent on individual-level action by women, rather than

recognizing structural-level factors that shape the context for women's abuse (Campbell & Mannell, 2016). We rely on Mahmood's definition of agency 'as a capacity for action that historically-specific relations of subordination enable and create' to inform this work (2001, p. 203). Building on our earlier work, we define institutional agency as institutions that enable or disable women's capacity to make choices that support their health, development and wellbeing: with the South African public health system serving as a key venue for women who experience IPV, particularly antenatal care settings (Sprague et al., 2016).

Agency is recognised as tethered to specific social contexts that restrict, limit or enable what women are able to do and be, their capabilities (Sen, 1999; Sprague, 2018). Recent literature reflects greater emphasis on capturing the multiplicity of women's lives by disrupting binaries of helpless victim vs. savvy survivor (Shefer, 2016). Agency literature has started to give greater consideration to women's expressions of thought (Mahmood, 2001), silences (Parpart & Parashar, 2018), and choice, including the decision to strategically remain in abusive relationships (Meyer, 2016; Horn, Puffer, Roesch & Lehmann, 2016). Agency is certainly informed by political economy, intersectional identities and determinants, including race, ethnicity, socio-economic status and socio-cultural norms (True, 2014; Logie & Daniel, 2016). Equally, agency as a concept has been explored and has evolved in concert with other theoretical approaches, such as post-structural feminism, queer theory and the sociology of gender (Canon, Lauve-Moon, & Buttell, 2015).

In South Africa, abuse of women has widely become normalised (Boonzaier, 2005; Meyersfeld, 2008), as it has in other patriarchal contexts (McCLEary-Sills, Namy, Nyoni, Rweyemamu, Salvatory, & Steven, 2016). The agency of girls, adolescents and women is informed by dominant social constructions of gender norms and accepted gender roles in South Africa, including being submissive to male partners, being sexually available, and affording men the decision making power related to sex (Jewkes, Nduna, Jama Shai, & Dunkle, 2012). Of significance, HIV prevalence in women of reproductive age (15 to 49 years) is particularly high in South Africa, averaging over 26%, and 29% or greater in pregnant women annually, since 2004 (Simbayi et al., 2019). HIV poses additional, significant health risks to women and their children. Social determinants and structural factors of poverty, unemployment, lack of financial security and independence are recognised as contributing to IPV and HIV in this and other settings (WHO, 2013c). Indeed, scholars have emphasised that sexual health, vulnerability to HIV, other sexually transmitted infections and HIV risk behaviours cannot be effectively understood or addressed unless attention is paid to constructions of gender, sexuality, and how women perceive and express agency in South African social-cultural context (Shefer, 2016; Casale, Rogan, Hynie, Flicker, Nixon, & Rubincam 2011).

Design and methods

We employed qualitative design and methods, which have increasingly been incorporated into different stages of randomised controlled trials (RCTs) (Davis, Minckas, Bond, Clark, Colbourn, Drabble, Hesketh, Hill, Morrison, et al., 2019). This rise may accord with frameworks, such as the UK's Medical Research Council (2000); and reflect growing understanding of the applicability and value of qualitative methods for interventions. If

RCTs ask the broad question, does the intervention work?—then the incorporation of qualitative methods to explore intended and unintended changes introduced by interventions is based on the assumption that such methods can assist in investigating, for example, ‘why does the intervention have therapeutically beneficial aspects?’ (Oakley, Strange, Bonell, Allen, & Stephenson, 2006). Understanding the mechanisms underpinning the intervention that generate change is essential to determining how effects occurred and might be replicated. Of significance, fit with context is key to intervention success and understanding context is important in interpreting intervention findings (Moore, 2015). Qualitative methods are well-positioned to explore these complex determinants influencing women’s health and health equity (Griffith, Shelton, & Kegler, 2017). This includes social-structural factors that may even lie outside of conscious awareness (Burke, Galen, Pasick, & Barker, 2009). Moreover, qualitative techniques are predicated on establishing trust with participants, thus allowing for probing sensitive or stigmatised subjects like IPV (Sprague, Scanlon & Pantalone, 2017).

We did not hypothesize or assume changes in the agency of participants in advance of the qualitative study, which began after the trial ceased. Rather, in line with the use of social theory in applied social science research, we allowed expressed changes in agency to emerge and be grounded in the respondents’ statements to reflect their views and experiences.

Ethics approval for the study was received from ethics research committees of the University of the Witwatersrand and the World Health Organisation. Each participant provided informed, written consent prior to interviews.

Data collection and analyses

The goal of the qualitative data collection and analyses was to capture health provider perceptions of changes in their own agency or that of patients after taking part in the *Safe & Sound* intervention. We used two primary data collection techniques to yield insights from different sources: in-depth interviews and participant observation. For triangulation, we also collected supplementary data sources: intervention session debriefings and field notes (Jones & Smith, 2017). Two authors on the intervention team [NW and AMH] conducted participant observation and collected debriefing notes to capture salient insights and the context for and changes taking place in the health system (Mays & Pope, 1995). The first author [CS] kept field notes.

Using purposive sampling to identify respondents with knowledge and direct or indirect contact with *Safe & Sound*, we conducted in-depth interviews in July 2016 with the following: health professionals aware of, but not directly involved in, the intervention, including: nurses and counsellors (8); research nurses who implemented the intervention (5); and intervention team staff (3) (n=16 total).

To minimize the risk of social desirability bias, all in-depth interviews were conducted by the first author, who was not involved in the intervention (Lincoln & Guba, 1985). Question guides were semi-structured and tailored to each group: non-intervention health professionals in the clinical sites; the research nurses; and intervention staff. The guide for non-intervention health providers explored their perceptions of the *Safe & Sound*

intervention, role and preparedness of the health system, barriers and benefits, policy and leadership. The guides asked health providers to reflect on any perceived changes in their own agency related to patient care, including attitudes, behaviors or knowledge, resulting from the intervention. The guide for intervention nurses added questions concerning patients' behavior and perceived changes; nurses' experiences implementing the intervention components; and perceived changes after training and intervention implementation.

We managed data collection, coding and analysis in Microsoft Excel and Word. We conducted initial coding, with follow-on, iterative coding and comparative analysis that synthesised and categorised the data by analytical themes. We established common factors in the narratives, based on broad coding; then completed supplementary, finer coding. We paid attention to dominant perceptions and shared experiences across those interviewed vis-à-vis agency as a construct, producing the analytical themes based on participants' reflections. Throughout, we followed an iterative code-recode strategy that enabled reflexivity and greater in-depth insight among the group: a process associated with greater rigor in qualitative data analyses (Lincoln & Guba, 1985).

Setting and sites

Research was conducted in urban Johannesburg in five antenatal clinics within the South African public health system where the *Safe & Sound* intervention was implemented. The antenatal clinics served primarily low-income women of African descent.

South African nurses (called 'research nurses') implemented the intervention components: all were black South African women with bachelor-level education and no previous IPV training. They received a 30-hour manualised training developed by three mental health professionals and a social scientist. The modules encompassed a range of soft skills and technical aspects associated with recognising and addressing IPV. An ongoing, crucial aspect of the intervention was the mentorship and supervision of the nurses leading the 'empowerment counselling' by expert intervention staff (Dutton, 1992; Hatcher et al., 2018; Pallitto et al., 2016). Following the 30 hours, mentorship occurred by one of the model developers (McFarlane & Wist, 1997; McFarlane, Groff, O'Brien, & Watson, 2006). Thereafter, supervision occurred during weekly debriefings among the intervention team. These two-hour sessions reviewed progress over the week, with detailed discussion of one or two difficult cases of patients experiencing IPV, and strategies to better manage professional roles and boundaries. The model was trauma-informed and team learning occurred in a collaborative, consistent manner, with an emphasis on the establishment of a safe, emotional space for debriefing of fears, challenges and difficulties. The goal of debriefings was to promote learning, enhance knowledge, increase problem-solving and case management skills.

Findings and discussion

A set of analytical themes emerged from the two cadres, who again had very different experiences of the intervention, reflecting their level of engagement with the trial. Of note, the first cadre of health providers (HPs) who were not involved in taking direct responsibility for intervention activities (2011–2016), but sensitised to IPV-related activities,

primarily highlighted changes in agency that were enhanced in their patients. In contrast, the research nurses who implemented *Safe & Sound* communicated marked changes in their agency vis-à-vis caring for IPV-exposed patients, captured in the dominant themes of *enhanced relational agency* and *expanded collective agency*. Additionally, they reported their own agency developed, as *increased self-efficacy*.

We begin with the first cadre (n=8), six were professional nurses (all black South African women) and two were counsellors (both African men: one from Zimbabwe, the other South African) The chief themes were: (i) *enhances health promotion agency* for women patients; and (ii) *advances their help-seeking agency*.

Non-intervention health professionals

Enhances agency in women patients' health promotion—Notably, all respondents communicated that the intervention was important to enhance the agency of women patients, to advance women's health promotion for themselves, as well as their children. HPs indicated they began to recognize that abuse in intimate partnerships could be the underlying cause of physical injuries or mental health problems for their patients that was largely untouched, as Busi stated:

As nurses, we did not poke enough about violence [prior to the intervention]. We have a focus on physical health, such as high blood pressure. Now we know there may be an issue underlying the hypertension, and we [ask], 'how is home?'

In this manner, health professionals consistently communicated their recognition that IPV was like a slumbering giant at the root of women patients' poor health that they hadn't dared disturb.

Multiple respondents emphasised the link between presenting symptoms and IPV. Thobeka observed:

IPV in South Africa is a very big problem...25% of women experience IPV. I do have mothers here: she had a bruise on the eye. She said the partner beat her up. The other day, a woman with a broken jaw. The screening that [research nurse name omitted] did, she found a lot of [abused] women presenting with lower abdominal pain, but this has something to do with abuse.

Continuing, Thobeka reflecting on the value of the intervention for women's health:

'this [intervention] helps women emotionally, physically, HIV.'

Rufaro characterised the role of the IPV intervention as essential for: 'the safety of mothers.' Rufaro also noted that the intervention offered a 'structure for health and support' for patients:

'[It] provides a location [for] women to be screened and to address violence.'

Lindiwe emphasised a primary benefit of women becoming aware of risks associated with IPV exposure:

'Patients become sensitised to IPV health risks.'

Nomonde stressed the importance of consistency in IPV screening:

‘[it is] very important if it is routine.’

These health professionals, commenting on the addition of a tangible mechanism and way to address IPV in the health system, seemed to be highlighting that the structure created by the intervention was an enabling one for women’s health promotion.

Of import, the majority of respondents emphasised the critical role of *Safe & Sound* in connecting women to HIV treatment and prevention within South Africa’s high HIV prevalence setting. HIV management in ANC encompassed access to prevention of mother to child HIV transmission (PMTCT) programs (Hatcher et al., 2016; Sprague, Chersich & Black, 2011). Siphon communicated the value of IPV interventions for HIV management in his patients:

It [IPV intervention] may help with HIV management and the baby will grow up in a safe environment.

Health professionals also characterised a function of IPV interventions, as starting the conversation to be able to focus on women’s health needs, including and importantly, HIV stigma. Women are often not aware of the full range of HIV services so essential to access in pregnancy. HIV stigma has been shown to significantly impede women’s uptake of HIV services (Logie, Lacombe-Duncan, Wang, Kaida, Conway, Webster, 2018; Hatcher et al., 2016). Rufaro points to this problem:

Ladies are left HIV positive... Mothers are stigmatised... Most of these women were infected with HIV by a partner... not aware of HIV services.

Rufaro states that ‘opening the conversation’ about women’s abuse allows for addressing HIV as an inter-connected health concern.

Like the previous respondents, Thobeka focused on HIV but stressed a different dimension: the role of the intervention for HIV testing and rights’ sensitization for women—part of South Africa’s constitutional commitment. HIV testing is a first step in gaining an HIV diagnosis, as she stated:

‘It may facilitate HIV testing and rights. It can help.’

Health professionals also stressed the importance of intervening to protect the health of infants, as well as women. Nomonde emphasised:

‘Negative impacts on the baby’s health could be detected [through screening].’

Continuing this theme, Thobeka emphasised that one location was not enough: this aim could be better achieved if the intervention were to be implemented in multiple locations of the South African health system:

There should be a [research nurse name omitted] in every department or ward where there are mothers or children. Should be in ANC. In labour ward and other wards. Especially TOP [termination of pregnancy] because men force women to terminate.

In addition to physical health, HPs perceived the intervention as helpful for women's mental health, including alleviating depressive symptoms. This view was reinforced by most respondents, and captured by Lindiwe here:

It does make a good impact. This client she [intervention nurse] saw, there was a great difference... No more depressed... Much better than her first time.

Across the narratives, respondents communicated that the intervention allowed them to make the connection between presenting health symptoms and abuse in the home. Respondents saw the intervention as supporting the health promotion agency of women and their children. And, they characterised *Safe & Sound* as a vehicle for the enhanced agency of HPs to promote and protect the physical and mental health of their patients.

Advances help-seeking agency

A second primary theme was HP perceptions of the role of the intervention in advancing help-seeking for women patients who were experiencing abuse, as Siphso observed:

The time that [intervention staff omitted] were here, I think it made a difference because...patients [were] wanting to know more. People are looking for help. [Women] may have no place to live because the partner left her.

Information on shelters, legal services and social grants were all viewed as valuable resources for patients seeking assistance. Reflecting on the value of the intervention, Faith echoed that patients who disclose violence are actively seeking help:

It is very good because we know that there is violence but we were not involved because they [research nurses] understood how to assist the patient... Patients who come forward want help....We see that women need it.

Siphso indicated that more women were seeking resources and information as help-seeking, citing figures to support his perception and attributing this change to the intervention:

Per day we have 11 new visits: six of them are interested in the information on violence...Patients become sensitised to...the services available [and] [it] provides an alternative service to the police.

Health providers emphasised that 'the referral and resource lists alone' were seen as 'highly valuable' for health professionals to assist patients with help-seeking. In addition, Thobeka stressed that counselling women to know their options in order to improve their safety was crucial:

'[The counselling] helps abused women to find ways out.'

Lindiwe emphasised, 'colleagues in the health system see the value and benefit...that it supports women's safety [and that] it is our duty.' Respondents also seemed to emphasize help-seeking as a precursor to longer-term health and wellbeing for abused women. She continued:

'[If they can] get help, women are okay. They have safety, protection.'

Strikingly, these individuals were not responsible for directly implementing the intervention; and thus their perspectives were informed and shaped over a five year period of 'witnessing'

and ‘watching’ as the intervention activities unfolded. The importance of help seeking, or ‘finding ways out’ cannot be over-emphasised in a context where the majority of this low-income population is economically dependent on their partners. Indeed, HPs observed that women may not take steps in the short-term but information, resources and referrals could inform women’s options, health and safety over the longer-term.

Research nurses

Among the health professionals chiefly responsible for implementing the intervention, three principal themes emerged: (i) *increased self-efficacy*; (2) *enhanced relational agency*; and (3) *expanded collective agency*.

Increased self-efficacy

The first change in perceived agency was in the research nurses’ self-efficacy to execute and manage the intervention components. Bandura conceived self-efficacy as an integrated theory to reflect confidence in the ability to assert control over one’s own motivations, behaviors and social environment (1977). In analyzing and interpreting the findings, we found that the changes in agency expressed by the research nurses—after five years of training and implementation during the trial—reflected specific advances in knowledge, skills and confidence that were best captured by a more precise concept of self-efficacy (rather than agency alone). We employ Bandura’s definition, where self-efficacy is an individual’s belief in her capacity to engage in those behaviors necessary to produce specific performance attainments (1977, 1997).

As part of the first theme, all research nurses (RN) emphasised the difficulties of engaging violence at the outset of the intervention, before describing how they managed those challenges. Lesedi refers to the stigma associated with IPV and the need to build trust before broaching this sensitive subject matter with her patients:

It was an untouched subject [intimate partner violence]. Women [patients] were unsure, not trusting in the beginning.

Lesedi is referring to the shame and stigma commonly associated with IPV, making it a difficult concern for the research nurses to probe.

Speaking to this issue, Thandekile commented:

It was challenging [to engage IPV with patients] at first. Women may be in a toxic relationship. Lots of emotional abuse. Physical violence was easier... visible.

Dominant social-cultural norms were also highlighted by Palesa as a potential barrier to overcome:

She [the patient] needs to trust you. As Africans you should not share [abuse].. should not discuss family matters with a stranger.

Similarly, Nokuthula drew attention to the very difficult nature of IPV work, and drawing out women’s experiences of abuse at home:

It has been emotional, confronted with women with severe violence. It wasn't going to be easy to deal with this.

Respondents described engaging in training and practice, gaining supervision, as well as mentoring and debriefing difficult cases. Over time, they described developing more mastery of the intervention components. Lesedi described how she learned to gain her patients' confidence:

As you continue [in IPV training], they begin to open up. I became more sure, had a better approach...and understanding [of] how to approach women.

Nokuthula accentuated the importance of recognizing one's own assumptions about the patient population and IPV, while adopting an attitude of nonjudgment and careful listening:

The training was very useful. We dealt with our assumptions, biases. We learned to not judge, to listen, and give them the intervention, which is not advice, just make the women aware, tell them about the cycle of violence, safety measures, referrals.

Lesedi reflected on the evolution in her ability to implement the intervention components, while noting key skills she gained to understand various dimensions associated with IPV:

[We] began to go deeper—to probe into psychology, behaviors, how to dig deeper, looking at nonverbal communication.

In addition to probing and reading body language, Lesedi continued to relay other skills she learned to employ and practice:

[We] learned how to give them [patients] appropriate time...[how to] be understanding...hide your shock to gain trust...[I] referred to the training manual often, revisiting it... developing a tool [for screening].

Reflecting their newfound understandings of effective IPV work, the research nurses repeatedly reported the realization that they could not make the choice for women; that they needed to establish boundaries between themselves and their patients, as Nokuthula observed:

'One could not decide [for the woman].'

Equally, Zama remarked:

'The purpose is for the woman to find the solution herself.'

Nokuthula described how she began to gain confidence in implementing the intervention. She, too, emphasised the role of active listening and non-judgment in working with her patients:

Because of the training, I was able to listen to the problem and listen and show them available resources. [Before] I was too sympathetic, crying with them. I learned to listen and not being judgmental. How to deal with giving them information.

Remarking on this same approach, Lesedi stressed:

'Having a nonjudgmental attitude... is key to getting them to open up.'

Palesa also underscored the importance of learning to listen without judgment, and how she was able to master this over time as a skill requiring diligent practice—ultimately gaining confidence in implementing the intervention:

At first, I was not comfortable asking women about violence. I gradually became confident. Nurses should not be judgmental. We must have [a] loving, listening attitude. We should be there as people and human beings, not as nurses.

In their statements, respondents depicted an essential set of skills they were learning to hone when addressing IPV in their patients, including overturning their own assumptions, listening actively without judgment, while establishing needed boundaries between provider and patient—a hallmark of effective IPV work (McFarlane et al., 2006, 1997). This skill set required practice over time to become effective and to achieve mastery. For the research nurses, the increases in knowledge and skills affected their self-efficacy in implementing the intervention. As their confidence increased, so did their self-efficacy.

Enhanced relational agency

Drawn from social theory, relational agency has been used to describe agency in relation to others, as opposed to a focus only on the individual (Burkitt, 2016). In the context of the intervention, the research nurses characterised themselves and their agency as changing vis-à-vis their IPV-exposed patients. Palesa spoke of her knowledge concerning her patients in the domain of relational agency:

[I] developed empathy, communication skills, probing for violence...getting to the core.

Zama articulated some of the other ways she had changed in terms of how she engaged with her patients, following the intervention experience:

It has changed me...so much. [My] self-learning and development. I'm more sensitive than before...Normally I'm an introvert [with difficulty] intruding in people's space but now I can do it.

Zama continued, describing further shifts in her own understanding and behaviors:

I fell in love with nursing—not focusing on medical issues only. I'm [now] focusing on a person as a totality... We think psychological issues are meant for psychologists. [My] knowledge has improved.

Zama reflected further on her own development:

It made me to be a comprehensive health provider. I have more empathetic... Nonjudgmental. I have increased confidence supporting a woman emotionally [through] counselling.

Nokuthula described the knowledge and skills she gained in communicating with her patients about help-seeking and community resources:

I would make them aware [women experiencing abuse that] the relationship was violent by explaining the cycle of violence and help with safety, also referring them to relevant resources in the community.

Palesa highlighted her increase in empathy for her patients and her growing understanding of and confidence in IPV work:

Now I can understand how patients feel. I understand everything emotionally. I have a depth of understanding. I have confidence.

Similarly, Lesedi stated that her interpersonal communication skills advanced significantly:

I am more sensitive to many aspects [including] detection [of IPV], screening, counselling, reading people, interpersonal skills of building rapport, establishing trust. Sensitivity to violence and interviews, qualitative research methods.

Lesedi continued, highlighting her increased understanding of patient care, through *Safe & Sound*:

You have to trust yourself. I feel confident about [my] skills dealing with any type of abuse, for any age. I can offer counselling to different age groups. I understand prevention [of violence] and drivers. [This is] total patient care: psychosocial and emotional, too, [offering patients] more autonomy and control...[the intervention] gives a totality; it enhances.

Relational agency was fostered between these health professionals and their patients. The achievement of this enhanced agency seemed to occur through routine debriefing, supervision and mentorship among the intervention team. After overcoming difficulties and challenges, the research nurses developed greater understanding of IPV dynamics and the complexity of their patients' psychology and circumstances. They described a new understanding in terms of what mindset and skills were required to make a difference for women. Indeed, respondents characterised changes in themselves as more empathic styles of engagement, including being a 'container' for women—absorbing what patients said. They described how they learned to establish an enabling, empowering environment for their patients without expecting or forcing change; or deciding for them. They indicated they came to view themselves as better providers, able to offer more responsive, holistic care.

Expanded collective agency

Collective agency refers to social problems, like IPV, and solutions that necessitate collective action, or action on the part of a group (Bandura, 1977). At the outset of the intervention, the research nurses described not being politically aware or motivated to take social action on IPV. Nokuthula highlighted her newfound understanding of IPV as a larger, social problem beyond the clinic walls:

It [the intervention experience] taught me not to be ignorant. It [IPV] seemed a bigger problem that needs to be challenged by the health department, the social department, the police, working together.

As a result of her experience implementing the intervention, she characterised the changes in herself as expanding her awareness and skills in ways that could be deployed in other domains to address IPV as a broader social problem:

[But] there is something I can do for other women. I think I have become a specialist in victim-empowerment...I can train other women, empower other women.

Continuing to highlight changes in her own life, Nokuthula drew a link between her newly-acquired knowledge, skills and her ability to contribute to schools, the community and society, including the global goals:

I learnt to have patience with people and problems. I feel confident. I am more empowered. I can teach them and I can teach the community. I can go to schools and churches. I feel good about myself. I feel I am useful to the [health] system. There are Millennium [Development] Goals. I can contribute to lower the level of maternal and child death related to violence.

Lesedi, too, emphasised that the experience of being part of the intervention was pivotal for her, shaping her future trajectory, to take action in her community:

It instilled an urge to open my own empowerment center—male, female, boy, girl —having a family orientation [to violence].

She continued:

I feel confident about my skills, dealing with any type of abuse, from any age. I can offer counseling to different age groups.

Thandekile described how she was transferring her knowledge to other spheres:

[I'm] taking the knowledge home. I brought [the knowledge] to my social clubs where I'm playing an educating role... I now know that colleagues may have problems of their own [they may experience abuse, too].

Referring to herself as a new person, Zama said:

The new Zama...can approach the situation at any given time, even on the street. I started applying my knowledge to my daughter [and her risk of violence].

Notably, nurses' location within a context of IPV, and a South African social activist culture, may have influenced provider motivation to expand their collective agency, which might also be reflected in some other LMICs.

Implications

Non-intervention health providers communicated clear benefits for women's agency in promoting and protecting their physical and mental health for themselves and their children. They also perceived the intervention as addressing a gap in advancing the help-seeking of IPV-exposed women. The extant literature indicates that higher levels of emotional and social support can modify the physical and mental health effects of IPV (Coker, Watkins, Smith, & Brandt, 2003; Coker, Smith, Thompson, McKeown, Bethea, & Davis, 2002); and that help-seeking behaviours can be protective against IPV (Gerino, Calderera, Curti, Brustia, & Rollé, 2018). Yet, in spite of IPV's widespread occurrence, Demographic and Health Survey data from 30 countries found only four in ten IPV-exposed women sought help, attributing this to limited knowledge and trust in legal and institutional support

systems, poverty and adverse gender norms (Klugman, Hanmer, Twigg, Hasan, McCleary-Sills, & Santa Maria, 2014; Logie & Daniel, 2016; Meyer, 2016; McCleary-Sills et al., 2016).

Findings captured here contribute to this literature by affirming that robust IPV-related training in LMICs can support health professionals to implement IPV interventions with confidence. The intervention research nurses reported that participation in the training and related components increased their self-efficacy, and enhanced their relational agency vis-à-vis their patients, allowing them to establish a foundation of trust. The trust forged between patients and providers created the safe space and opening for patients to seek help, and for intervention providers to offer accurate, timely help-seeking resources. By implication, our findings suggest IPV interventions in LMIC health systems may assist with overcoming well-documented barriers that impede women's help-seeking agency.

Moreover, these findings indicate that interventions like *Safe & Sound* may have wider benefits for society. The nurses involved in the intervention characterised their agency as expanding at the collective level. As their knowledge and skills advanced, so did their motivation and desire to take greater action on IPV. They recognised IPV as a larger social problem to be addressed within the clinic setting and outside it. This was an unintended outcome of the intervention that could be bolstered in future projects by encouraging social action alongside health care interventions.

Notably, even the providers not involved in implementing the intervention indicated they became more sensitised to gender-related concerns that undergird IPV. Several non-intervention providers noted that the acceptance of IPV and adverse social-cultural norms and constructions of gender can be questioned within health care settings. Indeed, and strikingly, HPs even viewed adverse gender norms as modifiable, as one health professional, Nomonde, powerfully stated: 'Black women are taught to be a certain way. [The] intervention creates an awareness to break the code. The norms are changeable.'

Our findings indicate that the use of specialty-trained IPV staff could enhance the institutional agency of South African primary health care clinics, equipping them with the potential to become gender-sensitive locations. In this type of supportive setting, health providers could be trained and sensitised to recognize linkages between health and gender, promote health agency and help-seeking agency for IPV-exposed patients, while offering what providers termed 'holistic' or 'total' care. We posit that interventions like this one could lead to new norms in clinical settings that align with conceptions of social justice and gender equality.

The burden of mental health disorders in this patient population is high (van Heyningen, Honikman, Myer, Onah, Field, & Tomlinson, 2017). Integrating mental health services into routine, primary ANC services is recommended in South African public health settings, in line with existing policy (Lund et al., 2010). While nurses are most appropriate to offer interventions and integrate care and treatment (e.g., HIV care, pre-eclampsia), our findings emphasize that non-skilled professionals can provide some interventions, as part of calls for task shifting (Ventevogel, 2014). Regardless of cadre, we found that ongoing supervision,

mentorship and feedback was essential for health professionals to establish the knowledge and skill-building necessary to advance their self-efficacy in delivering the intervention.

Limitations

First, the findings are specific to an urban, middle-income country setting with high antenatal care attendance and a higher health provider to patient ratio than in some LMICs. Second, health professionals' time to participate in interviews in five antenatal clinics in urban Johannesburg was limited and interrupted in some cases due to the competing demands of their work, reinforcing why studies in LMIC health settings, are fewer, yet essential. Third, the positioned subjectivity of the two authors who were part of the intervention poses a limitation and a strength—both are acknowledged within qualitative research methods (Lincoln & Guba, 1985). The limitation is potential social desirability bias for the intervention to be viewed positively by respondents. We sought to mitigate this risk by having the first author, who was not known to respondents, conduct all interviews and write up the first drafts of coding and subsequent analytical themes. The strength of this positioned subjectivity is that we might not have achieved access to and obtained the trust of participants who were directly and indirectly involved in the intervention, nor the depth of understanding and insight, without the eyewitness experiences of two authors in the intervention.

Conclusion

Implementation science has called for effective, complex health interventions that can address the health needs of the populations they are designed to serve (Colquhoun, Squires, Kolehmainen, Fraser, & Grimshaw, 2017), an especially crucial need in constrained LMICs. Findings contribute to a slender literature on the agency of LMIC health systems and to perceptions of health providers involved directly and indirectly in an intervention for IPV-exposed women in five antenatal clinics in urban Johannesburg. Of significance, health providers communicated that IPV interventions can effectively be undertaken in the health system in South Africa, despite constraints. These findings offer insight into how health systems in South Africa and other locations can become more responsive to IPV around the time of pregnancy—a key tenet of gender-responsive health systems. If health providers enact new ways of engaging IPV and gender-attentive care, we posit that locations within the South African health system can be socially constructed as spaces of empowerment where women feel understood, validated, accepted, safe and informed; and as a place of community where women can establish social ties and networks—with health providers and with other patients—all aspects that strengthen the institutional agency of health systems, and particularly, women's agency in health promotion and help-seeking.

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Box 1**The RCT**

A randomised controlled trial was conducted to test a nurse-led empowerment counselling intervention, originally developed for high-income settings and adapted for urban South Africa. The primary outcome was reduction of partner violence, with secondary outcomes including improvement in women's mental health, safety and self-efficacy. The study recruited 423 pregnant women from five antenatal clinics in urban Johannesburg who were randomised to the nurse-led empowerment arm (two 30-minute counselling sessions) or enhanced control condition (a referral list) and were followed up 6 weeks postpartum (for details, see Hatcher, Woollett, Pallitto, & Garcia Moreno, 2018; Pallitto, Garcia-Moreno, Stoeckl, Hatcher, MacPhail, Mokoatle, & Woollett, 2016).