

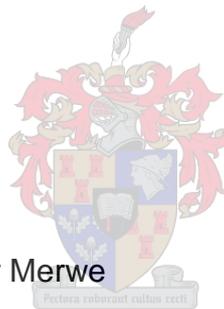
An exploration of clients' agency regarding their own reproductive health while living with intimate partner violence.

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Thesis presented in partial fulfilment of the requirements for the degree Masters of Nursing Science in the Faculty of Medicine and Health Sciences Stellenbosch University

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Declaration

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Abstract

Background: The overall objective of this study is to explore the use of agency by women when making reproductive health choices within the context of intimate partner violence. This qualitative study was based on a feminist phenomenological method. Although the feminist perspective has many dimensions when challenging injustices to women and giving women a voice, in this study, the focus is on the use of agency. Agency is the ability to practise self-rule for oneself as a woman, to have self-directedness and be recognised as part of society, in decision making concerning personal choices. It includes the capability to exercise autonomy while experiencing coercion. The study was conducted at Macassar CHC.

Methods: Ten women were interviewed using a semi-structured interview guide. Interviews were conducted in English and Afrikaans. All the women in the study had experienced intimate partner violence. Although the women are of different ethnic and religious backgrounds, they shared similar experiences and responses to violence, specifically when making reproductive health choices.

Results: The lack of autonomy and agency challenges women's ability to make reproductive health choices. Intimate partner violence further challenges women's agency in a society where women have a lower status than men.

Conclusion: Women in Macassar living with intimate partner violence are at risk of unwanted pregnancies, sexually transmitted infections and HIV. This is mainly due to the lack of autonomy and agency.

Keywords: Intimate partner violence, Autonomy, Agency, Reproductive health issues.

Opsomming.

Agtergrond: Die oorhoofse doel van hierdie studie is om die gebruik van agentskap te verken deur vroue wanneer reprodktiewe gesondheids keuses gemaak word, binne die konteks van 'n verhouding waarin intieme maat geweld ervaar word. Die kwalitatiewe studie is gebaseer op 'n feministiese fenomenologiese metode. Alhoewel die feministiese perspektief baie dimensies het wanneer ongeregthede teen vroue uitgedaag word en vroue 'n stem gegee word, is die fokuspunt in hierdie studie op die gebruik van agentskap. Agentskap is die vermoë om selfregering as vrou uit te oefen, om selfgerigtheid te he en as deel van die samelewing erken te word, veral wanneer dit kom by besluitneming aangaande reprodktiewe gesondheid. Dit sluit in die vermoë om outonomie uit te oefen terwyl dwang ervaar word. Die studie is uitgevoer op Macassar CHC.

Metode: Tien vroue is ondervra deur 'n semi-gestruktureerde onderhoud gids te gebruik. Onderhoude is gevoer in Engels en Afrikaans. Al die vroue in die studie het intieme maat geweld ervaar. Hoewel die vroue van verskillende etniese en godsdienstige agtergronde is, deel hulle soortgelyke ervarings en reaksies op geweld, spesifiek in verband met reprodktiewe gesondheid keuses.

Resultate: Die gebrek aan outonomie en agentskap daag vroue se vermoë uit om reprodktiewe gesondheid keuses te maak. Intieme lewensmaat geweld is 'n verdere uitdaging vir vroue-agentskap in 'n samelewing waar vroue 'n laer status as mans het.

Slotsom: Vroue in Macassar wat met intieme geweld lewe, loop die risiko van ongewenste swangerskappe, seksueel oordraagbare infeksies en MIV. Dit is hoofsaaklik te wyte aan die gebrek aan outonomie en agentskap.

Sleutelwoorde: Intieme maat geweld, Outonomie, Agentskap, Reproductiewe
gesondheid kwessie.

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Chapter one: Foundation of the study

1.1. Introduction

South African primary healthcare services are the first access point to the health care system. In a study of women attending a Western Cape primary health care clinic only 9.6% of women experiencing intimate partner violence were recognised (Joyner & Mash, 2012). The reasons behind why women remain in abusive relationships often seem elusive. These reasons, including those choices women make in respect of reproductive decisions, may be more practical in nature (Meyer, 2015). Trauma deprives women of agency that plays a significant role in women's decision making (Meyer, 2015).

Agency allows women the ability to exercise a level of control over their bodies when making decisions about their sexual health (Abrams, 1999:806). Social circumstances including violence influence women's agency with regards to reproductive health decision making, including family planning choices (Stephenson, Beke, & Tshibangu, 2008:66). Intimate partner violence has particularly serious consequences for women's reproductive health as it can lead to gynaecological pathologies, unwanted pregnancies, unsafe abortions and sexual dysfunction (Glacier, Gulmezoglu, Schmid, Garcia-Moreno, & Van Look, 2006:1).

South African women experience high rates of intimate partner femicide. More than half (57%) of the women who are killed in South Africa die at the hands of their own partners (Weiner, 2015:59). For example, Uitenhage teacher Jayde Panayiotou was found murdered and her husband was charged for orchestrating the murder, by hiring hit-men (Weiner, 2015:59). Dr Naeemah Abrahams, gender and health specialist at the Medical Research Council, ascribes causation to a "combination of things: our psyche, intergenerational trauma, of people who only know violence as a way to deal with conflict, our easy access to guns" (Weiner, 2015:59). The fatal shooting of South African model Reeva Steenkamp by her para-Olympic athlete boyfriend Oscar Pistorius brought international attention to the plight of South African women. We reside in a country that has high rates of violence, particularly against women and girls, where intimate femicide is five times the global rate, and the highest recorded rate in the world (Weiner, 2015:59).

In a cross-sectional study in South Africa, it was found that legal gun ownership contributes to exceedingly high rates of femicide and suicide of perpetrators. It is more likely that a white perpetrator of higher socio-economic status would use a gun and commit suicide (Mathews, Abrahams, Jewkes, Martin, Lombard, & Vetten, 2008). Zaheda Peters was critically injured when her boyfriend warrant officer Nevill du Toit of Macassar police station shot her and then himself with his service pistol. This incident was a result of Zaheeda breaking off the relationship (Serra, & Abbas, 2015).

A Bloemfontein businessman was arrested for female genital mutilation, magnifying the extent of women's sexual abuse in South Africa. Police found amputated labias and clitorises and vials of sedatives used for humans and animals in his possession (Enca, 2015). Female genital mutilation or female circumcision is not unique to South Africa. It is estimated that more than 125 million girls and women alive today in the Middle East and Africa have been mutilated (WHO, 2014).

These procedures are usually carried out on young girls between infancy and early teens, occasionally on adult women that have not yet been circumcised. The reasons for female circumcision has its roots in culture and religion. Social pressure is motivated by beliefs about what is proper sexual behaviour for women and girls. Mutilation of the genitals eliminates the possibility of orgasms, thereby significantly reducing female sexual pleasure. It is also a belief that by removing the clitoris she would be 'clean' (WHO, 2014). Whilst working in the labour ward at Macassar CHC, I noticed many women from Africa that have been circumcised. These women labour with difficulty and often sustain unavoidable tears to the perineum whilst giving birth.

Pregnant women are also often victims of assault by their partners despite their vulnerable state. A study conducted amongst women attending antenatal clinics in a township in Johannesburg in 2002, found that 21.8% of women seeking care experienced multiple assaults by a male partner (Dunkle, Jewkes, Brown, Yoshihama, Gray, McIntyre, & Harlow, 2004:238). The added vulnerability during pregnancy decreases the ability of women to negotiate or even defend themselves.

As a practicing, primary health care nurse, I have observed that many women who are in abusive relationships, do not access reproductive services. These women tend to be inconsistent with attendance, presenting at the family planning clinic when they are

already pregnant. This study aims to develop insight into how intimate partner violence influences women's decision making and reproductive choices.

Violence against women does not limit itself to one particular form nor does it discriminate between contexts. It also permeates social attitudes and beliefs, contaminating new generations with sex-role stereotypes that amputate the human spirit, preventing individuals from experiencing richer, more fulfilled lives. It commonly includes sexual violence and even homicide (Me, Bisongno & Malby, 2011:11). Women whose sexual rights are violated through intimate partner violence often experience powerlessness and a sense of being trapped. They tend to have limited or no ability to make any choices about reproductive health without suffering further violation of their rights through abuse (Dunkle, Jewkes, Brown, Yoshihama, Gray, McIntyre & Harlow, 2004:234). Women's obligation to bear children is the cornerstone of marriage in certain societies. Wives are acquired through payment of bride wealth in the form of cattle and sheep, and women are seen as their husband's property with their major purpose being to produce children for their husband's lineage and serve all his household and sexual needs (Bawah, Akweongo, Simmons & Phillips, 1999:60).

Similarly, in Muslim marriages a compulsory part of the marriage contract includes a "mahr" which is payment to the bride. There is no guide to what the payment should be and the groom offers what he feels he can afford. Payment may be made in any form ranging from money or livestock to property. This payment is made to the bride for her services to her husband and it belongs to her (Welchman, 2004:168).

Young girls are socialised to believe that they should respect and obey their husbands as the head of the house. Divorce is considered shameful (Gharaibeh & Oweis, 2009:380). Men control the finances and women run the home and bring up the children. Men are encouraged to enjoy sex while women are taught not to enjoy sex. Consequently, pleasing a woman sexually is not considered important and usually women accept this, being powerless to question, let alone reject, cultural practice (Watts, Keogh, Ndlovu & Kwarambu, 1998:57).

In communities where intimate partner violence is common practice, women and their support systems accept this behaviour as normal (Shamu, Abrahams, Temmerman, Shefer & Zarowsky, 2012:4). Thus, to provide effective reproductive health care services, healthcare practitioners need skills in providing appropriate contraceptives

and also awareness of the social context within which women live, especially those living with violence (Wood & Jewkes, 1997:41).

1.2. Purpose of the study

This study aims to explore and describe women's agency with regard to their reproductive health choices within the context of intimate partner violence.

1.3. Conceptual and operational definitions

A conceptual definition is the actual meaning of the concept being explored. An operational definition describes how the concept will be drawn on in the study (Burns & Grove, 2009:712).

Intimate partner violence (IPV): refers to interpersonal violence in all its forms (physical, emotional, sexual, economic, verbal, or spiritual) where the perpetrator is a current or ex-intimate partner. Women who have been in a violent relationship form the focus of the study.

Reproductive health issue: refers to any issue related to having or not having children. This would include the use of family planning and care preceding, during, and after childbirth. It also includes other women's health problems related to sexuality such as sexually transmitted infections, chronic pelvic pain and HIV.

Community health centre (CHC): These centres offer primary health care services for eight hours per day for five days per week. Some centres also have extended hours, up to twelve hours per day on certain days. Macassar offers an extended hours service on a Thursday until 19H00. The maternity obstetric unit (MOU) within these centres functions for 24 hours, 7 days per week. Note that women are not able to access reproductive health care at Macassar, not even emergency contraception, after the primary health care clinic has closed.

Agency: In the realms of sociology and philosophy, agency is the ability of any entity (human or other living being, or soul-consciousness in religion) to act in any given environment. Agency is the ability to practise autonomy within one's life. Agency thus ranges from having self-directedness over decision making concerning one's body to being recognised as a social unit in one's own right. Further, it includes but is not

limited to, the capacity to exercise autonomy while experiencing coercion. Agency adds to autonomy in itself, by taking a more individualistic approach and acknowledging that the individual has a history and is subject to the influence of various others. The individual is also subject to obligations and commitments that can constrain choice (Abrams, 1999:807).

1.4. Research Paradigm

A paradigm is essentially a worldview, a framework of beliefs, values and methods within which a study takes place (Creswell, 2009:6). In this research the advocacy and participatory worldview has been used. The philosophical assumptions of the advocacy/participatory approach hold that research inquiry needs to be intertwined with social and political agendas (Creswell, 2009:9). A researcher's paradigm or philosophical perspective can be conceptualised through clarifying ontological, epistemological and methodological assumptions (Collons, du Plooy, Grobbelaar, Puttergill, Terre Blanche, van Rensburg & Wigston, 2006:19).

Ontological assumptions deal with the nature of reality (Grove, Burns & Gray, 2013:58). In this study the researcher believes that social reality is meaningful and that knowledge is based on individual experience and interpretation of an event. Women's agency speaks to important social and structural issues that constrain women's choices when making reproductive health decisions within the context of intimate partner violence. This creates a reality unique to this study's participants. Women were given the opportunity to freely express their views during interviews.

Epistemological enquiry deals with basic beliefs about the nature of knowledge (Collons *et al.*, 2006:21) and so can be seen to address the relationship between researcher and participants. Here the researcher maintained a participatory role as informed by participants during the interviews, attempting to position herself on the same level as these women, as she lives and works in the same community.

Methodological analysis looks at how the researcher goes about finding out what may be known. It refers to the rules and procedures of research work (Collons *et al.*, 2006:21). Interviews were conducted in Macassar aiming to capture and describe an insider's perspective of how abused women experience the challenge of making

reproductive health choices. Experiences and values were described differently from each other, and each woman's experience was significant.

The research inquiry in itself became an emancipatory process changing the lives of participants and researcher by initiating a hitherto undeveloped awareness of agency. The ability to give a voice to social issues such as disempowerment, inequality, domination, suppression and alienation allows participants to collaboratively describe reality (Creswell, 2009:10).

1.5. Research context

Macassar is a small community in the Western Cape. It is a predominantly coloured community of lower socio-economic status. There are high rates of drugs use, violence and alcohol use in the community. Unemployment and gangsterism are also common in this small community. These social problems are not uncommon to Macassar but are generally evident in most communities in the Western Cape. The researcher has lived and worked in Macassar for the past nine years and understands the dynamics of the community. Participants were reassured and if they chose to participate they were included in the study. At least three women refused to participate and were offered the referral resources available in the community (appendix B). During the interviews, mental health nurses were on standby if needed for containment.

1.6. Research Problem

A research problem is an identified area of concern where there is a gap in knowledge that is of importance for nursing practice (Burns & Grove, 2011:547). Research is then conducted to produce knowledge that addresses this practice concern (Burns & Grove, 2011:44).

Women living with intimate partner violence are often deprived of agency when decisions are made about their reproductive health issues. To date no published studies, appear to have focused on the impact of intimate partner violence on the agency of women attending primary health care services in South Africa regarding their reproductive health issues. Studies have been conducted on the ability of primary health care services in South Africa to respond to intimate partner violence (Rees, Zweigenthal, & Joyner 2014) (Joyner, Mash, 2012; Joyner & Mash, 2014). These studies recognise the inadequate response of primary health care services to provide

immediate and long term care for such women. In a study by Wood and Jewkes (2015) in-depth semi-structured interviews were conducted with pregnant adolescent women. These women attended a South African midwife obstetric unit for antenatal care. It revealed that male coercion and violence within the sexual relationships strongly influenced reproductive health choices.

1.7. Research methodology

The methodology used in this study was a qualitative descriptive method. A brief description of the research design, research technique and data collection method are given below.

1.7.1. Research design

A qualitative descriptive research design was used in this study. Descriptive research is aimed at giving the specific details of a situation, social environment or relationship as experienced by research participants (Collons *et al.*, 2006:95). Descriptive and exploratory research often overlap. Before a researcher can describe an experience, she should be clear about the main aspects or reality being described by participants. This familiarisation becomes an explorative process (Collons *et al.*, 2006:95). A qualitative research design encourages women's agency by giving women a voice and platform to express themselves freely.

1.7.2. Research technique

The researcher conducted ten semi-structured interviews. Interviews were held face-to-face and privately, allowing meaningful interaction between participant and researcher. This allowed the researcher to get detailed descriptions of the participants' experience, obtaining fresh first-hand information from participants. Before engaging participants, the researcher and supervisor conducted practice interviews. These were done to practise interview technique for data collection and recording.

1.7.3. Data collection

Immediately after receiving ethical approval from the university and permission from the department of health, the researcher started sampling. Purposive sampling was done by approaching information-rich key informants and inviting them to join the study. The research process was explained and written consent was taken if the

women agreed. Data collection was done as the participants were able to meet with the researcher for one on one interviews.

Individual interviews were conducted and lasted approximately one hour each. No time limits were set for participants during the interviews. Interviews were done over a period of six months. Participants were given the option to listen to recordings and read transcripts when they became available. Women were interviewed in a comfortable, familiar, private room. These interviews were held either at Macassar CHC or at the Macassar victim support room at the local police station. The researcher continued the process of sampling and interviewing until the point of data saturation was reached. A total of ten women were interviewed.

1.7.4. Trustworthiness

The process of establishing the validity and reliability of qualitative research and accurately representing the experience of the participants establishes trustworthiness. Lincoln and Guba (1985:326) define trustworthiness as a means of evaluating the worth of research. Trustworthiness involves establishing credibility, transferability, dependability and conformability. In this research the aspect of trustworthiness has been established in the following ways.

- Credibility refers to confidence in the 'truth' of the findings. The researcher had prolonged engagement with the women who attended Macassar CHC.
- Transferability refers to the applicability of findings to other settings. This study describes the experience of a particular sub-set of women who attended Macassar CHC. However, given the male-dominated and chauvinistic values that have permeated all of SA society, legitimising excessive rates of gender-based violence nationwide, it is likely that there will be similar sub-sets of women at CHCs throughout SA.
- Dependability shows that findings are consistent and can be repeated. The study design was descriptive, detailed the experiences from interviews held with ten women. These findings are unique to them. The study can be replicated to see how similar or different other women's experiences are.

Conformability refers to the extent to which findings of a study are shaped by the respondents and not researcher bias, motivation, or interest. In this study the researcher has had first-hand experience

of intimate partner violence. This added value since the researcher was able to identify her own position and allow the women to express themselves in a safe, non-judgemental manner. Interview transcripts were read by the supervisor. All themes were verified and validated by the supervisor.

1.8. Research question

How does intimate partner violence influence women's agency with regards to reproductive health choices?

1.9. Aim

To explore and describe the lived experience of women's agency in relation to their own reproductive health care, while experiencing intimate partner violence.

1.10. Objectives

1. To explore and describe women's agency over their own reproductive health while experiencing intimate partner violence.
2. To describe how living with intimate partner violence influences women's susceptibility to sexually transmitted infections, including HIV.

1.11. Significance of study

The findings and awareness created by this study could facilitate nurses who are practising at Macassar Community Health Centre to become sensitised to women's agency when making reproductive health decisions while living with intimate partner violence. By making services more user-friendly, more women would access them, leading to better health for mothers and families. I hope to encourage management to make emergency contraceptives available around the clock at Macassar CHC thereby allowing women better access to contraception. This study would add to the body of knowledge related to intimate partner violence and women's agency. Further research in the area of reproductive health issues of women experiencing intimate partner violence could be conducted.

1.12. Chapter outline

Chapter two reviews existing literature on intimate partner violence, focusing on women's contextual agency when making reproductive health choices.

Chapter three details the methodological aspects applicable to this thesis. This chapter includes the purposive sampling method used. A detailed description of the interview process is given, assuring women's agency as vulnerable women informants. The framework method was used to code and analyse the qualitative data collected.

Chapter four presents the study findings from the ten women attending Macassar CHC who were interviewed.

Chapter five details a discussion of these findings in relation to the literature. It addresses the limitations of the study, and provides recommendations for promoting women's agency within the healthcare setting.

1.13. Conclusion

The study gives a comprehensive summary in everyday terms, of interpersonal events as experienced by the ten women who were interviewed. This is a qualitative descriptive study that gives a voice to a marginalised and vulnerable sub-population. The next chapter is a literature study.

Chapter Two: Literature review

2.1. Introduction

Women living with intimate partner violence are in particular need of perceptive reproductive health care. The advancement of gender equality joins with the empowerment of women to take back their bodies and make their own choices about motherhood (Glacier, Gulmezoglu, Schmid, Garcia-Moreno & Van Look, 2006:1). Key is the elimination of all kinds of violence and it is interesting to note that both gender equality and reproductive health issues are cornerstones of development programmes. Predictably however, the increasing effects of male-oriented, conservative political, religious and cultural forces threaten to undermine progress (Glacier *et al.*, 2006:2).

Intimate partner violence has serious negative health consequences for women in developed and developing countries. These include the risk of gynaecological pathologies, unwanted pregnancies, HIV/AIDS, sexually transmitted infections, unsafe abortions and sexual dysfunction (Odero, Hatcher, Bryant, Onono, Romito, Bukusi, & Turan, 2013:783). Intimate partner violence has also been linked to complications in pregnancy, including stillbirth and maternal death (Bott, Morrison & Ellsberg, 2005:12). Women who experience intimate partner violence are at greater risk of developing mental health disorders like mood and anxiety disorders including post-traumatic stress disorder and substance use disorders (Rees, *et al.*, 2011:513).

2.2. Feminism and feminist theory

Feminism refers to a range of ideologies that share a common goal of redressing the dualistic hierarchy that exists between genders. It is based on the premise of equality for women in the political, economic, cultural and social rights within social systems (Alcoff & Potter, 1993). Feminist theory is the extension of feminism into theoretical or philosophical discourse. It aims to understand the nature of, and then transform, gender inequality.

Feminist epistemology is a term that marks the alliance between feminist ideologies and philosophy (Bowel, 2015). It is based on the assertion that women perceive and experience the world differently from men. Feminist epistemology is challenged by the contradictory pull between concrete and abstract. Feminist scholars from various

disciplines have advocated taking women's lived experience as the starting point of scientific enquiry (Bowel, 2015).

2.3. Self-direction from autonomy to agency

Scientist Benjamin Libet was the first to study self-agency. He discovered that brain activity predicts our actions before we have conscious awareness of this intention. This theory acknowledges that individuals are influenced by their history and are subject to obligations and commitments. These entanglements often constrain individual choice or autonomy (Abrams, 1999). Self-agency or agency is the sense that actions are self-generated. Agency and autonomy are linked and often used interchangeably. However, Daniel Wegner, an American social psychologist, created the three criteria for self-agency (Bayne, 2006).

- Priority- an action must be planned before the action is initiated.
- Exclusivity- the effects are due to the person's actions and not because of any other potential oppressive force.
- Consistency- an individual's planned actions must occur as planned.

2.4. Feminist perspective on sexuality and sexual health

Relative to male sexual roles, female sexuality and cognition are often overlooked (Ross, 2010:13). The development of sexuality and sexual role definitions is often combined with pressures felt by females based on family roles. Women's sexuality and sexual health is directly affected by the low status of women. This statement forms the essence of the feminist perspective, that status influences sexuality and sexual health outcomes. Women's status is however not limited to sexuality but affects all facets of a woman's life. The lack of autonomy within the paradigms that women live, increases their risk of not only violence and high-risk sex, but also their ability to seek help (Amaro, Raj & Reed, 2001).

Women live in societies plagued by sexism, racism and anti-feminism robbing them of their individuality and autonomy (Peroni, 2015:1557). The interplay between sexism, male dominance, and intimate partner violence has deep rooted influences penetrating

society from interpersonal influences to policies that govern countries. Increased women's autonomy through progressive change and gender equality tends to trigger reactionary violence (Goicolea, Ohman, Torres, Morras, & Edin, 2012).

A 2004 Ecuador study showed that of the 46% of women who had experienced violence, 95% of cases had occurred in the home. This is despite the country making progressive political change by putting violence against women on the public agenda and establishing a law against violence against women in 1995. In 2007 a presidential decree was passed in Ecuador addressing the states responsibility to eradicate gender based violence (Goicolea, *et.al*, 2012).

Despite the awareness throughout the world, women remain marginalised. Women are not treated as equal citizens and they remain trapped within oppressive systems.

2.5. Women's sexual rights

Women's sexual rights are encompassed within human rights and are internationally recognised as such. They include the rights to be free of coercion, discrimination and violence in accessing the highest attainable standard of reproductive health services (Glacier *et al.*, 2006:3). Women should have the right to choose when and how to be sexually active. Women should have the right to choose their own partner, to consent to marriage and to negotiate safe sex and parenting issues with their partners, starting with when to have children, or not at all. It should be the right of a woman to pursue a pleasurable, satisfying and safe sexual life (Glacier *et al.*, 2006:3).

Women whose sexual rights are violated through intimate partner violence are often powerless or trapped in abusive relationships with limited or no ability to make any choices about reproductive health without suffering further violation of their rights through abuse (Dunkle, Jewkes, Brown, Yoshihama, Gray, McIntyre & Harlow, & 2004:234). Among women attending an antenatal clinic in Soweto, South Africa, 55.5 % of participants reported being physically and/or sexually assaulted by a male partner at least once during their lives (Dunkle *et al.*, 2004:234). Among these women, 72.1 % reported continued physical violence as well (Dunkle *et al.*, 2004:234). The reported age of first intercourse ranged from 5 – 29 years old. Women who started being

sexually active at an early age where more likely to have been forced (Dunkle *et al.*, 2004:234). Of the women who had first intercourse before the age of thirteen, 97% reported it being forced (Dunkle *et al.*, 2004:234). In South Africa in 2008, a study conducted in the Eastern Cape and KwaZulu-Natal, nearly one third of men (28%) admitted that they have raped at least one woman (Shamu, Abrahams, Temmerman, Shefer, & Zarowsky, 2012:1).

Sadly, if intimate partner violence becomes common practice within a community, women themselves, as well as the rest of their support system, start accepting this behaviour as normal (Odero *et al.*, 2013). Within this context, many women see themselves as “saving” their relationship by submitting to their partner’s demands. Accepting abuse as part of her duty as a woman, would be an important factor in how she would negotiate her reproductive care (Shamu *et al.*, 2012:4).

Women are generally robbed of their right to agency and autonomy. There remains a large divide between the reality of what women experience and the ideal of treating men and women as equal citizens.

2.6. Relationship power inequity and lack of agency

Ideally, in a relationship both partners should be equally entitled to making decisions. However, this is not usually the case with women experiencing intimate partner violence (Chapaign, 2006:164). Conflict of interest results in the partner with the most power within the relationship having the final say (Chapaign, 2006:164). Women who are being abused fear voicing disagreement as this frequently results in further abuse or other adverse consequences. For example, in a study in Kenya, women felt that the very sanctions that were put in place to protect them i.e. jail or fines, often deprived them of the financial support they received from their partners (Odero *et al.*, 2013:784)

2.7. Religious and cultural belief systems

Anthropologist E.B.Tylor defined culture as “that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits

acquired by man as a member of society” (Tjale & De Villiers, 2004:44). In a study of Arab Muslim Jordanian women, women stayed in abusive relationships for fear of the social consequences of divorce, lack of family support due to cultural pressure to stay together for the sake of their children. Gharaibeh and Oweis (2009:380) reveal that culture-bound women are easily made victims of abuse through cultural practices. The submissiveness of women in Arab Muslim culture, where daughters are supported by their families provided they do not deviate from restrictive social norms, makes them vulnerable to abuse from men (Gharaibeh & Oweis, 2009:380). Young girls are socialised to believe that they should obey and respect their husband as the head of the house and that divorce is shameful (Gharaibeh & Oweis, 2009:380). Similarly, Zimbabwean women revealed that men and women had rigidly defined roles in society (Watts, Keogh, Ndlovu & Kwarambu, 1998:57). Men control the finances and women bring up the children.

Amongst the Kassena-Nankana of Northern Ghana, male dominance in gender relations is ensured by marriage customs and related institutions of lineage such as polygamy with consequent family pressure. Women are valued as property within this male dominated society (Adongo, Phillips, Kajihara, Fayorsey, Debpuur & Binka, 1997:1791). There is a strong lineage system and corporate running of families where co-wives share household duties (Adongo *et al.*, 1997:1791). The husband is recognised as being the head of the household making or approving all decisions including reproductive choices for his many wives (Adongo *et al.*, 1997:1791).

Traditionally, women’s obligation to bear children has been the cornerstone of marriage. Wives are acquired through payment of bride wealth in the form of cattle and sheep. They move into a life of being their husband’s property, their value residing in their ability to augment their husband’s lineage (Bawah, Akweongo, Simmons & Phillips, 1999:60).

Despite cultural differences of alcohol consumption and aggression when drinking, alcohol is linked to greater aggression and increased severity of effects on the perpetrator, victim or both (Graham, Bernards, Wilsnack&Gmel, 2011:7). Culture defines the way violence towards women is perpetrated as well as how reproductive decisions are made by or for women (Bawah *et al.*, 1999:60). Women who have more cultural freedom and autonomy would have more control over their own fertility without

fear of victimisation (Stephenson, Beke & Tshibangu, 2008:66). Since communities' cultural practices and recognition of the status of women vary, nurse practitioners need to have an in-depth understanding of the community they work with to provide appropriate effective reproductive care (Tjale & de Villiers, 2004:237).

2.8. Contraception and unintended pregnancy

The lack of agency that results from intimate partner violence has particularly serious consequences for women's sexual and reproductive health (Oderoet *al.*, 2013:798). In Northern Ghana, a qualitative study on contraceptive use revealed that women fear asking their husband's permission to use contraception. This exposes the hierarchical nature of their relationship and in particular, her relative powerlessness. Women worry that if they do use contraception secretly, contraceptive side effects will expose their secret use, leading to abuse (Bawah, Akweongo, Simmons & Phillips, 1999:55).

Similarly, 14% of Pakistani women who experienced intimate partner violence reported using contraceptives surreptitiously, without their spouse's permission, highlighting the potential conflict surrounding the use of contraceptives (Fikree, Jafarey, Korejo, Afshan & Durocher, 2006:255). Among the Kassena-Nankana of Northern Ghana, men opined that fertility regulation was tantamount to conjugal refusal, depriving a man of his sense of ownership of a woman and denying him children that he has ostensibly purchased with bride wealth (Adongo, Phillips, Kajihara, Fayorsey, Debpuur & Binka, 1997:1795). Particularly in adolescent girls, unintended pregnancy and unsafe abortions are associated with violence and sexual coercion (Glacier, Gulmezoglu, Schmid, Garcia-Moreno & Van Look, 2006:1).

The governments of developing countries have concerns about rising rates of unintended pregnancies and induced abortions (Glacier *et al.*, 2006:4). Only 3 % of the nineteen million abortions that take place every year take place in developed countries. Most abortions occur in developing countries where women cannot access services safely (Glacier *et al.*, 2006:4). Half the deaths from abortions arise in Africa where one in four abortions are unsafe and done on teenagers (Glacier *et al.*, 2006:4). South Africa has one of the most progressive abortion laws. The choice of termination of pregnancy Act of 1996 provides women with legal access to abortions.

If pregnancy is not prevented using contraceptive methods, women and girls should be offered the option of terminating the pregnancy. These women and girls should also be able to freely choose termination as a safe option (Cybulska, 2012:143).

South African women living in wealthier communities who have a higher level of financial autonomy are more likely to use more effective forms of contraception (Stephenson, Beke & Tshibangu, 2008:66). Similarly, women in communities in which females have higher levels of education and higher mean ages of first sexual intercourse, have a greater likelihood of using oral contraceptives instead of injectables. Injectable contraceptives dominate as the choice of poorer women with low female autonomy (Stephenson *et al.*, 2008:66). These studies indicate that when women are given the freedom to choose, they make choices based on their knowledge and needs (Stephenson *et al.*, 2008:66).

The nurse needs to be aware of the struggle of introducing family planning. Women often have both individual and shared issues. In communities where educational levels are low, there are often many misconceptions. These usually amplify the difficulties women face. A common misconception is the belief that contraception would inflict harm like infertility or death (Adongo, Phillips, Kajihara, Fayorsey, Debpuur & Binka, 1997:1789). Culture and religion are deeply seated and have been practised for generations; trying to challenge these is often met with violence. Women will only enjoy autonomy when, these practices can be changed.

2.9. Violence during Pregnancy

In a study in a Cape Town township, men who had partners who were pregnant reported the highest rates of perpetrating intimate partner violence (Eaton, et al., 2011). Pregnancy evokes varied responses among perpetrators. Some survivors report increase victimisation whilst others report cessation. The midwife or clinical nurse should be aware of this and respond appropriately (Jasinski, 2004:54). Underprivileged women in developed and developing countries are at higher risk of abuse during pregnancy (Campbell, Garcia-Moreno & Sharps, 2004:781). Poor communication, distrust, and fear of violence weaken the significance of a woman's

reproductive preference in deciding the number of children she will bear (Adongo, Phillips, Kajihara, Fayorsey, Debpuur & Binka, 1997:1795).

Intimate partner violence has been associated with unwanted and unplanned pregnancy, including health complications correlating with abuse during pregnancy (Campbell, Garcia-Moreno & Sharps 2004:770). As a result of violence during pregnancy, women are at greater risk of obstetrical complications, including late entry into antenatal care, sexually transmitted infections including HIV, cystitis, miscarriages/abortions, premature labour, foetal distress, bleeding in pregnancy, inadequate weight gain, smoking and substance abuse (Ellsberg, 2006:327).

2.10. Sex in an abusive relationship

Jordanian women spoke of sexual desertion or marrying another woman as an added form of abuse (Gharaibeh & Oweis, 2009:377). In a study on Zimbabwean women, it emerged that women's partners either forced them to have sex or stopped having sex with them as punitive measures (Watts, Keogh, Ndlovu & Kwarambu, 1998:57). Forced sex was more likely to occur in contexts where women felt they had the right to refuse. Forced sex is often preceded by violence and threats, or as part of an abusive episode (Watts *et al.*, 1998:62).

Men may withdraw sex to punish or to coerce women. In practice, men are able to choose when to stop being sexually active and for how long, as they are often culturally entitled to multiple partners. Women do not have the same power within a relationship to make decisions concerning sex. Refusing sex would jeopardise the relationship and make her vulnerable to assault and forced sex (Watts, *et al* 1998:63). Forced sex and withdrawal of sex represents an abuse of power within a relationship. Both these forms of abuse are supported by the same gender inequalities that perpetuate intimate partner violence (Watts *et al.*, 1998:63).

Beliefs concerning the acceptability of withdrawal of sex are influenced by culture, as well as the belief system as to whether women have the right to have sex regularly within a relationship (Watts, *et al* 1998:63). Women motivated by the desire to keep their partner, force themselves to endure violent sex no matter how painful (Shamu, Abrahams, Temmerman, Shefer, & Zarowsky, 2012:6)

2.11. Sexually transmitted infections including human immune virus (H.I.V.)

South African women in Soweto who experienced intimate partner violence had a significantly higher associated HIV sero-positivity (Dunkle, Jewkes, Brown, McIntyre, Gray, & Harlow 2003:50). Men who had extra-marital sex were six times more likely to report sexually abusing their wives than men who remained faithful (WHO, bulletin 2004:3). Abusive men are also more likely to engage in extra-marital sex and put their partners at risk of contracting HIV and other sexually transmitted infections (WHO, bulletin 2004:3). In a national population-based study in India of the relationship of spousal abuse of women to wives' infection status, married women who experienced intimate partner violence were four times more likely than non-abused women to be infected with HIV (Silverman, Decker, Saggurti, Balaiah & Raj, 2008:707).

Women's helplessness to negotiate condom use and seek reproductive healthcare was highlighted where men refused to disclose their HIV status to their partners, refused condom use and perpetrated violence (Shamu *et al.*, 2012:6). They also refused testing, claiming that if their partners tested negative, this meant they were also negative. These men believed that since they were not using condoms they would be HIV negative, if their partner tested HIV negative (Shamu *et al.*, 2012:6).

2.12. Healthcare provider's attitudes

In developed countries, medical control bodies provide guidance for practitioners on intimate partner violence (Watts & Mayhew, 2004:208). In January 2013, the United States Preventative Services Task Force recommended that women attending primary health care services be assessed for intimate partner violence (McCall-Hossenfeld, Weisman, Perry, Hillemeier & Chuang, 2014:3). In Sub-Saharan Africa, however, there has been limited discussion of the role of reproductive healthcare workers in dealing with intimate partner violence (Watts & Mayhew, 2004:208). Health care workers are often reluctant to get involved and are frequently themselves dealing with intimate partner violence. Furthermore, health care workers see intimate partner violence as a social problem and not a medical problem (Joyner & Mash, 2012:2).

Secondary victimisation at the hands of insensitive, incompetent health providers can compound the patient's problems (Watts & Mayhew 2004:208). Women fear disclosure if they suspect confidentiality will not be maintained. Healthcare providers need to be mindful of this in creating a conducive environment (Watts & Mayhew, 2004:209).

2.13. Socio-economic factors, drugs and alcohol

Financial dependence on a partner, economic hardship and traditional gender beliefs each increases women's risk of experiencing violence. Drug use including alcohol, crack cocaine and methamphetamine (TIK) tend to lower sexual inhibitions and increases the risk of unsafe sex. (Golden, Perreira & Durrance, 2013). Alcohol plays a significant role in intimate partner violence. Female impulsivity which is conceptualised as involving a preference for quick action, carelessness and disregard for negative consequences is increased with the use of alcohol in all ethnic groups (Chartier & Caetano, 2012:84).

In a qualitative study by Wight, Tompkins and Sheard (2007:419) drug use creates a platform for abuse. Women in this study were dependent on their male partners because of the skill needed to administer the drug and to get supply of the drugs. Men also usually injected women after injecting themselves making them more vulnerable to HIV exposure. McKinney, Chartier, Gaetano and Harris (2012:9) examined the relationship of alcohol outlet density and neighbourhood poverty with binge drinking and alcohol-related problems. Their finding revealed neighbourhood poverty was positively associated with binge drinking and alcohol related problems amongst male drinkers. Their findings also revealed a positive relationship between male drinkers as perpetrators of intimate partner violence.

The combined risk of drugs, alcohol and economic dependence puts women at risk of not only violence but also HIV (Wechsberg, Parry & Jewkes, 2010:1). Despite cultural differences of alcohol consumption and aggression when drinking, alcohol use is linked to greater aggression and severity through the effects of alcohol on the perpetrator, victim or both (Graham, Bernards, Wilsnack&Gmel, 2011:7).

2.14. Stockholm syndrome and post-traumatic stress disorder

Two of the most frequent long term results of intimate partner violence in abused women are post-traumatic stress disorder (PTSD) and Stockholm syndrome (Demarest, 2009). Both these conditions directly influence women's autonomy. Women experience PTSD more frequently due to sexual or physical violence from a partner. This may be attributed to women being less powerful and having less control within a relationship (Gavranidou&Rosner, 2003:136). When persons perceive uncontrollability, they are more likely to alter the meaning of the situation to change their emotional states. This would influence their decision making with regards to themselves and others (Gavranidou&Rosner, 2003:137).

Stockholm syndrome is the term used to describe a condition that evolves from an aggressor and the victim's relationship. It may also develop as part of PTSD. The victim develops positive feelings towards the abuser, other symptoms may include reciprocal feelings from the aggressor or negative feelings on the part of the victim towards the authorities (Demarest, 2009).

2.15. Relationship between language and culture

Language is used to express feelings, needs, experiences, and attitudes whilst also entrapping the traditions and values of the time (Salehi, 2012:76). Language cannot exist in isolation to culture as it is an inherent part of culture. Once this close relationship is understood it becomes possible to interpret the use of language within a given social setting within a culture (Elmes, 2013:12). Language symbolises cultural reality and words have different meaning for different people. This is a challenge when trying to interpret or translate data. It is therefore imperative to interpret and translate within a cultural context (Salehi, 2012:81). Healthcare workers need to be responsive to women's needs; this includes being mindful of culture and language in understanding what is being expressed.

2.16. Healthcare response to intimate partner violence

In 2013, the World Health Organisation published guidelines on evidenced-based recommendations for health care workers to respond to intimate partner violence (Ferder, Wathen & MacMillan, 2013). These guidelines support women-centred care where healthcare workers need to be prepared to respond to women who disclose intimate partner violence. First line responses include emphasising confidentiality and recognising its limits. In some cases, disclosure is necessary to ensure safety of women and children that may be in imminent danger. Healthcare workers should be able to appropriately respond by providing immediate support and referral (Ferder, Wathen & MacMillan, 2013).

In the light of these ground-breaking guidelines, current healthcare providers in South African primary health care services lack the necessary skills to respond to intimate partner violence (Joyner, 2013). Healthcare providers remain confined within the biomedical paradigm, diagnosing and treating diseases. This leaves healthcare providers at a loss when trying to provide a holistic health service to women experiencing intimate partner violence (Joyner, 2013).

Routine screening for intimate partner violence is contentious despite the need to identify vulnerable women. Women who are routinely screened had no difference in health outcomes to those who were not screened.

2.16.1. Western Cape policy framework

On 9 October 2013, the Western Cape Minister of Health, Theuns Botha, introduced the Healthcare 2030 Policy Framework, a strategic plan for increasing wellness of the

population of the Western Cape. In its 2030 policy, the Western Cape Department of Health has prioritised certain focus areas. This framework will direct service delivery to address the areas of greatest need in the Western Cape. Six priority areas that can be directly linked to the focus of the proposed study are to:

1. decrease the incidence of infectious diseases (HIV and TB)
2. prevent violence
3. advocate healthy lifestyles to address non-communicable diseases
4. emphasise women's health
5. emphasise antenatal and child health
6. emphasise mental health

(Western Cape Government: Healthcare 2030, 2013:19).

2.17. Conclusion

In this chapter the issues challenging women's agency when seeking reproductive healthcare were reviewed within the context of the healthcare policy in the Western Cape. The critical lens of feminist theory was introduced. Chapter three will describe the methodology of this study in detail.

Chapter Three: Research Methodology

3.1. Introduction

Within this chapter, the qualitative research design used is informed by a feminist perspective. The tenets of qualitative research are grounded in value-laden, multiple realities, and often specific to an individual or group (Burns, & Grove, 2011:73). It includes description of the rigorous process of constant consideration between what is experienced by the women being interviewed and how the researcher will describe it. This aims to produce an accurate account of the reality of their experiences (Creswell, 2009:177).

3.2 Research design: Qualitative research

The research design is a flexible plan that the researcher puts in place to guide the study. This is very relevant in a qualitative research design as there is less rigidity. This allows the researcher to adjust questions during the interviews to extract relevant information and detailed descriptions from the women. The design clearly outlines the planning, implementation and collection of data (De Vos, Strydom, Fouche, & Delport, 2012:308). It allows the qualitative researcher, to delve deeply and piece together the true meaning of the phenomena being studied (Burns, & Grove, 2011:73). Qualitative researchers use a descriptive approach to understand the experiences of individuals or groups of a phenomena (Creswell, 2013:44). Using a descriptive study design also allowed the researcher to examine and describe the situation more clearly, based on the various perspectives of the participants (Burns & Grove, 2011:359).

3.2.1. Qualitative descriptive approach with an imbedded feminist perspective

Feminist enquiry attempts to give a voice to issues concerning women. It is a body of theory based on the premise that women experience the world differently to men. Women learn and express themselves differently to men. The principle of feminist enquiry values women's ways of knowing, including the integration of reasoning, emotion, intuition, experience and analytic thought. Questions are open ended, allowing freedom for deep description and layered description of key concepts (De Vos, Strydom, Fouche, & Delport, 2012:9). Feminist research is thus a liberating enquiry. It not only documents aspects of reality but takes a personal, political and engaging stance on the world (Crotty, 1998:54). This research is concerned with the

lived experience of women and their use of agency. Agency refers to the ability to practise autonomy. Both reproductive health issues and intimate partner violence are women's issues, making it squarely a feminist issue.

Describing lived experiences has been conceptualised as an overarching philosophy on which all qualitative research draws (Kafle, 2011:182). Kafle (2011:189) describes the researcher as a signpost directing towards the essence of the research approach as well as the experience being described. Descriptive qualitative research recognises an experience as being unique to an individual (Burns, & Grove, 2011:76). Hermeneutical inquiry offers a particular lens to apply when interpreting qualitative research. It is a process of analysing texts from transcripts of interviews by the nurse researcher to increase the understanding of human behaviour (Burns, & Grove, 2011:76). Hermeneutic descriptive qualitative research is concerned with creating a rich and deep account of an experience through analysing texts (Kafle, 2011:190).

Having said this, it would be unwise to exclude the broader aspects of the society we live in, as women also belong to specific cultures and ethnic backgrounds. Ethnicity gives meaning to language, and the way people communicate, and would therefore influence the data interpretation process. Certain elements of culture influence peoples' choices, particularly those related to reproductive health, and should not be overlooked when trying to gain an understanding of women's reproductive issues (Burns, & Grove, 2011:76).

3.3. Research setting

Macassar Community Health Centre (CHC) is a primary healthcare facility offering women's health service as part of its package of care during regular clinic hours, namely 7h30 to 16h00. The average total headcount for the facility was approximately 6000 clients per month for the first quarter of 2013. An extended family planning and women's health clinic is offered every Thursday between 16h00 and 19h00. On average, between 80 and 100 women attend each clinic. There is also a 24-hour midwife obstetric unit. Interviews were held in a private room that was identified within the facility.

3.4. Sample population

In this study, the population refers to women living in Macassar who have experienced intimate partner violence. Purposive sampling was conducted. Women known as key informants were approached and invited to join the study. This sampling technique allowed the researcher to select women who were able to relate their stories with depth and detail. This sampling technique has been criticised because it is often difficult to evaluate the accuracy and relevance of the researcher's judgement. Therefore, the researcher indicated the characteristics they desired in study participants. These characteristics are described in the inclusion criteria (Burns & Groves 2011:313). The researcher identified themes after the first interview and added new themes as they emerged with each new interview. Women were interviewed until themes started repeating.

3.4.1. Inclusion criteria

Firstly, women had to be 18 years of age and older and attend Macassar CHC. They needed to be willing to give written consent to participate. The women had to have experienced an intimate partner abusive relationship. Participants needed to be comfortable with expressing themselves in either English or Afrikaans.

3.4.2. Exclusion criteria

Women who have insufficient cognitive ability to actively participate in an interview were excluded. This was determined by the woman's medical history. The researcher familiarised herself with the participants' previous medical history prior to sampling. The researcher also advised participants about the exclusion criteria during the consent signing. Women that were at the time involved in legal proceedings which could potentially interfere with the data collection process were also excluded, as well as women who could not express themselves in English or Afrikaans.

3.4.3. Sample size

Ten women were interviewed. The achievement of data saturation determined the sample size. When no additional information could be extracted from further

interviews, the interviews were stopped (Burns & Groves 2011:371). The researcher interviewed and coded data as she received it. After having the first set of codes, themes were created and subsequent interviews added to the data set. With the seventh participant, it became apparent that no new information was emerging. The researcher however continued with three more interview to confirm such.

3.5. Data Collection

Female patients who attend Macassar CHC and are known to the researcher as information rich cases were invited to join the study. Women who willingly shared their experiences were interviewed. Women were approached in a confidential manner and asked by the researcher if they would like to share their experiences. The researcher had previous contact with the participants and selected women who were able to relate their stories. Understanding the circumstances of the women the researcher was considerate of the women's needs. Priority was given to confidentiality allowing the women to choose the place and time that best suited them. Women were treated with respect and dignity. Women were not identified to each other; a factor which strengthened privacy. The researcher only intervened in routine medical interventions at the request of the participant. The researcher provided support during labour to two participants. The researcher provided contraceptives to one participant outside of normal clinic hours.

3.5.1 The role of the researcher

In descriptive research the researcher positions herself in close proximity to the participant. The researcher was able to accompany three of the participants during medical procedures. The researcher also assisted and provided support during ante-natal and labour ward examination in four cases. Two of the participants only attended the interview session and were not attended to by the researcher for any other medical

interventions. All the participants were known to the researcher prior to being approached to be interviewed. The participants were selected for their ability and willingness to relate their very personal stories. The researcher assured the participants that all personal identifiers would be kept private. A trusting relationship had been formed with some of the participants who have attended the Macassar community health centre over many years and have had numerous interactions with the researcher. The researcher selected participants with different demographics to give a voice to diverse women and add perspectives. The collaborative participation allows the participant to express freely her lived experiences in a safe, non-judgemental environment (Crotty, 1998:58). Enquiry during interviews is flexible and adapted to the specific context that the participant's particular experiences and ability to relate these are communicated to the researcher (Elliot & Timualak, 2005:150). The researcher accepts these narratives as true, using these to understand and describe the complex experiences that women have lived through (Crotty, 1998:58).

The researcher constantly revisited the interview transcripts and recordings to make certain she remained truthful and limited bias. Reflexivity is a rigorous process where the researcher is acutely aware of her own reality (De Vos, Strydom, Fouche, & Delport, 2012:310). The same experience could be analysed differently depending on the researchers' reality, beliefs of social reality (ontology) and of how social phenomena are known (epistemology) (De Vos, Strydom, Fouche, & Delport, 2012:310).

The relationship of researcher and participant is in itself feminist, rejecting roles of superiority and encouraging an open dialogue (Terre Blanche, Durrheim, & Painter, 2011:503). The researcher recruited women to the study by providing a brief explanation and agreeing on a venue and time. On meeting the women at a private convenient location, the researcher explained the research process clearly in easy-understandable terms to the participants. Informed consent was taken, including permission to record the interview. The consent form was explained in detail. Any terms the participant did not understand were clarified. The researcher set the participant at ease by engaging her in conversation and sharing stories. Each participant was unique and had different, yet in some ways similar, experiences. A participant's information leaflet was explained and discussed with each participant. The latter was invited to sign an informed consent in order to participate in the study

(Appendix A). Interviews were documented on a research interview form (Appendix C). Interviews were recorded using an electronic voice recording device.

If the woman declined, she was offered available resources. These included mental health services, the family violence community liaison officer at Macassar police station and/or social services (Appendix B).

3.5.2. The interview

Semi-structured in-depth interviews were conducted. The researcher noted non-verbal gestures and audio recorded each interview digitally. Recordings are stored in a password protected computer that is safely stored in a locked cupboard. All recordings will be destroyed once transcribed, authenticated, research submitted and published. During interviews pseudonyms were used where women chose to. The women were set at ease and rapport created by engaging women in conversation and sharing stories. The framework method was used to code and analyse data. The framework method has been used since the 1980s. It was developed by researchers, Jane Ritchie and Liz Spencer and it provides clear steps for data coding and analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013).

Questions were used with flexibility to guide the interview and allow the researcher to gather the relevant information. There were no time limits set for the interviews allowing for rich, sensitive engagement of participant and researcher. Staying with the principle of feminist enquiry the interview process was mutually liberating for participant and interviewer. The conversation allowed participants to freely talk about issues that may be taboo. A participant aptly described this process when she said, "it is very difficult for us (women), we don't talk about things like this". The difficulty was not in expressing oneself but in finding someone who was willing to listen. The conversation amongst women in itself challenged to a small degree the power inequity that exists within society.

The following questions were asked:

- How has the abusive relationship influenced your choices regarding having children?

- Please help me understand how your partner reacts to using contraceptives/condoms?
- Do you and your partner agree about condom use?
- How did you go about planning to have children?
- Can you describe how you negotiate/use your power within the relationship when using contraceptives/condoms?
- In your relationship experience, how safe do you feel about not contracting a sexually transmitted infection?
- Do you regret any decisions that have been made about your family planning? If so, what?
- What advice would you give other women in similar situations?

3.6. Rigour

Rigour is determined by the measures taken by the researcher in striving for excellence. This encompasses the entire process of research with each step being meticulously and accurately detailed, defined and accounted for (Burns & Groves, 2011:39). Rigour in qualitative research is represented by its dependability and trustworthiness (De Vos, Strydom, Fouche, & Delpont, 2012:421). Within this study, rigour was attended to in the following ways.

- Reflexivity- feminist researchers recognise shared human attributes of the researcher and participant. Reflexive notes were kept throughout to observe growth and feelings that the process evoked. This helped me to keep focused and to deeply understand the concepts that were emerging. The researcher when writing up the research report provides comment on the researchers' subjective response to the research process (Terre Blanche, Durrheim, & Painter, 2011:506). During the research process, I, as the researcher, became aware of my own agency and lack thereof in dealing with cultural and religious practices. As I began challenging these as a woman, I experienced first-hand how difficult it is. I began questioning deep-rooted practices that I had been socialised into, without being able to choose. I learnt through this process what an embodied and genuine, true experience of agency is.

- Transferability- interpretive research aims to explain common human experiences (Terre Blanche, Durrheim, & Painter, 2011:91). Transferability can be achieved by the rich texts creating depth and adding value through a detailed research report. Each participant was recognised as unique and her experience although similar to others, was respected for its uniqueness. This process of rigorous creation of themes allowed me to lift out similarities as themes.
- Dependability- is maintained via a detailed description of the methods used. It refers to the degree that the reader is convinced that the research is thorough. Interpretive researchers do not assume that the reality that they are investigating will remain constant and can therefore yield different results if repeated (Terre Blanche, Durrheim, & Painter, 2011:93). The concept of dependability in qualitative research was attained by interpreting the data using a detailed framework method. This allowed me to sieve through the data in an organised manner, spending hours reading and listening to transcripts to pick up on the nuances and deeper meaning attached to words.
- Conformability- member checking will be used in the study. The researcher will continually test her interpretation of data with participants. This will ensure that data has accurately reflected what the participant has said (Krefting, 1990:219). This was applied during the process of performing the hermeneutic cycle that constitutes reading, reflective writing and interpreting, repeatedly in a rigorous fashion, using language that truly expresses the essence of the phenomena as expressed by the participant. This included use of informal language, adages and maxim (Kafle, 2011:195).
- As I received transcripts I contacted the participants. Seven participants came to read the transcripts and verify accuracy. I also discussed sub-themes that I identified with them, as this added to the truth value of the data. I did not want to misrepresent what they had said. I did not however discuss other participant's stories or themes in other transcripts not related to their specific stories. I felt this would not be helpful to my participants. The value of what they had said was maintained and respected.

3.7. Limitations

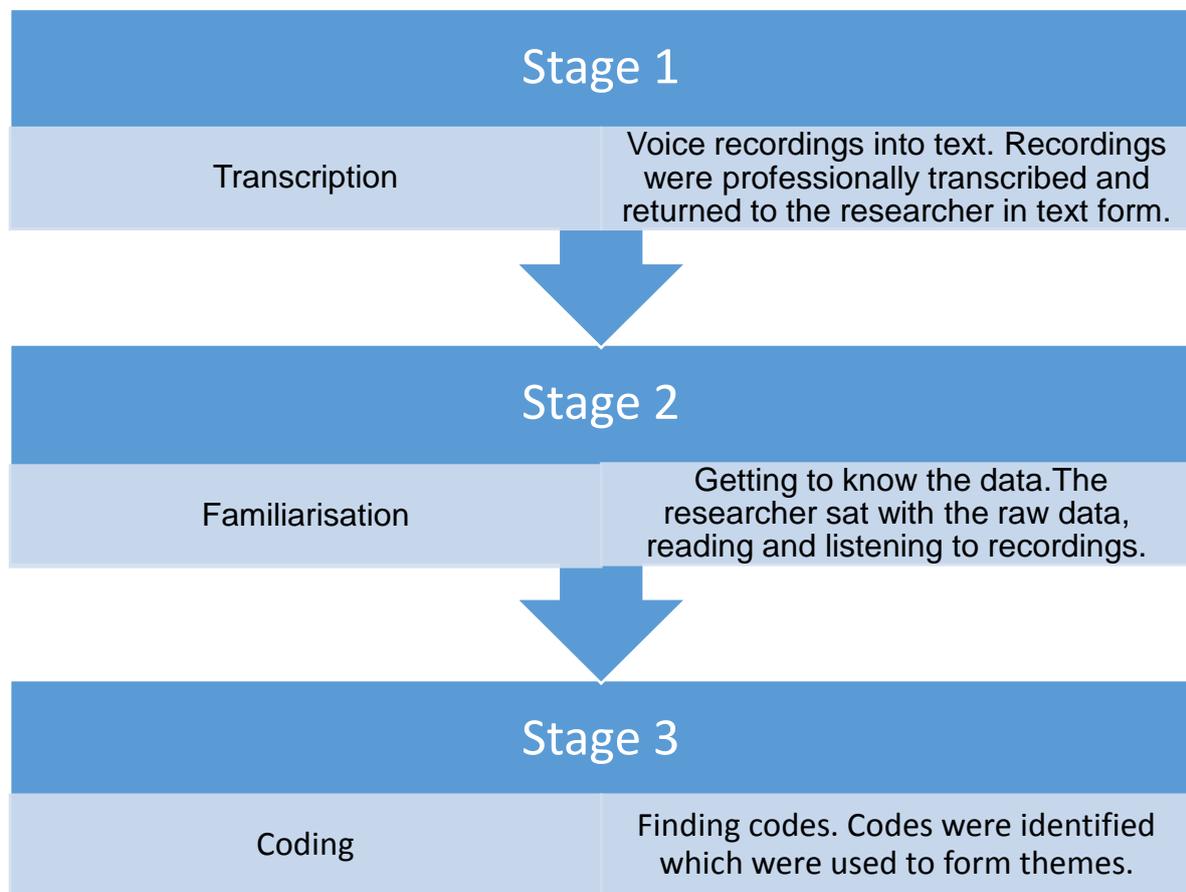
All interviews were conducted in either English or Afrikaans. This was agreed with the participants beforehand. However, it is accepted that women whose mother tongue is not English or Afrikaans, may have been disadvantaged in terms of, for example, the ability to express themselves meaningfully. Three of the participants' home language is isiXhosa. The researcher encouraged the participants to explain in detail words as well as cultural practices she was not familiar with.

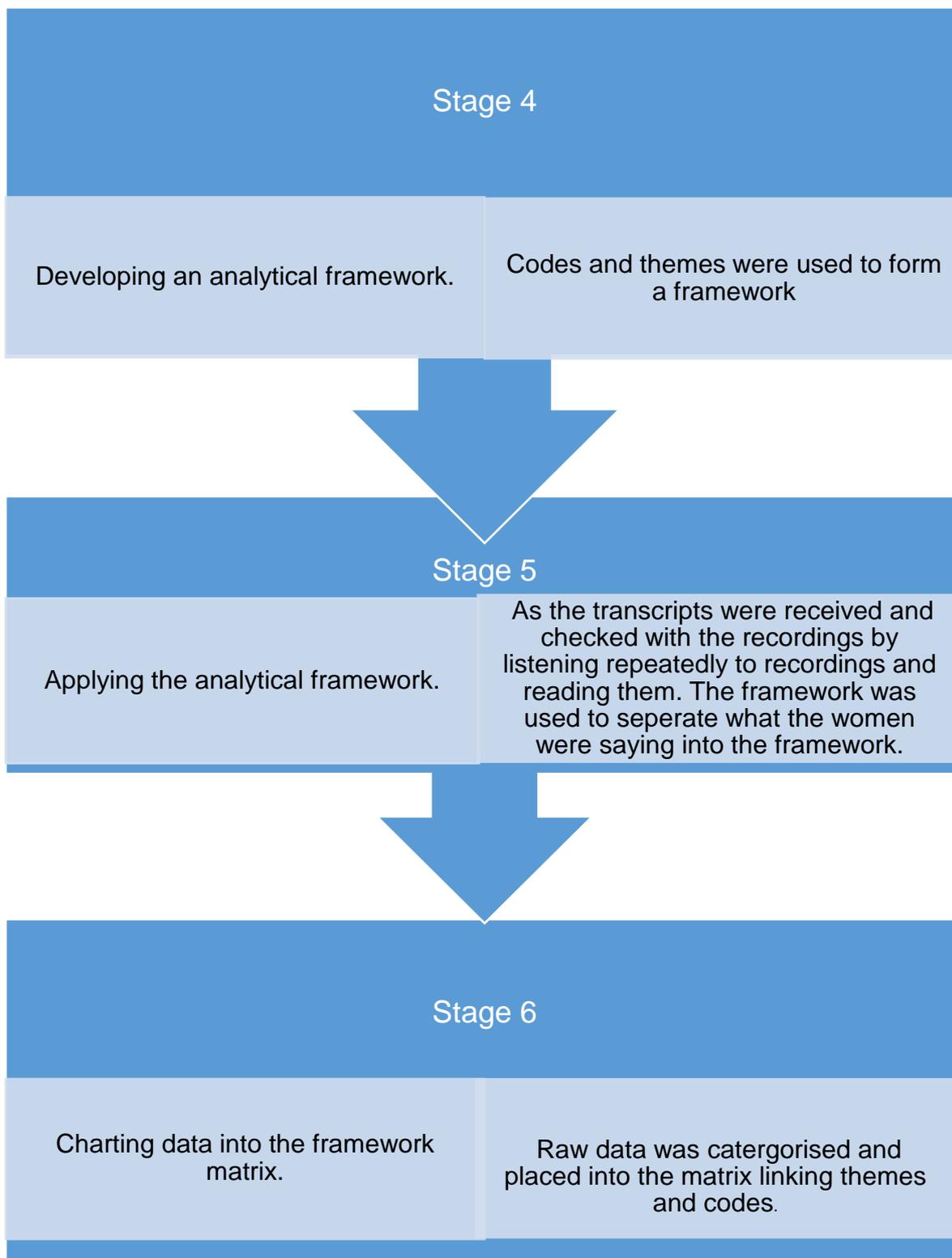
3.8. Data analysis

As the researcher familiarised herself with the data, trends and themes were identified and coded to create meaningful interpretations that were used to describe experiences (Grove, Burns, & Gray, 2013:465). The researcher engaged in prolonged meaningful interaction with participants by accepting the truth value of what participants related. The researcher verified with the participants words and phrases she did not fully understand. This encouraged rich data while still maintaining scientific objectivity, through reaching the truth as perceived by participants (Krefting, 2009:217). All the data and themes were scrutinised by the supervisors. This allowed for a detailed description of the experiences.

The framework method is a rigorous and meticulous approach that was used to analyse data (Pope, Zieblund, & Mays, 2000:114). This approach involved working through the following stages:

Figure 1: Stages of data analysis





Stage 7	
Interpreting the data.	Themes were separated, interpreted and compared to analyse and provide meaning within the context of providing a description of events as experienced by the women.

Stage 1 Transcription- All interviews were transcribed as recorded by a qualified transcriber and the researcher made several spot checks to ensure that congruency exists between the recorded material and transcripts.

Stage 2 Familiarisation- The researcher immersed herself in the raw data, by listening to recordings and reading transcripts to identify themes and key ideas. As she did this, she remained focused in a caring manner on the detail and realities of what was shared, accepting the truth value thereof and withholding prejudice and bias. She took time to understand what the women said and to provide a detailed description. The researcher went back to some of the participants to clarify what they had said to make sure she had understood the full meaning (Pope, Zieblund, & Mays, 2000:116). This also allowed her to reflect and contextualise the data (Gale, *et. al*, 2013)

Stage 3 Coding- The researcher identified the key and recurring issues, concepts, and themes that emerged from the data and created relevant data codes. Coding aims to classify all the data, so that it can be compared methodically with other parts or codes (Gale, *et. al*, 2013). These emerging themes originate from the participants' response to questions as well as issues raised by participants themselves (Pope, Zieblund, & Mays, 2000:116). At the end of this step, the researcher had a detailed index of the data codes which labels the data into manageable parts to read and explore (Gale, *et. al*, 2013). An example of the codes and themes including the reflective notes are included at the end of the stage 7.

Stage 4 Developing an analytical framework- After coding the first of the transcripts, a set of codes were established. These codes were used to create the thematic framework (Gale, *et. al*, 2013). These were applied to analytically and systematically index all the data in text form, by annotating all transcripts in the margin (Pope, Zieblund, & Mays, 2000:116).

Stage 5 Applying the analytical framework- The working framework was then applied to all subsequent data collected. Codes were assigned with a number so that codes did not have to be written out in full each time (Gale, *et. al*, 2013).

Stage 6 Charting data into the framework matrix- Charting involves summarising data without losing the true essence of its meaning (Gale, *et. al*, 2013). A chart for each theme with columns for the different issues was created (Joyner, 2009:154). Data was re-arranged according to the appropriate part of the framework that it relates to (Pope, Zieblund, & Mays, 2000:116). An abstract of the matrix is included after stage 7.

Stage 7 interpreting the data- The research objectives as well as themes that may have emerged during interviews were used as a guide to index and map data. Charts were used to make sense of, and interpret the data in order to extrapolate meaningful data, providing a description of the experience of women for the findings (Pope, Zieblund, & Mays, 2000:116). The entire process provides an audit trail for verification (Gale, *et. al*, 2013). This was done by keeping detailed notes.

An example of the matrix is given below.

Table 1: Abstract of data in framework matrix

Theme	Subtheme	Experience as described by client	Reflective notes
Agency: choice regarding having children	Lack of discussion/ poor communication	R: I was deciding to have children. I had three children and then he went for a vasectomy. It was ok.... He didn't tell me that time.	Respondent says it was her choice but husband was actually in

	and ability to negotiate		control. She hesitated before telling me “It was ok...”
Condom use/ awareness of risk of infections	Power imbalance	R: Ek wil kondoms gebruik, ma hy glo nie in dai nie hy is mos ‘gesunat’ so hys a man wat nie maklik infeksie kry van vroumense nie.... Dan slap ek net minder met hom Ek voel da is nog n risiko. Translationa: “I want to use condoms but he doesn’t believe in that because he is circumcised so he is a man that doesn’t get infections from women easily...so I just have sex less frequently ... I feel there is still a risk”	Respondent did not have enough power within the relationship to get what she wants i.e. condom use. She was not convinced that he being circumcised eliminated the risk to her.

3.9. Ethical considerations

This research involved interaction with vulnerable women. This interaction that includes the process of data collection, analysis and sharing of findings raises ethical issues that needed to be considered. The researcher protected participants by anticipating risks and protecting the participants from these risks. This was done by considering the following:

- Autonomy refers to the respect for the unconditional worth of an individual and individual thoughts and actions (Pera & Van Tonder, 2012:53). In this study, informed consent was taken before participants were interviewed. Participants were encouraged to express their opinions freely, and the researcher made

every effort to remain empathic and non-judgemental. Women had the freedom to withdraw at any time without any negative effect on them. They also had the right to decide what to share and how to share it without coercion.

- Non-maleficence and beneficence was assured by putting participants' safety first. Women were assured that they may withdraw at any point. They were not obliged to engage in any discussion if they choose not to. Research participants' expectations were clarified, so women were clear about their reason for participation and expectations. A detailed explanation of the consent form was given to the woman by the researcher. Women gave written consent to participate in the research which includes consent to be audio recorded for the purpose of transcribing. The process was empowering to the woman; she was made aware that she has rights. She was given importance and priority and the process of expressing herself and being heard created a platform for her own self-expression. The researcher made every effort to attend to the respondents immediate and long-term needs as the respondents requested.
- Justice refers to participants being treated fairly. Fairness is partly based on the method of selection and remuneration (Burns & Groves, 2011:107). In this study participants were selected through purposive sampling. They were remunerated if they incurred cost for transport and they were provided with snacks prior to the interview. They did not receive any further financial benefit from participation in the study. The research setting was comfortable and respondents were able to express themselves without fear.
- Confidentiality- Measures were taken by the researcher to ensure that the privacy of the participants was respected (Pera & Van Tonder, 2012:61). All interviews were held in a private location. Locations were chosen by the respondent. Interviews were held in a private room at Macassar CHC and at the victim support room at the police station. The principal researcher using pseudonyms and coded transcripts. All personal identifiers, namely the name, contact details and hospital number, of the clients that were interviewed have been removed from final analysis. These were only retained initially to enable

the researcher to validate data with the client when required. The researcher read and verified audio recordings transcripts, then coded and analysed them using the framework method as described. I listened to the recording together with the transcript in private to ensure that not only the written words were correct, but also to understand the emotions and deeper expression in the voices of the participants. All data has been carefully stored and filed by the researcher and will be made available on request for authentication (Gale, *et. al*, 2013). I have a recording device that has been stored in a locked cupboard that is not accessible to any other parties.

3.10. Protection of women participating in this study

The nature of the study is sensitive and difficult, as the interviews explored complex, sad and emotional matters. Participants often experienced increased, or decreased, levels of anxiety, grief or depression. The researcher was mindful of this and provided support by giving attention to the client's immediate needs and allowing the client to express herself in as safe environment. Physical and emotional safety were prioritised by ensuring that meetings were kept confidential and adequate privacy was ensured not to expose participants. I created a partnership with existing mental health services at Macassar CHC to accommodate women by giving them priority if the services of a psychologist or mental health nurse would be required. Existing relations with the community liaison officer dealing with domestic violence was strengthened to create a referral pathway for women requiring assistance.

3.11. Anticipated risks and measures to minimize risk

Every effort was made to protect the anonymity and confidentiality of participants. The researcher has worked at Macassar CHC for seven years and was mindful of the dynamics of this small community. To minimise such risks, interviews were arranged to suit participants' time schedules. Interviews were conducted in private in a secure setting. Women were not made conspicuous as study participants. They were able to decide on their own whether to talk about their involvement in the study or not.

3.12. Conclusion

In this chapter the methodology was discussed in detail. Throughout this process the researcher remained mindful of the essence of a descriptive qualitative study with a specific focus on women's agency. During the interviews and all other interactions women were encouraged to express themselves freely in an accepting, open and non-judgemental manner. The next chapter will present and discuss the findings.

Chapter Four: Findings and Discussion

4.1. Introduction

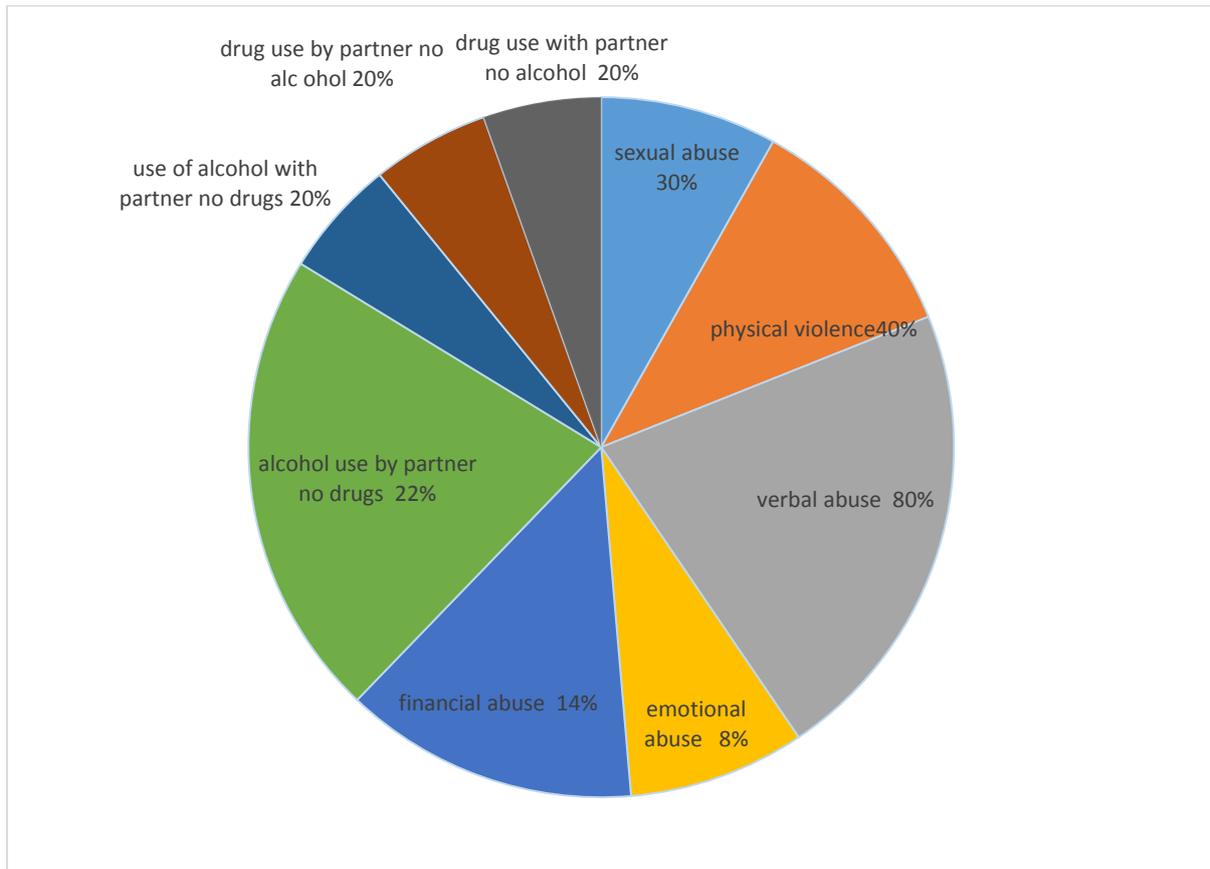
The previous chapter outlined the research methodology within the context of feminist enquiry, agency and qualitative research principles. The primary focus of the qualitative descriptive method was to capture how women used their agency whilst living with intimate partner violence. When exploring how women negotiated the realities of reproductive health, significant complexity emerged.

In this chapter, biographical data is summarised and presented as a chart. This provides perspective on these ten women's experience of different types of abuse. Themes are discussed and supported by three identified sub-themes, namely social norms, mental state and agency, and "This is it!" (Table 1).

4.2. Biographical data

The ten women interviewed had all attended Macassar CHC at some point and were chosen to be the key informants of this study. Two of the participants were married. Two of the participants were divorced. Six of the women were single, three of whom lived with their partners, while the other three lived on their own. All the women had children, on average between two and four children, although ages ranged from newborn to twenty-six. Eight of the participants reported that their partners used alcohol, whilst two of the participants admitted to using alcohol with their partners. Two participants reported using drugs and not alcohol with their partners regularly. None of the women reported using drugs and alcohol simultaneously with their partners. This data has been summarised in figure 2.

Figure 2: Types of abuse experienced, and substance abuse reported, by ten participants.



4.3. Themes emerging from the interviews

During the interviews themes emerged that linked to women’s agency when making reproductive and sexual health choices. It emerged that women have limited agency that influences not only their reproductive and sexual health but their daily lives.

Themes and sub themes are summarised in Table 2 below.

Table 2: Themes and sub themes.

Theme	Sub theme
Social norms	Alcohol use Masculinity vs. femininity Reproductive health issues Culture and religious pressure Love and belonging
Mental state and agency	Psychological trauma
This is it!	“I am a mother; I am a daughter”. “I didn’t tell him.”

4.3.1. Theme: Social norms

Social norms can be understood as the benchmark of acceptable behaviour within a social group. Behaviour is often controlled by negative pressure exerted by members on those that deviate (Eskilson & Wiley, 1987:136). These pressures play an important part in either empowering or disempowering women. The concept ‘social pressure’ is defined as a means of control exerted by forces within society on those who form part of it (Eskilson & Wiley, 1987:136). Society demands certain behaviour roles regarding masculinity and femininity, alcohol use, and pregnancy which tend to be sex-role stereotyped. Consequently, women’s roles in society are tightly circumscribed. In many cultures women are pressured to accept and endure violence because of the acceptability that men act in that way, especially when using alcohol (Eskilson & Wiley, 1987:142).

4.3.1.1. Alcohol use

The participants experienced that the use of alcohol by their partners increased the frequency and intensity of the abuse they experienced from them. With the increased consumption of alcohol amongst men, the severity of their violence and aggression made women more vulnerable. Women were less able to negotiate sex and contraceptive use.

“... It (abuse) started off early in my marriage. It was quite fine, the relationship and everything, but after five years of marriage my husband used to drink a lot and stay away from home the whole day. He would come back late afternoon or evening, and then he would just be abusive.” (1:1:13).

“... And I thought, okay, maybe it’s because of the alcohol that changed his personality or something like that” (1:1:20)

“...kom ek stel dit so, net as hy drink, hy kom van sy vrinne af, maar dan wil hy aangaan” (3:1:42)

Translation: “...let me put it like this, when he comes home from drinking with his friends than he wants to carry-on (be abusive) ...”

“When he was drunk he was talking the whole night ‘N mens kan dit nie hou nie (a person cannot tolerate it), because he is talking and skelling (shouting) and vloeking (swearing) the whole night, until he goes to sleep.” (10.4.6)

4.3.2. Masculinity vs. femininity

Men in Macassar who are in abusive relationships seem to subjugate women as a means of proving their manhood to their peers. Their abuse and aggression seem to be a means of exercising control over women while boosting their egos and feelings of masculinity. This is especially evident when men are seen by their peers and other members of society which reinforces how this illegal behaviour is enforced as a norm within this community, which is typical of the Western Cape.

“.....sodra sy vrinne nou miskien vir hom kom optel, dan wil hy gesien wees voor sy vrinne, so. ... As sy vrinne vir hom kom haal, dis amper so te sê, ek verkleineer jou, so.” (3:2:11).

Translation: “...when his friends maybe come and fetch him than he wants to be seen (recognised as being the man in the house) by his friends ...when his friends come its almost to say he belittles me...”

Equally, the women of Macassar express their femininity in very traditional ways. Behaviour for women is very regulated and confining. The participants rarely express themselves freely, abiding by rules. Women in this study accepted abuse as part of their role as a woman.

This behaviour has become so ingrained in women that they function outside of awareness. According to trauma specialist Judith Herman, this behaviour stereotype often puts women at risk of abuse (2001:199). When an awareness of abuse is created, women start questioning their traditional responsibility and acceptance of violence. This awareness often gives her the ability to hope and reconnect with herself and find her own femininity and ability to make choices (Herman, 2001:198).

As I have observed living and working in Macassar, it is very common in Macassar that women are treated as property and do not enjoy equal rights as human beings. This is not only evident within relationships but also in the way the community reacts to the violation of women. Most women have little freedom to choose for themselves and have no control over their lives or bodies, where brutality to the point of death

goes unmentioned despite the close proximity of many of the residents to each other. The quote that follows was related by a married woman. She is not allowed to choose her own friends or move around the neighbourhood at will.

“...he was used to coming home and finding me at home cooking, caring for the kids or just watching TV. But now I had friends and I could go to their homes. If he comes home the kids will say mummy is next door. So he wanted me for himself. He didn't want me to go out and have friends.... he was punching me on my body where nobody can see the bruises, but then afterwards he punched me in the face so that everybody can also see....” (1.3.4)

Social norms dictate that women should be obedient, despite experiencing abuse. He self-righteously assaulted her, blaming and shaming her for pursuing innocent friendship out of the house on the grounds that she had not obeyed her husband. This reveals destructive social norms pertaining to a wife's child-like status within a marriage and a sinister parenting style that relies on punishment via the infliction of physical pain and damage.

4.3.1.3. Reproductive health issues

The male partners of this study's participants were reported as not being eager to communicate about women's reproductive wellbeing and often became aggressive. Women were frequently pressurised to bear children. Similarly, in a study in Ghana, men stated that the use of contraception would empower women. This view seemed to be founded on the belief that a wife was his property and therefore under his control (Adongo, Phillips, Kajihara, Fayorsey, Debpuur & Binka, 1997:1790).

Pregnancy and fatherhood evoked different responses. Some women experienced that men were less violent while the woman was pregnant, while others reported an increase in the perpetration of violence. Pregnancy is a time of increased vulnerability and dependence. It is evident from the interviews that this community requires women to take full responsibility for their children while the fathers are absolved from same.

Pressure is exerted sometimes by family and relatives for women to remain in abusive relationships to maintain her perceived duty to her children.

“Because each and every time I told people that I was going to leave this man they always told me, even his mother and my mother, ‘but what about the kids? You must think about your kids’. And then I told them, but I am thinking about my kids....” (1.3.38)

When this participant sought support from her network, including her mother and mother-in-law, she was pressurised with the unquestioned norm that an abused mother should stay with her violent partner “for the sake of the children”. She responds saying she is thinking of her children, revealing her insight into the damage this is doing her mental and physical health and theirs. She clearly understood that it was damaging for her children to witness their mother being degraded in this way, quite apart from the atmosphere of tension and even terror that pervades the household. The men in this study clearly did not share the responsibility. In the example that follows abuse worsened during pregnancy, with an abusive partner who showed no mercy despite the participant being in a vulnerable state.

“Nee, hy het nie opgehou nie. Hy was net al erger. Dis amper so, hy het nie eers omgee nie dat ek swanger is nie. Hy het nog altyd deur daai vir my geabuse.” (2:5:24).

Translation: “No, he didn’t stop (abuse). He just became worse. It’s as if he didn’t care that I am pregnant. He abused me throughout”

Amongst the male partners, fatherhood evoked the gamut of responses from complete non-involvement to taking possession of children and claiming sole custody. Male children appeared to be valued more highly than female children by their fathers.

“I decided I must get another baby because I’m turning forty years, then I must get my baby. And I was planning also a girl, thanks god, I got a girl. It’s my baby.” (7.2.11)

This participant’s male child was taken away by her husband and she knew he had no interest in a female child. She was relieved that she had a girl, because she could keep the child. This indicates that in the eyes of some fathers, male children had far higher status and value than female children.

4.3.1.4. Cultural and religious pressure

Women experienced pressure to behave and conform to male chauvinistic cultural and religious norms which are endorsed by society at large. Speaking about family planning within certain cultures as experienced by a participant was not acceptable.

“According to our culture, we don’t speak such things to our husbands. Sometimes things are so complicated for us.” (6:4:20).

This highlights the poor communication and quality of relationship that characterises their partnerships. There is minimal communication and support from her partner regarding her choice to have children or not. It seems strictly expected that she bears children for her partner. It has also become much more common for women to be working to support their children and partner to boot. This reveals a double standard operative for men which is predicated on entitlement and impunity.

“Now most of the time you have to work for your children. If you don’t work, then your children are suffering. They can say they want the children, but at the end of the day they don’t support the children.” (6:5:37)

“Ek was ‘n bietjie upset maar hy het gese die Here sal my nie iets gee wat ek nie kan dra nie. Dit is meant to be, dit moet seker maar so wees.” (2:2:38)

Translation: "I was a little disappointed but he told me the Lord will not give me things I cannot bear. It is meant to be; it must surely be like this"

This disempowering use of religion related to family planning or lack thereof. Abusive men are able to manipulate their partners using religious and cultural teaching to force them to bear children for him. Women have been socialised to believe and enact these teachings even if it goes against their own wishes (Gharaibeh & Oweis, 2009:380).

Violent behaviour perpetrated by men is socially acceptable. This participant quoted below endured years of abuse before deciding to retaliate with similar violence. She took a broken bottle and stabbed her partner as he was about to assault her. The community intervened and sanctioned her negatively by threatening her with jail. For all the years, she suffered violence attacks, her injuries and broken spirit was completely overlooked. But when she finally defended herself, it was her partner who

enjoyed the sympathy of the community as the victim. Once again, this bears witness to the double standard operative for men, and endorsed by community norms.

“I used to fight with a knife. I used to fight with a bottelkop (broken glass bottle) or whatever. So now the other day I just stabbed him, really stabbed him, and then they say, but you see now, you are going to jail because you are going to kill this man.” (6:3:37)

Most women in this study were socialised into a social structure where women are treated as submissive and inferior to men. Women are socialised from childhood to accept certain values and behaviour as being socially acceptable. This stems from deep rooted chauvinistic practices where abusive behaviour has become normative. This is evident in the daily lives of women when they are expected to endure abuse because it is “the right thing” for a woman to do, married or not. However, there are counter voices, as evidenced by the quote below:

“I have three daughters and they can’t grow up in a house where they can see their father is abusing me. Because they will grow up just like me and think it must be like this... it must stop. They will think like all the girls here - my boyfriend or my husband must also treat me like that” (1.3.41)

The quote below highlights the myth of rampant, insatiable male sexual desire. Why is it that fathers find it appropriate to emotionally abuse their partners by being unfaithful? They also risk bringing HIV and other sexually transmitted diseases into their family setting while their partner is temporarily unavailable.

“the time I was breastfeeding I was not doing sex that’s why he got another girlfriend our people we don’t do sex when we breastfeed it’s not good for the milk.....” (7.5.3)

It is socially acceptable, and even considered manly when men act out by being unfaithful to their childbearing partners (Eaton, Kalichman, Sikkema, Skinner, Watt, Pieterse & Pitpitan, 2012). Women are not recognised as having similar needs. This

participant has been socialised to believe that her milk will not be good enough if she has sex. She makes the sacrifice of abstinence. She accepts her role as a breastfeeding mother. This reveals deep double standards with regards to sexuality. Men are allowed unlimited sexual behaviour whilst women are required to fulfil her partner's needs at the expense of her own. It has an emotionally debilitating influence on the wellbeing of the mother and her new-born baby. While he is permitted to remain infantile, unencumbered by the duties of parenting, the baby's well-being rests solely with the mother.

In my experience as a midwife, we encourage women to breastfeed given the scientifically accepted nutritional benefit. This contradicts what women are subjected to or told about sex and breastfeeding by their communities. These conflicting messages add to a woman's stress and state of confusion. This is not only a violation of her agency and human rights but also extremely cruel, making her believe her milk becomes tainted because of sex.

Women are subjected to various social pressures that not only rob her of autonomy but also trap her in a state of dependency, where she will be further victimised by judgemental others who see fit to pass negative comments about her inability to leave abusive relationship.

"...Now everybody is saying we (she and her children) are rude to him because we kick him out. But it's like I'm in the middle of a thing because he is sleeping now in the house Now we must endure... because he is my husband and the children's father"
(10.5.6)

This woman and her children live with abuser because of social pressure. They were made to feel guilty at creating separation because he is her husband and the children's father.

"...I didn't want children from different men I thought it was my fault when he raped me and I was pregnant.... That's how me and my husband got together" (10.2.46)

As I have deduced from interaction with this participant, she has been socialised into believing that having children from different men was wrong and made her bad. This resulted in her making her life with her rapist which led to years of intimate partner violence. Trying to divorce him resulted in the community ostracising her. She was made to feel guilty by the community and labelled a bad mother and wife for asking him to leave. She allowed him back into the home under duress. Consequently, she continues to live with abuse daily. Women remain trapped in situations unaware of their rights. South Africa has a world-class constitution, yet many women remain oblivious to their right to bodily integrity and sexual freedom.

4.3.1.5. Love and belonging

Women in this study have the desire to be loved within a relationship and sacrifice for love to conform to societal norms. They give up their agency and submit to what a partner want in the hope of receiving love and a sense of belonging. This leaves them disillusioned and deeply traumatised.

"He raped me....so he was looking for me then afterwards and said, yes, but I am his girlfriend. So, I thought, oh, maybe it is so, because I was pregnant now from this guy. And if I am going to tell you I loved him, I'm going to lie to you" (10.3.47)

This participant endured eight years of abuse trying to please her partner. She stayed with him because she thought he loved her. She had grown up in a violent society and experienced abuse in her parental home causing emotionally trauma from a young age. She longed to have a husband who loved her and was able to give her a safe haven. She had three children from him, hoping with each pregnancy and child that he would change.

".. I was trying to see what I can do to change and to maybe see if it's going to work, if it was going to make him happy. Maybe not to do the things that was actually upsetting him I actually went to learn stuff to do that I knew he was interested in, like shooting pool, stuff that I know he is doing all-day long, so that we could have something to share. But that even didn't work. That man was furious when he heard that Because my neighbour is also in an abusive marriage.... her husband and mine they were close friends so we went together. Those two didn't ever come back

to that place they didn't want us there. So, that is what I told her: we tried to do something" (1.4.6)

Despite her efforts at building a friendship with her husband she was rejected and humiliated. This act of humiliating the mother of his children in public and not wanting her in his social group reveals a serious lack of friendship and affection. She had already found him flirting with other women in her presence, so infidelity may well be the sub-text of his behaviour towards her. It also highlights the acceptability of him having a circle of friends and activities while she is forbidden the same.

4.3.2. Theme: Mental state and agency

This theme relates to the state of women's frame of mind that hinders their ability to promote agency for themselves. The mental state of the participants directly influence their decision-making ability. This impacts both their agency and their ability to function within their daily lives. Women in this study frequently portray signs seen in patients with depression, Stockholm syndrome and post-traumatic stress disorder. This range of trauma-related disorders render the participants of this study vulnerable, at times unable to plan or make decisions.

4.3.2.1. Psychological trauma

".....there was mos not money, so I went to the farm where my mother worked and they had their own graveyard. So I went there and asked to bury my baby there. So he (farm owner) said yes, but I must work for two weeks firstso I buried my baby. I carried her in my hands and I buried my baby in the grave myself. Because it was a small white coffin. He (her husband) was not there nobody was there, because they didn't believe me. So then afterwards when I went back to him.... I don't know what happened there It was so traumatic... I lost my baby" (10.2.13)

The quote above shows the austere trauma that this participant experienced. She married her rapist who continually physically and sexually abused her during

pregnancy resulting in her having a still born baby. Her husband and family did not support her when she lost her baby and even blamed her. She was expected to take responsibility for the burial of her child on her own. This left her so traumatised that she had no recollection of what happened when she returned to her husband.

This is symptomatic of post-traumatic stress. The depth of her abandonment, despair and misery, resulted in her dissociating. She is now able to talk about the incident but could not at the time tell her husband. He knew that she had left the hospital with a still born baby but did nothing to assist her. It is not uncommon that women in extremely desperate situations are further marginalised by lack of sympathy from those they encounter. This inhumane treatment is highlighted here where she has to find burial space despite having no money to pay for it. The farm owner makes her work to pay for the grave space.

An example of Stockholm syndrome is evident in the quotes above. Stockholm syndrome occurs when a victim develops an unnatural bond with her perpetrator (Demarest, 2009). She often defends his actions and even blames herself. The participant says her partner is helping her despite his being very abusive. She further defends his actions by saying he doesn't get any support from his family. This is the same man who had assaulted her with an axe and locked her up in their house until her wounds healed, thereby preventing her from accessing medical assistance.

“Die man help my nou baie. Hy help my nou baie. Hy kry eintlik nie support van hom kant af nie” (9.4.31)

Translation: “This man helps me a lot. He helps me a lot. He doesn't really get any support from his side (family)”

The next quote is from a woman who defends her husband although she found her husband with another woman.

“... I saw him flirting with other women I don't know; I don't think he was ever involved with someone else. He was just partying with friends and drinking. Because he was always telling me that how afraid he was that one day I would leave him....” (1.4.34)

The comment below from a woman is an example of the difficulty women face in making decisions regarding their own well-being. Her boyfriend wanted a child, she did not.

“My ding is net, elke keer sê ek vir myself, ek moet op family-planning gaan, ek moet op family-planning gaan, maar nooit..... dis net ‘n minuut se loop. Maar my ding is net gewees, ek sal nie swanger raak nie. Ek weet nie hoe kon ek so gedink het dat ek nie gaat swanger raak nie.” (2.4.20)

Translation: "the thing is, every time I tell myself I must use family planning, I must use family planning, but never.....it's only a minutes' walk my thing was I will never get pregnant"

Clouded judgement, perhaps as part of a depressive mental state, resulted in women making decisions that they couldn't explain and did not want, and which were often detrimental. The pressure of living in an abusive relationship while traumatised seems to result in poor decision making and minimal agency.

“...ek wou nie rerig getrou het met hom nie. Ons het mos gebly in so een huisitjie ons het daar gewerk en my ma-hulle was baie strict gewees. Ons mag nie saam geslaap het nie. As jy nie getroud is nie, slaap jy nie saam nie. Dit het by my gebly tot vandag toe..... So we stayed with my aunty in the flat before that and my uncle abused me my uncle died.... Soos ek nou is ek was skaam om vir family planning te gaan dan raak ek net weer swanger” (10.6.36)

Translation: “I didn't really want to marry him. We lived together in a house where I worked and my mother and they were very strict. We were not allowed to sleep together if you are not married you don't sleep together. That stayed with me till today. So we stayed with my aunty in the flat before that and my uncle abused me my uncle died.... Like I am now I am ashamed to go for contraception then I just get pregnant again.”

This participant was sexually abused as a teenager whilst she lived with her aunt and uncle. The adults kept telling her sex is for marriage yet she was being sexually abused

by her uncle. Her uncle was one of the adults living with her. This revealed the sense of entitlement that males have over females and the hypocrisy that allows them to fulfil their own needs, in this case at the expense of the female relative and minor in his care. While living, and working at the CHC for eight years, the researcher became aware that abuse of girls by males within their homes is not uncommon in Macassar, yet it is not readily reported.

Women experience themselves as being helpless and unprotected. This resulted in them repeatedly surrendering to traumatising. Surrendering both physically and psychologically results in her loss of ability to exercise her right to make choices for herself (Herman, 2001:83).

Girls are often made to feel ashamed of what has happened to them. When her boyfriend raped her, as her uncle had done many times and she became pregnant she eventually married him. Her only experience of sexual intimacy was being raped. Housing was provided by their mutual employer forcing them to live together. This brings us back to social norms. Pressure is exerted on women to adhere to male-defined and/or male-oriented social rules. These rules disempower women by influencing their decision-making ability. This disproportionate pressure exerted on women compared to men robs women of their autonomy.

4.3.3. Theme: This is it!

This theme relates to the reasons women gave for eventually breaking free, finding agency and getting what they want. Health care services as well as other social support agencies should be able to provide the support structures needed by these women when they seek help (Campbell, Woods, Chouf, and Parker, 2000:224). Women in this study found their voices when they had sufficient support.

A study in California compared women who received family planning from a trained counsellor and those who received standard care. Women who received care from a counsellor trained in contraceptives and intimate partner violence had better outcomes. There was a reduction in pregnancy coercion and an increase in reporting of incidence of violence (Miller, Decker, McCauley, Daniel, Levenson, Waldman,

Schoenwald, & Silverman, 2011:274). In Macassar, there is clearly a lack of support for women from their immediate network to the wider community structures. This lack of support adds to the difficulty of women trying to make choices to improve their lives.

4.3.3.1. I am a mother, I am a daughter

Women in this study wanted to be examples for their daughters. They didn't want their daughters to suffer the same fate. As previously quoted the participant did not want her daughters to be trapped in the same circumstances that many girls and women find themselves in Macassar.

Another reason was that the children pushed them or became aware of abuse as they got older.

"...mummy you must now make the decision to leave this man because we can't deal with it anymore. When they told me that I thought by myself, but even your kids say that, then you must really make up your mind." (1.3.45)

This participant found the ability to use her agency after her children spoke to her, about their unhappiness. She valued her role as mother more than that of submissive wife. Added to the atmosphere of tension and even terror that pervades the household. She understood that it was damaging for her girls especially, to witness their mother being degraded.

4.3.3.2. I didn't tell him

Women experiencing the psychological effects of intimate partner violence are particularly vulnerable when seeking reproductive health care. These women require healthcare workers who are perceptive to their needs. Healthcare workers should be able to provide for their patients' agency without further traumatising them. Current fragmentation of services adds to the difficulty of adequately addressing women's needs (Campbell, Woods, Chouf, and Parker, 2000:224).

In this study women found agency by not involving their partners in reproductive decision making, often to get what she wanted and avoid conflict. Women delayed or did not disclose a positive HIV result, contraceptive use and pregnancy test results. This proved to be a prudent decision. The partner was not able to interfere or rob her of her own free will. She was still caught in the relationship but saved herself from additional unwanted pregnancies and further dependence.

"... ek het self besluit. Maar as ek vir hom se ek gaan vir my op die inspuiting laat sit, dan se hy vir my ja is net vrouemense wat rond wil slaap wat sulke dinge gebruik."
(4.1.26)

Translation: "... I decided myself. But if I tell him I'm going to use the injection (contraception) then he tells me it's only promiscuous women that use such things."

She has been manipulated to believe that she is promiscuous, yet he is the one that has been unfaithful. She has contracted sexually transmitted infections yet has only had sex with him, hence the irony that he is the promiscuous one. He uses drugs and then demands sex. She is unable to escape the relationship because of financial dependence. She has decided she cannot have another child. She is in a relationship where she enjoys little freedom. Her partner treats her like a child giving her an irrational reason for not wanting her to use contraceptives. Here he hides his true intention of wanting her to bear children for him. She came to the clinic because she felt she would get contraceptives without being judged for promiscuity.

".... Daar's maar baie ways... Ek het skelm geloop" (9.1.32)

Translation: ".... There are many ways ...I went secretly"

This participant described how she had to find innovative, deceptive ways to use contraception. Hiding her true intentions, this also illustrates the lack of trust in the relationship and her inability to negotiate for her own agency. This woman attended the clinic and was able to access contraceptives and medical care because she felt she trusted the confidentiality at the clinic.

In a South African study conducted amongst mostly female patients attending a primary healthcare facility, very few of the women experience tangible effects of the legislative policy to advance their rights (Khumalo, 2010). Integration of services allow women who seek to report crimes against them and should allow sufficient support

and scope to exercise their right to choose. If she chooses to leave, there should be a safe place, a haven with adequately trained staff that gives her immediate and ongoing support.

In communities where violence is common, violence against women becomes the 'norm' and does not evoke an appropriate community response (Odero, Hatcher, Bryant, Onono, Romito, Bukusi, & Turan, 2014:784). The social dynamics of alcohol use, male dominance and lack of male responsibility in parenting, challenges women to endure enormous hardship before finally either standing up or losing themselves in an endless cycle of abuse.

4.4. Conclusion

The abuse of women and girls takes so many forms which mostly pass unnoticed. Many females live in desperate circumstances. Through various methods of sanctioning by their partners, as well as social groups within the community, women are kept silent and robbed of their agency, leaving them with little autonomy and self-respect. From a human rights' perspective, though, women should not feel guilty about making choices to protect their well-being and that of their children.

Chapter Five: Conclusion

5.1. Introduction

The study's overall aim was to reflect deeply on the lived experience of women's agency in relation to their own reproductive health care, while experiencing intimate partner violence. This chapter summarises the interpretation of how the findings met the objectives of this study as described in chapter one. The chapter will also outline the limitations of the study. Recommendations are suggested to improve care for these vulnerable women.

5.2. Conclusion

The study had two main objectives which were interrelated.

1. To explore and describe women's agency over their own reproductive health while experiencing intimate partner violence.
2. To describe how living with intimate partner violence influences women's susceptibility to sexually transmitted infections, including HIV.

In the previous chapter the major themes that emerged gave a picture of women's limited agency, and often complete lack of agency, when making reproductive and sexual health choices. This put them at risk of unwanted pregnancies, sexually transmitted infection and HIV.

Abrams argues that women try to live as autonomous beings by striving to be self-directed in a world that is "full of judging eyes, tangled commitments and weakness of will complicated by uncertainty" (1999:806) and all this within realms of violence, poverty and a lack of status. This status quo results in autonomy and agency remaining an elusive dream for most women when making reproductive health choices. Living with intimate partner violence further reduces their agency in male dominated societies where women have little status.

5.3. Recommendation

Currently, service delivery at Macassar CHC appears fragmented. Service points are designated to deal with a limited scope of health problems, to the exclusion of others. An effective referral system for ongoing reproductive health support would enhance the current service. Women are given dates to return for follow up doses of contraceptives. An improved service would pay attention to other women's health issues, including intimate partner violence during these visits. Routine screening for sexually transmitted diseases and selective case finding for intimate partner violence are poorly integrated into current client contact sessions. There are no clear structures or policies in place to provide guidance when attending to women presenting with a history of abuse. This was highlighted when training was provided in August 2014 yet, although staff seemed to understand intimate partner violence related issues, subsequent changes to practice were not observed. Despite lip service to the issue, health staff's behaviour shows a determination to keep the issue of intimate partner violence invisible.

It is recommended that the health repercussions of living with intimate partner violence are taken more seriously within reproductive health services. To do this I will discuss two approaches involving integrated care: firstly, integrating existing services and secondly, adopting a human rights approach to healthcare service delivery. I will also discuss the Western Cape department's 2030 plan, which essentially combines the two approaches.

It is recommended that meetings be held with community organisations as well as religious leaders and social groups to address, and hopefully improve, women's social and personal agency within communities at large. Advocating for women's rights should be encouraged at primary facility level by staff dealing with clients before they present with serious assaults and trauma. Creating awareness could reduce the severity of consequences. Women's rights organisations, like Uthando, that promote women's rights should be encouraged to join the discussion on health care at all levels.

Continued research and collaboration with centres of education is recommended to align services with evidence-based activities. This collaboration will benefit service delivery points, decision makers and curriculum developers. Accountability for continued involvement in research and self-development needs to be part of staff performance plans. These should include issues relating to women's rights, reproductive health and intimate partner violence. Furthermore, note that it will be highly beneficial if both men and women are screened for alcohol and drug abuse and referred to rehabilitation centres or support groups within the community.

5.3.1. Integrated service delivery

As a means of using the existing resources, it is suggested that service points be made multi-functional. Healthcare providers need to be trained to manage the diverse needs of women presenting with intimate partner violence related issues and be equipped to provide appropriate care. Caring for women goes beyond the treating of symptoms. Healthcare workers need to be sensitised to develop vulnerable women's self-agency needs. In a South African primary care study it was found that less than ten percent of women experiencing violence are recognised. Women present with multiple reasons for entering healthcare services. These complaints may not be the primary reason for the encounter as intimate partner violence tends to hide behind complaints of stress, headaches, infections, backache and chronic diseases (Joyner & Mash, 2012).

Intimate partner violence should be an agenda point at reproductive and clinical governance meetings at all facilities: primary, secondary and tertiary. Women's health issues relating to intimate partner violence should be prioritised at all levels. Inter professional partnerships should be nurtured between medicine, nursing, social services and the police. There should be a dedicated champion for women's health who liaises with various stakeholders to ensure the best possible care for women. This can be led by the Ministry of Women. Individual provinces need to take responsibility for monitoring and evaluating intimate partner violence and other women's health priorities through its provincial ministers and district representatives. Each level of care should have an identified person who is held accountable.

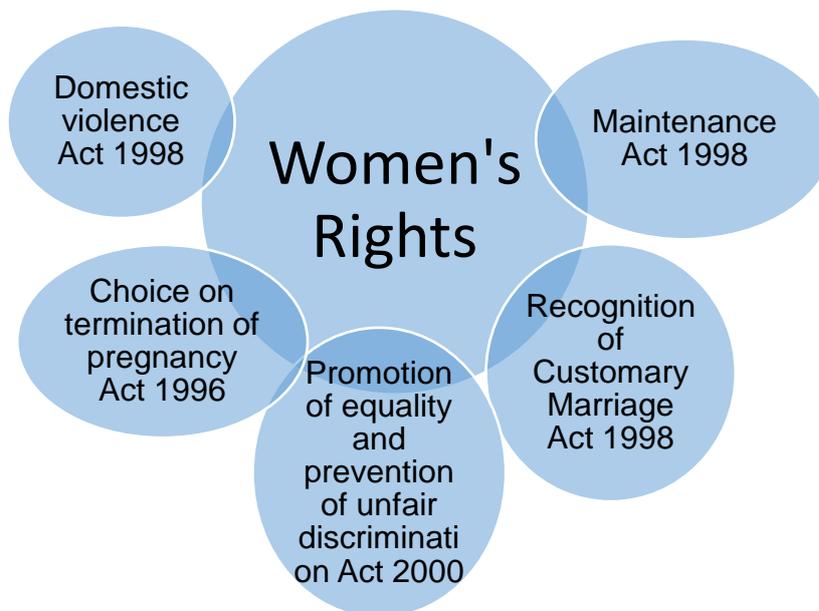
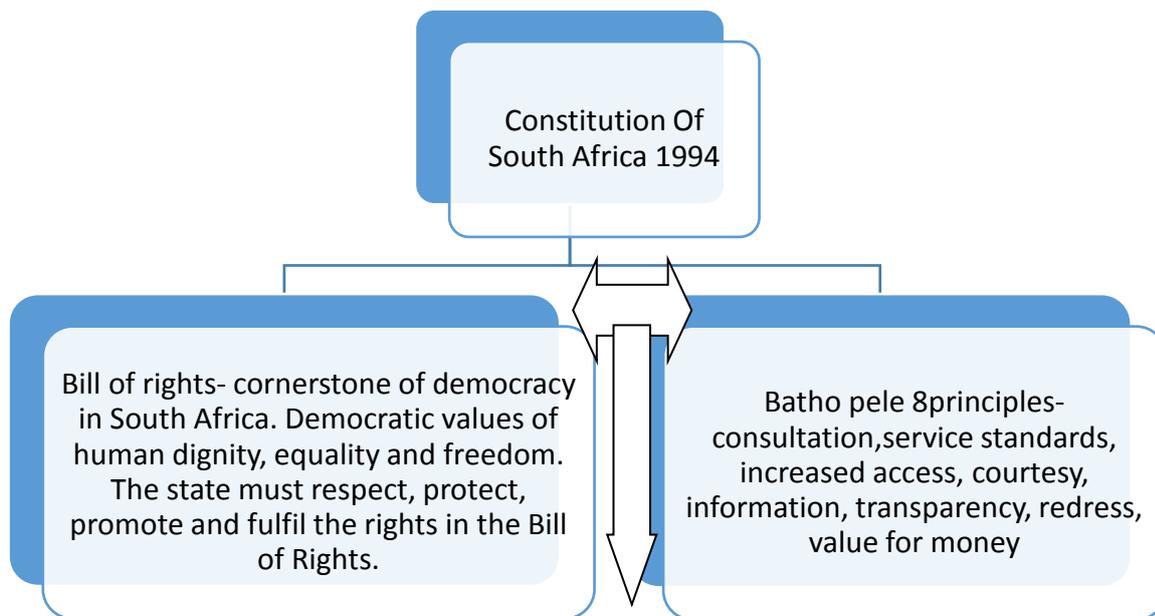
5.3.2. Human rights approach to health care

A human rights' approach to health care is critical for marginalised groups. This should include women seeking reproductive agency in the context of intimate partner violence. Without adequate commitment and resources, disproportion in services will persist and could even grow. This disproportion creates the breeding ground for violence, unwanted pregnancy, HIV infection, alcohol abuse amongst others. All these factors influence women's agency (Singh, Darroch, & Ashford, 2014). A human rights' approach alters the fundamental basis of program development.

A World Health Organisation study on a human rights' based approach to women in four countries (Brazil, Italy, Malawi and Nepal) demonstrated that it would lead to better health outcomes. In each country, constitutional and international rights to health were translated into improved health. Health services through laws, policies and programs that apply principles such as accessibility, participation, quality and accountability lead to better health outcomes for women (Singh, Darroch, & Ashford, 2014). Healthcare programs directed at women's health set targets regarding the number of patients seen as an indicator. When these programs focus on goals related to promoting and protecting individual rights, then privacy, agency and choice can be ensured. By protecting the rights of a woman, her mental health and physical safety and that of her children are indirectly improved.

South Africa has one of the world's most admired constitutions worldwide in its claim to protect the human rights of all citizens. It has led to many laws being passed that should better the lives of women. Although there has been some improvement, a large gap between the constitution and service delivery at facilities still exists. Many policies have never become real for women, especially those living with intimate partner violence. Women still stand in long queues at clinics that give minimal attention to their dignity despite policies to improve patient-centred care.

Figure 3: Legal framework for women's health care.



Similarly, at Macassar CHC, it appears that women are not getting the standard of care that is their constitutional right. Turning women's rights into significant reportable outcomes would make a tangible difference in women's lives.

5.3.3. Healthcare 2030: The road to wellness.

The Western Cape's strategic plan for delivering healthcare to citizens is outlined in the Healthcare 2030 plan. The vision of Healthcare 2030 is to provide access to patient-centred quality care (Healthcare 2030, 2014:25).

A patient-centred approach as described in the strategic plan refers to:

- Improved person-centred experience
- Improved technical quality of service
- Caring for the carers (Healthcare 2030, 2014:29).

Clients are to receive effective treatment delivered by staff that they can trust. Communities and clients should be involved in decision making. They should have fast access to reliable healthcare advice and clear, comprehensible information for self-care. Physical comfort and a clean safe environment including empathic, emotional support are other priorities alongside the ability to involve friends and family in their care and have smooth transition throughout the health care system (Healthcare 2030, 2014:29).

The involvement of non-governmental organisations in decision making and other stake holders aim to place the patient at the centre of service delivery (Healthcare 2030, 2014:29).

This plan was implemented provincially in 2014 but still needs to be translated into tangible healthcare delivery changes for women. Collaboration between communities, patients, family members and providers is key to ensuring that appropriate support is given to patients to ensure continuous care.

5.4. Limitations

The study was done in the small community of Macassar. Utilising a qualitative methodology, ten women were interviewed. Although the sample cannot be seen to reflect the entire Western Cape, findings are nevertheless similar to those of numerous international studies as reflected in the literature review of chapter two. This study however only reports the findings of ten women interviewed in Macassar.

5.5. Self-reflection

As a researcher and a woman, it was often difficult to remain mentally and emotionally separate from the research. I initially attempted to be clinical in my analyses and interviewing. It was not possible for me to listen to these very real experiences and not experience some vicarious trauma. Listening to these women, lead me to deeply question my own agency and autonomy. Living in the community of Macassar, I experienced my lack of agency first hand when challenging social norms. I realised through this personal process that despite being a professional woman, the autonomy I thought I had was in fact mostly an illusion. This resulted in me taking breaks from my research process to dramatically transform my life circumstances until this imbalance had been redressed. Reflecting on this with my supervisor was a means of checking that I was maintaining accuracy in my presentation of the data.

5.6. Future research

Research into the effectiveness of current programs to address women's health and intimate violence is necessary, so as to improve them. The referral and support systems are clearly ineffective and academic research could aid in improving services. Further research needs to be done on the struggles and injustices that women face daily. Women's agency needs remain unmet; more research in the area of empowering women to act autonomously is strongly recommended. This research should be aimed at all women's health programs as well as other spheres of government such as the legal system and social services

5.7. Conclusion

It is an essential human right to be protected, whether one is male or female. The healthcare service has a pivotal role and arguably, a moral duty, in ensuring this right. Women's agency remains central to address their reproductive health needs. Gender disparity is unlikely to be completely eradicated in the lives of the women in Macassar but by creating awareness, change can be set in motion. These inequalities should not continue to go undocumented

Appendices.

Appendix A.

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

An exploration of clients' agency regarding their own reproductive health while living with intimate partner violence.

REFERENCE NUMBER: S14/02/026

PRINCIPAL INVESTIGATOR: Sumaya Joseph

**ADDRESS: Macassar Community Day Centre
Corner Hospital and Musica Avenue
Macassar, 7134.**

CONTACT NUMBER: 021 857 2330

Thank you for taking the time to read this information document.

You may decide to sign the consent form after you have read the information document.

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the Sumaya Joseph (principal investigator) any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved.

Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- *The study involves interviews that will be recorded using a recording device/cell phone and then typed out on paper. These interviews will take place at Macassar CDC at a convenient time for you. Pseudonyms will be used in all recordings to protect your identity.*
- *The typed out paper data will be checked with the recordings for accuracy and a follow up interview may be arranged if needed. A list will be kept by the principal investigator with the pseudonyms. This will be destroyed once the data has been validated. All recordings will be stored electronically on a password protected computer and destroyed at the end of the study.*
-
- *The time and venue of the interview can be arranged with Sumaya Joseph (principal investigator) who will be conducting the interviews. This will not interfere with your regular clinic visit. You may choose a convenient time which can be arranged for after regular hours, that is after 4pm.*
- *You will be interviewed individually in a private room. This will further ensure your privacy and make it easy for you to speak about your experiences.*

Why have you been invited to participate?

- *Women who have experienced intimate partner violence have been invited to participate in the study to describe their unique experiences.*

What will your responsibilities be?

- *To freely participate in an interview with Sumaya Joseph (principal Investigator). At Macassar CDC. To choose a pseudonym.*
- *To select a suitable time for the interview.*
- *To communicate any difficulty you may have.*

Will you benefit from taking part in this research?

- *This study aims to better understand the needs of women who experience intimate partner violence. It would assist in improving the services we provide.*

This may not be of immediate benefit to you, but it may benefit future patients who access the health service.

Are there in risks involved in your taking part in this research?

- You may experience increased levels of emotions and require an intervention. You may request an appointment with the health clinic. These appointments will be arranged for you by Sumaya Joseph (principal investigator) with a psychologist or mental health nurse at Macassar CDC.

If you do not agree to take part, what alternatives do you have?

- *I have included a resource list of services available in our community. You may contact them irrespective of you consenting to the study or not.*

Who will have access to your medical records?

- *All information collected about you will be treated with confidentiality. No record will be placed in your hospital folder that you took part in a study unless it relates to your further treatment and with your consent. If the data is published in any form your identity will be protected by removing all personal identifiers. All recordings will be stored until data analysis has been completed and then destroyed.*

Will you be paid to take part in this study and are there any costs involved?

No you will not be paid to take part in the study but your transport cost if any will be covered. Refreshments will be provided for each study visit. There will be no costs involved for you, if you do take part.

- You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your principal investigator.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I agree to take part in a research study entitled, **an exploration of clients' agency regarding their own reproductive health while living with intimate partner violence.**

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the principal investigator feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on

.....
Signature of participant

.....
Signature of witness

Declaration by investigator

I declare that:

- I explained the information in this document to
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above.
- I did not use an interpreter.

Signed at On

.....
Signature of investigator

.....
Signature of witness

Appendix B.

Contact Details of resources available in Macassar.

Macassar Mental health clinic.

Contact persons: Mr Derick Witbooi or Sr. Gail Hendricks.

Available on Tuesdays and Wednesdays

Contact number: 021 857 2330.

Macassar Police Station.

Contact person: Mrs Jooste.

Contact Number: 021 857 3366. Emergency 10111.

Social Services.

Women and child welfare.

Contact person: Mrs Adams.

Contact number: 021 857 4689.

PATCH Helderberg.

Assists sexually abused children under 18 years old.

Contact number: 021 852 6110

Rape crisis.

Contact number: 021 852 5620.

Ambulance for emergency: 021 852 1653 or 10177.

If you have any difficulty accessing services or would like appointments to be arranged for you, please feel free to discuss your needs with Sr.Sumaya Joseph.

Appendix C

Research interview form.

Patient pseudonym: _____

Attach patient's sticker here

Date: _____

Time: _____

Checklist:

Document	Tick if checked and completed
Participant information leaflet	
Consent signed	

Researchers

notes: _____

Appendix D

Extract of transcripts

Interview 1

I just raised the kids. Going nowhere. I had no friends. But then I went to study, and after that it was happening.

SJ: So you think he felt threatened by you getting more empowered; by being more independent.

R: I think that was the case because in my four years of study, when it was exam times for me, he was always giving me a hard time, always. I don't know, he just wanted me not to succeed I think.

SJ: And that was also a form of disempowerment that he wanted to keep you in that situation.

R: Ja, he wanted to keep me from being...how do you say now...

SJ: You can speak Afrikaans if you feel more comfortable.

R: Independent, right, is the word. He wanted to keep me from that. Because I never worked. I always relied on his money, everything from him.

Interview 4

R: Sien suster nou, maar hy glo nie aan kondome nie. Hy's nie 'n oukie vir dit nie. Hy's 'n oukie wat nie kondome hoef te gebruik nie want hy's skoon. Want mense wat gesunat is kan nie nog eintlik gou siektes optel en sulke goed nie.

SJ: En hoe voel jy daaroor?

R: Nee, ek sê vir hom, nee, brother, die way die lewe vandag is en die tikkoppe is, nooit, julle manne wat tikmeisies inkoop, nee, dit gaan nooit werk nie. Ek het kinders om na te kyk. Ek kan nie so aangaan nie.

SJ: Maar aan die einde, dan wat gebeur?

R: Ek slaap maar net minder met hom dan, sien suster. Naweke, hy loop miskien nou Vrydag en dan kom hy Saterdag oggend huis toe, nou los ek hom laat hy die naweek so aangaan. Nou Maandag wil hy heel week slaap. Dan sê hy ek moet saam met hom kom lê en slaap. Dan sê ek, nooit, ek het dinge om te doen. Ek moet nou weer daar wees by die creche met Sakila, hulle makeer weer daai, so. Elke keer net 'n verskoning opmaak. Toe sê ek vir hom agterna, ek gaan nie meer dat hy by my slaap nie want ek weet nie wat loop doen jy in die nagte as jy so loop nie. Dit is nie reg nie. Glad net niks reg nie. Maar verder aan, hy's all right 'n kêrel, maar net daai wat hy my so slaan, man, dit kan ek nie hanteer nie, en die manier

hoe hy my skel. En hy is nie 'n slegte oukie nie, buiten die feit dat hy nou saam met Elaine deurmekaar geraak het, buiten daai, is hy nie 'n slegte oukie nie. Maar hy kan nou net sy verantwoordelikheid aanneem, man. En ek moet te veel al die blame vat vir al sy dinge. Ek kan nie. Dis onmoontlik, sien suster.

Interview 9

R: Ek het gebly by hulle. Toe het ek nou pregnant geraak, maar hy het my baie geslaan en so. En so na vier jaar – my meisiekindjie was vier jaar – en toe los ek hom want hy het my baie geslaan. Hy het my een Saterdag aand met 'n byltjie oor my boud geslaan en toe is hier 'n gat, maar die gat het toe al toegegroei weer. En ek het nooit vir my pa-hulle vertel van dit nie.

SJ: En was jy hospitaal toe?

R: Nee, suster. Toe het hy my gehou daar by hom tot die plek nou gesond was; dan het hy my huis toe gestuur.

SJ: So hy het nie laat jy hospitaal toe gaan nie.

R: Nee, suster.

Interview 10

R: Because when I was young I had the sense...I was I think 13 or 14...I always told my sister, one day if I have children, I want that all the children must be one man's. That was my desire. I didn't want children from different men. So this thing had a negative effect on me because I didn't know that when he had the baby with me, it was wrong. I thought it was my fault when that happened to me and he raped me.

SJ: But why did you think that? Because it's not your fault.

R: Because I was abused from six years until twelve years at home. At home I was abused. And I only told my mother for the first time when I was 44. So when I got home I stayed with my grandfather and my grandmother that time. So my uncles...my mother's sister-in-law's brother, he also abused me. And I was raped many times. Since I was a baby (I was one month old), I stayed here and there and there.

Appendix E: Stellenbosch HREC approval



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisennoot • your knowledge partner

Approval Notice New Application

08-May-2014
JOSEPH, Sumaya

Ethics Reference #: S14/02/026

Title: An exploration of clients' agency regarding their own reproductive health while living with intimate partner violence.

Dear Sister Sumaya JOSEPH,

The New Application received on 11-Feb-2014, was reviewed by members of **Health Research Ethics Committee 1** via Minimal Risk Review procedures on 08-May-2014 and was approved.
Please note the following information about your approved research protocol:

Protocol Approval Period: 08-May-2014 -08-May-2015

Please remember to use your protocol number (S14/02/026) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (hcalthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Helene Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389657.

Included Documents:

HREC Application Form

Protocol

CV Sumaya Joseph

Investigator declaration

Protocol
CV Kate
Supervisor declaration
Application form
Synopsis
HREC Checklist

Sincerely,



Franklin Weber
HREC Coordinator
Health Research Ethics Committee 1

Investigator Responsibilities

Protection of Human Research Participants

Some of the responsibilities investigators have when conducting research involving human participants are listed below:

1. Conducting the Research. You are responsible for making sure that the research is conducted according to the HREC approved research protocol. You are also responsible for the actions of all your co-investigators and research staff involved with this research.
2. Participant Enrolment. You may not recruit or enrol participants prior to the HREC approval date or after the expiration date of HREC approval. All recruitment materials for any form of media must be approved by the HREC prior to their use. If you need to recruit more participants than was noted in your HREC approval letter, you must submit an amendment requesting an increase in the number of participants.
3. Informed Consent. You are responsible for obtaining and documenting effective informed consent using only the HREC-approved consent documents, and for ensuring that no human participants are involved in research prior to obtaining their informed consent. Please give all participants copies of the signed informed consent documents. Keep the originals in your secured research files for at least fifteen (15) years.
4. Continuing Review. The HREC must review and approve all HREC-approved research protocols at intervals appropriate to the degree of risk but not less than once per year. There is no grace period. Prior to the date on which the HREC approval of the research expires, it is your responsibility to submit the continuing review report in a timely fashion to ensure a lapse in HREC approval does not occur. If HREC approval of your research lapses, you must stop new participant enrolment, and contact the HREC office immediately.
5. Amendments and Changes. If you wish to amend or change any aspect of your research (such as research design, interventions or procedures, number of participants, participant population, informed consent document, instruments, surveys or recruiting material), you must submit the amendment to the HREC for review using the current Amendment Form. You may not initiate any amendments or changes to your research without first obtaining written HREC review and approval. The only exception is when it is necessary to eliminate apparent immediate hazards to participants and the HREC should be immediately informed of this necessity.
6. Adverse or Unanticipated Events. Any serious adverse events, participant complaints, and all unanticipated problems that involve risks to participants or others, as well as any research-related injuries, occurring at this institution or at other performance sites must be reported to the HREC within five (5) days of discovery of the incident. You must also report any instances of serious or continuing problems, or non-compliance with the HREC requirements for protecting human research participants. The only exception to this policy is that the death of a research participant must be reported in accordance with the Stellenbosch University Health Research Ethics Committee Standard Operating Procedures www.sun025.sun.ac.za/portal/page/portal/Health_Sciences/English/Centres%20and%20Institutions/Research_Development_Support/Ethics/Application_package All reportable events should be submitted to the HREC using the Serious Adverse Event Report Form.
7. Research Record Keeping. You must keep the following research-related records, at a minimum, in a secure location for a minimum of fifteen years: the HREC approved research protocol and all amendments; all informed consent documents; recruiting materials; continuing review reports; adverse or unanticipated events; and all correspondence from the HREC
8. Reports to the MCC and Sponsor. When you submit the required annual report to the MCC or you submit required reports to your sponsor, you must provide a copy of that report to the HREC. You may submit the report at the time of continuing HREC review.
9. Provision of Emergency Medical Care. When a physician provides emergency medical care to a participant without prior HREC review and approval, to the extent permitted by law, such activities will not be recognised as research nor will the data obtained by any such activities should it be used in support of research.
10. Final reports. When you have completed (no further participant enrolment, interactions, interventions or data analysis) or stopped work on your research, you must submit a Final Report to the HREC.
11. On-Site Evaluations, MCC Inspections, or Audits. If you are notified that your research will be reviewed or audited by the MCC, the sponsor, any other external agency or any internal group, you must inform the HREC immediately of the impending audit/evaluation.

Appendix F: FDOH APPROVAL



**Western Cape
Government**

Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
Tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Kiebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 064RP2014
ENQUIRIES: Ms Charlene Roderick

**P O Box 101
Macassar
7134**

For attention: **Sumaya Joseph and Dr Kate Joyner**

Re: An exploration of clients' agency regarding their own reproductive health while living with intimate partner violence.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Macassar CDC Sr C Alexander Contact No. 021 857 2330

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

We look forward to hearing from you.

Yours sincerely

DR J EVANS
ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 13/06/14
CC **A HAWKRIDGE**

DIRECTOR: EASTERN/KHAYELITSHA DISTRICT

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