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"IF HE'S ABUSING YOU…THE BABY IS GOING TO BE AFFECTED": HIV-POSITIVE PREGNANT WOMEN'S EXPERIENCES OF INTIMATE PARTNER VIOLENCE

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Abstract

Pregnancy represents a time of increased risk for intimate partner violence (IPV), and an HIV diagnosis further increases the vulnerability of this at risk group. This study explores experiences of recent IPV using qualitative interviews with N=12 HIV-positive pregnant women recruited from a clinical setting in South Africa, a location with high global prevalence of IPV and HIV. Partner dynamics around IPV resulted in HIV shame and stigma, and adversely affected engagement in HIV care and HIV treatment behaviours. The results highlight the challenges women face in navigating disclosure of both IPV and HIV, accessing necessary support, and engaging in both HIV-related and pregnancy-related care in the context of an abusive relationship.

Keywords

intimate partner violence; HIV; pregnancy; South Africa

Intimate partner violence is a significant public health problem globally as well as in South Africa, and is associated with substantial adverse physical and mental health outcomes (Garcia-Moreno & Watts, 2011). Intimate partner violence (IPV) is defined as behaviour by a current or previous intimate partner that causes physical, sexual or psychological harm,

including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours (WHO, 2013a). IPV is a complex phenomenon, and involves a myriad of behaviours that people use to control, intimidate and otherwise dominate another person within the physical and psychological boundaries of an intimate relationship (Marais, 2015). These behaviours often escalate in frequency and severity over time (Marais, 2002).

The prevalence of intimate partner violence is estimated at 30% globally and 37% in Africa (WHO, 2013b). Although prevalence estimates of IPV in South Africa vary, rates are consistently high. According to a secondary analysis of data from the South African Stress and Health Study (SASH) - a cross-sectional, nationally representative community survey of mental disorders - 31% of the study sub-sample (n=1 229 married and cohabiting women) reported IPV exposure in their most recent intimate relationship (Gass, Stein, Williams, & Seedat, 2010). Emotional abuse is often central to violence and control in intimate relationships, and usually occurs concurrently with sexual and physical violence (Jewkes, Dunkle, Nduna, & Shai, 2010).

Women who are pregnant are at an even greater risk of experiencing IPV. Pregnancy involves significant changes in physical, psychological, social and economic needs and demands, and represents a time of increased risk and vulnerability for IPV (Van Parys, Verhamme, Temmerman, & Verstraelen, 2014). A wide range of IPV prevalence rates during pregnancy has been reported worldwide (Devries et al., 2010). In Africa, women of reproductive age constitute a particularly vulnerable sub-group, with IPV prevalence during pregnancy ranging between 2 and 57 % (a meta-analysis yielded an overall prevalence of 15%) (Shamu, Abrahams, Temmerman, Musekiwa, & Zarowsky, 2011). IPV prevalence among pregnant women in Africa are among the highest globally, with major risk factors being HIV infection, history of violence (varying from child abuse to previous year experience of violence) and alcohol and drug use (Shamu et al., 2011). Findings from a birth cohort study in South Africa indicated that a large proportion of pregnant women (N=263) experienced IPV, with exposure to emotional IPV most common (32%), followed by physical (28%) and sexual abuse (14%) (Koen et al., 2014).

IPV during pregnancy is of great societal and public health concern, and associated with a range of harmful maternal and fetal sequelae (Koen et al., 2014). In addition to the poor infant outcomes related to IPV, including preterm labor/delivery and low infant birthweight (Taillieu & Brownridge, 2010; Covington, Hage, Hall, & Mathis, 2001; Murphy, Schei, Myhr, & Du Mont, 2004; Koen et al., 2014), women exposed to IPV during pregnancy experience numerous adverse physical and mental health outcomes. Miscarriage, inadequate weight gain, depression and posttraumatic stress disorder have all been associated with IPV during pregnancy (Taillieu & Brownridge, 2010; Martin et al., 2006; Rodriguez et al., 2008; Koen et al., 2016). A South African birth cohort study (n=726 pregnant women) found a high prevalence of antenatal depression (21%) which was associated with past-year IPV (Brittain et al., 2015). Studies conducted in South Africa have found that maternal depression during the perinatal period is common (Tomlinson et al., 2014; Rochat, Tomlinson, Bärnighausen, Newell, & Stein, 2011), and that depressed mood is significantly more likely among women who have experienced IPV and are of lower income (Hartley et al., 2011).

The mental health difficulties – associated with IPV – transform the postpartum period from an already challenging process into a potentially overwhelming one, which may threaten the well-being of the mother, infant, and her other children. Furthermore, these emotional adversities may compromise a woman's ability to access the necessary support and social resources to increase safety for herself and her children (Johnson, Zlotnick, & Perez, 2008), and could increase her vulnerability to further abuse.

An HIV diagnosis among pregnant women who experience IPV further increases the vulnerability of this at risk group. In South Africa, this diagnosis often occurs at the first antenatal clinic visit for a newly pregnant woman, where HIV testing is standard. The intersection between IPV and HIV has been well established globally (Campbell, Baty, & Ghandour, 2008; Li et al., 2014), and in South Africa (Dunkle & Decker, 2013; Townsend et al., 2011; Jewkes et al., 2006; Pronyk et al., 2006; Maman, Campbell, Sweat, & Gielen, 2000). This literature demonstrates that IPV has been associated with HIV acquisition (Maman et al., 2000; Li et al., 2014). For women in an existing abusive relationship, HIV testing and subsequent disclosure to a partner increases the risk of violence for women (Hatcher et al., 2013; Shamu, Zarowsky, Shefer, Temmerman, & Abrahams, 2014; Meyer, Springer, & Altice, 2011). In addition, mental health disorders frequently associated with IPV (such as PTSD and depression) have been linked to poor HIV care engagement (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Cohen, Alfonso, Hoffman, Milau, & Carrera, 2001) and poor HIV-related health outcomes and engagement in care (Schafer et al., 2012). Trauma, shame and stigma of an HIV diagnosis have been identified as barriers in abused women's efforts to engage in medical care (Whetten, Reif, Whetten, & Murphy-McMillan, 2008; Blashill, Perry, & Safren, 2011). Furthermore, studies in Sub-Saharan Africa have demonstrated a significantly higher risk of IPV for women who were HIV-positive (Campbell et al., 2008), and a history of IPV has been associated with lower levels of disclosure among pregnant and postpartum women (Makin et al., 2008; Tam, Amzel, & Phelps, 2015). South Africa is an ideal location to extend our understanding of IPV and HIV among pregnant women – where the prevalence of HIV among currently pregnant women is 16.1% (Eaton et al., 2014). A recent study of HIV pregnant women attending primary health care clinics in Mpumalanga, South Africa (n=673), found that 56.3% reported having experienced either psychological or physical IPV, and 19.6% reported physical IPV (Matseke, Rordriguez, Peltzer, & Jones, 2016).

Qualitative research on IPV with HIV-positive women remains limited. A small number of qualitative studies have explored different aspects of IPV with pregnant women. Although a majority were conducted in high income countries (Izaguirre & Calvete, 2014; Rose et al., 2010; Bacchus, Mezey, & Bewley, 2006), a few studies were located in low and middle income countries, including South Africa. For example, Damra and colleagues (2015) explored Jordanian pregnant women's experiences of IPV disclosure and help-seeking from health care professionals and found that lack of privacy, continuity of care, time constraints, and barriers to disclosure contributed to women's dissatisfaction with the care they received. In one qualitative study in South Africa, IPV was described as a common barrier to ART adherence in pregnancy (Mepham, Zondi, Mbuyazi, Mkhwanazi, & Newell, 2011). Another South African qualitative study focused on the links between IPV and HIV by conducting focus groups and interviews with antenatal healthcare providers as well as pregnant women

seeking antenatal care (Hatcher et al., 2014). The study included interviews with a small sample of pregnant abused women (n=5) whose HIV status was not reported. The authors conclude that an HIV diagnosis during pregnancy, and subsequent partner disclosure, can be a common trigger of IPV, and that IPV, in turn, can worsen HIV-related health through lack of adherence and poor mental health.

Qualitative data on South African HIV-positive pregnant women's experiences of IPV can offer important contributions to this nascent evidence base, and is important in the context of high global rates of IPV and a 12.2% prevalence of HIV (Shisana et al., 2014). More needs to be known about the nature and impact of IPV during pregnancy – specifically within the context of being HIV-positive, and how it impacts on women's experiences of their current pregnancy and their future expectations. Furthermore, it is necessary to better understand the complex intersection of IPV and HIV, including shame and stigma related to both IPV and HIV, and how this in turn affects HIV-positive pregnant women's health and engagement in care. To the authors' knowledge, this is the first study to address these gaps by employing interviews with HIV-positive pregnant women (n=12) with recent histories of IPV. Qualitative research methods have been found to be useful in studies that explore extremely sensitive issues with complex layers of meaning (Chaitin, 2003), including narratives of intimate partner violence (Marais, 2015).

Method

Setting and Participants

Participants were screened and recruited from an HIV Maternity clinic at a tertiary medical hospital at the University of Cape Town between August 2014 and August 2015. Clinic records for the 2015 calendar year were subsequently reviewed in order to capture the characteristics of the clinic (which has been running since 2012). During January to December 2015, a total of 73 patients attended the clinic (39 were new patients, and 34 were follow-up patients). The average number of total patient visits per month was 19. On average 3 new patients were seen per month, and these patients had an average of 3 follow-up visits per year. The age range of the patients was 20–41 years, with a mean age of 31 years. The demographic profile of the 73 patients seen in the clinic in 2015 was as follows: Black/African and Xhosa speaking (84%), and Mixed race and Afrikaans-speaking (16%).

During August 2014–August 2015 women were approached in the waiting room by the researcher (a registered psychological counsellor), and invited to speak briefly in a private area whilst they were waiting for an appointment with a doctor or nurse. Women were informed about the purpose and nature of the study, and invited to answer screening questions to determine their eligibility for participation. To be eligible for inclusion, participants had to: a) be pregnant women; b) have self-reported HIV-positive status; c) be 18 years and older; d) have had a recent experience of IPV (within the last 12 months); and d) be able to converse in English or Afrikaans. The researcher took care to establish rapport with the potential participants by responding to them in an empathic, respectful and non-judgemental manner. She acknowledged that disclosure of IPV can be difficult for some women, and reassured them of confidentiality.

Experiences of IPV were assessed by a questionnaire that was adapted from the WHO multi-country study (Jewkes, 2002) and Women's Health Study in Zimbabwe (Shamu et al., 2011), and recently used in a large South African birth cohort study (Koen et al., 2014). The questionnaire assessed lifetime and recent (past year) exposure to emotional, physical and sexual abuse. In total, 78 women were screened - of which 28 (36%) had a history of IPV in the past 12 months. If eligible, we proceeded with informed consent procedures. Of these 28 eligible women, three declined to participate (10%); 25 women consented to participation in the study, with 12 successfully scheduled for interviews and 13 lost to follow up. On telephonic follow up with the 13 women lost to follow up, reasons for not returning for qualitative interviews included structural barriers (e.g. transport problems, not being able to get time off work, or not having someone to take care of their children), and partner-related factors (e.g. partners becoming suspicious of multiple hospital visits, or a recent increase in controlling behaviour and violence). Given the potential loss to follow up, the study procedure was adapted with interviews conducted on the same day as recruitment.

Study Procedures

Semi-structured interviews were conducted with N=12 HIV-positive pregnant women with recent histories of IPV. Women were asked questions pertaining to the following themes: experiences of IPV during their current pregnancy; impact of IPV during pregnancy on mental, physical and sexual health; impact of IPV on medical care engagement during pregnancy; and coping with both IPV and HIV during pregnancy (see Table 1 for examples of interview questions).

Individual interviews were conducted in a private room by a female study investigator who is a registered psychological counsellor, and lasted approximately 1.5 hours. Interviews started with a brief socio-demographic survey and measures of IPV and depression using the above-mentioned IPV questionnaire and the Edinburgh Post-Natal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) to better contextualize qualitative data. All interviews were audio recorded and transcribed verbatim, and one Afrikaans interview was translated into English. The study was approved by the Faculty of Health Sciences' Human Research Ethics Committee at the University of Cape Town (UCT).

Data Analysis

Our analytical approach was guided by both a thematic analysis (Braun & Clarke, 2006) and framework approach – which involves familiarization, identifying a thematic framework, indexing, charting, mapping and interpretation (Pope, Ziebland, & Mays, 2000). NVivo 10 – a qualitative software program was used to facilitate the data analysis process. (QSR international, 2012). Interview transcripts were read by two of the study investigators, and sub-themes corresponding to each of the main interview themes were generated independently. A set of codes were derived from transcript data. These codes included: (1) experiences of intimate partner violence; (2) perceived risk for IPV during pregnancy, and impact of IPV on pregnancy experiences; (3) perceived impact of IPV experiences on motherhood; (4) perceived relationships between IPV, HIV transmission and reinfection, and other related health outcomes; (5) perceived impact of IPV on medical care engagement and access to social support; and (6) perceived impact of IPV on HIV shame and stigma. Each

code resulted in the main themes and subthemes displayed in this paper. For example, code 4 mapped onto the main theme of 'Coping with HIV', and generated the following sub-themes: Experience of getting HIV diagnosis; HIV shame and stigma; HIV disclosure; coping with HIV in the context of IPV; coping with both HIV and IPV during pregnancy; and impact of IPV on HIV care engagement. The first coder (A. Marais) holds a Doctoral degree in Clinical Psychology, and the second coder (R. Julies – who conducted the interviews) is a psychological counsellor with a Bachelor's degree. A team workshop was held to verify codes and sub-codes (corresponding to themes and sub-themes) and reconcile differences, and care was taken to ensure the researchers accurately captured the respondent's meaning. Subsequent coding of the transcripts in NVivo was conducted independently by both study investigators.

Results

This section is divided into the main thematic results of the study (see Table 2 for a summary). This includes: 1) Participant characteristics; 2) Experiences of intimate partner violence during pregnancy; 3) Impact of IPV on pregnancy experiences; 4) IPV increases risk for HIV transmission and reinfection, and negatively impacts other health outcomes; 5) IPV decreases medical care engagement and access to social support; 6) IPV exacerbates HIV shame and stigma, and diminishes HIV care engagement, and 7) Impact of IPV on motherhood, and children serving as positive catalysts for change.

1) Participant characteristics

Study participants ranged in age from 18–34 years, with a mean age of 28 years. The majority of the women were Black/African, with Xhosa as their home language (n=8) (67%), and the remaining women were Mixed race, with Afrikaans as their home language (n=4) (33%). All the women were able to understand and converse in English, and all but one Afrikaans-speaking participant chose to do so. The mean gestation period was 28 weeks - with two women having given birth in the same week in which the interview took place. The majority of the women were of Christian faith (n=10) (83%), married or in a cohabiting relationship (n=8) (67%), unemployed (n=8) (67%), and with the highest level of education being between Grade 8 and 11. For the majority of the women (n=10) (83%) their current pregnancy was unintended, with seven of these women (58%) indicating that they wanted the baby. Three of the women (25%) had a previous miscarriage in the context of their current abusive relationship.

The majority of the women experienced emotional abuse (91.7%) and physical abuse (83.3%), with lower but still concerning reports of sexual abuse (58.3%). With regards frequency of occurrence of abuse, half of the women reported medium frequency (i.e. where there was more than one incident that occurred 'a few times'), and half reported high frequency of abuse (i.e. where any incident occurred 'many times'). For depression, scores on the EPDS ranged from 3 to 23, with 75% of the women scoring above 13. The threshold of >13 as indication of probable depression has been used in studies conducted in the South African LMIC context (Hartley et al., 2011; Koen et al., 2014).

2) Experiences of intimate partner violence during pregnancy

Women described a wide range of IPV experiences during their current pregnancy, including emotional, physical, and sexual abuse, and noted that certain aspects of IPV became more frequent and severe during their pregnancy. Women described experiences of verbal and emotional abuse, including being degraded, ridiculed, criticised, blamed and insulted (both in private and public spaces). Participants noted a marked increase in controlling behaviour aligned with pregnancy. One young participant described no longer being allowed to spend leisure time with her friends, or engage in her usual preferred hobbies during pregnancy:

> He would just start screaming and shouting: ‘why do you want to go, you’re pregnant’. It was confusing. I then also started getting my morning sickness. Every time I took the ARV’s I used to vomit it up again, and whenever he sees I'm bringing up the tablet, he would smack me and ask me, ‘are you stupid to bring it out? You are not thinking about your health or the baby’s health’… and that is where the abuse started. If I wanted to go somewhere, he would stop and say, ‘no you can’t go, you’re pregnant. You must lay with this baby… I tried to talk back and tell him it’s not a sickness, I still have a life, I can still enjoy life… Then things started getting worse, and he would beat me for every single stupid thing. (Participant 8, 18yrs, 37 weeks pregnant)

Across other interviews, women described a range of controlling behaviours, including partners limiting their contact with others (sometimes out of jealousy and possessiveness), controlling their daily routine and whereabouts, controlling their finances, and monitoring their completion of chores. Participants gave specific examples of control by partners relating to pregnancy needs (money, food and transport to hospital), and deprivation of potential protective factors for healthy pregnancies (e.g. contact with family, and getting enough rest and sleep during their pregnancy), as well as partner anger at requests for resources for the baby (e.g. buying baby clothes):

> When you’re pregnant and your husband is abusing you and not providing for you, then it worries you, like ‘what am I going to give this child?’ … How am I supposed to take care of the child?… You’d always be stressing yourself, like this man is not supporting me, we are staying together and I’m pregnant, he’s not supporting the pregnancy, how am I going to look after the child? And when he is abusing you, hitting you, then you worry that the child is going to get hurt. (Participant 4, 22yrs, 24 weeks pregnant)

In addition, women described incidents of physical abuse including slapping, hitting, punching, kicking and choking, which resulted in several women requiring medical attention over the course of their pregnancy. Only two participants experienced a decrease in physical abuse during their pregnancy (with their partners being more cautious not to harm the baby), although this resulted in their partners being more controlling and emotionally abusive. One woman recounted an incident when her partner had gone food shopping, and asked her if she needed him to buy her anything in particular. Upon his return home, she was watching TV and commented that she had a craving for some fruit, and wished that he could have bought it for her. He responded by becoming angry and violent:

> He was like, “you have to tell me at the time, are you stupid?” I then said, “I didn’t wish for it at the time, but I’m wishing for it now”…and then he slapped and kicked me, and shoved me to one side, and then went to buy it for me. By the time he came back, I didn’t want it anymore. Then he slapped me and said, ‘you waste my time’. (Participant 8, 18yrs, 37 weeks pregnant)

Finally, participants described sexual coercion in their relationships. Given the context of abuse, and the ongoing threat of harm, many women felt unable to refuse sex despite diminished interest in sex during their pregnancies. Some partners became angry, suspicious and made accusations of unfaithfulness if women refused sex (or suggested condom use), and others threatened to leave or have multiple partners. One woman described feeling coerced into sex when her husband made these kinds of threats:

> So now I have to do it, because he will tell me, ‘I will just go and look somewhere else’… Then I will think, ‘if my husband leaves me now, where will I go?’ Okay, I will end up doing it… Maybe others hit you because you don’t feel like doing it. (Participant 10, 24yrs, 10 weeks pregnant)

3) Impact of IPV on pregnancy experiences

Women voiced the devastating impact of IPV on their physical and psychological experiences of their current pregnancy. One participant described how she felt her needs and well-being were neglected compared to that of the baby:

> It’s only verbal abuse… He’s too protective over his child in my stomach. There are times I would say, ‘it’s all about the baby’, but he’s not here yet, you forget we are still here. We must still get what we are supposed to get in order for this baby to survive through me. (Participant 9, 29 yrs, 21 weeks pregnant)

For most of the women in this study, their current pregnancy was unintended, which they observed to be a direct or indirect result of the abuse in their relationships. Some women reported having forgotten to take their contraceptive pills due to the ongoing “stress” in their lives, whereas others were not able to safely negotiate condom use with their partners. As such, women voiced strong feelings of ambivalence about their pregnancy and having more children in the future in the context of their abusive relationships.

> My first pregnancy, I was still in Zimbabwe and he was here. So I was staying with my parents and it was fine because I had all the care I wanted… As for this pregnancy, I was not expecting it… I do feel happy that I’m pregnant, but I’m not really happy because it happened when I didn’t want it to happen… (Participant 4, 22yrs, 24 weeks pregnant)

Several had considered terminating their pregnancies in the early stage. Two participants had terminated a previously unplanned pregnancy due to their experience of abuse: “*You want to terminate the baby sometimes… The mother might be a problem for the baby because the boyfriend is abusing the mother while she’s pregnant… Sometimes you feel that you made a mistake by falling pregnant”* (Participant 1, 34yrs, 2 days after birth of baby). Many women noted the psychological distress of experiencing abuse at the hands of their partners during pregnancy.

> You’re not supposed to be abused. No one should be abused when you’re pregnant, you should feel comfortable…. when you’re pregnant it’s the time you need to get attention from your husband. I’m always hurt and always crying, but now I told myself that this too would pass, and I must focus on my pregnancy. (Participant 5, 23yrs, 36 weeks pregnant)

Distress was exacerbated because women felt pregnancy was a time when partners should be at their most attentive and nurturing. Participants were concerned about how the psychological stressors of experiencing abuse during pregnancy would impact on the safety and well-being of their unborn baby. Several women described the abuse as “a sickness” that could “infect”, “damage” or negatively affect their baby, or result in miscarriage. These women were mindful of how the “stress” of IPV was affecting their physical and mental health, impeded self-care, and were aware of how this was “not good for the baby”:

> This baby is not going to be right, because you are crying, you are always crying… When you are crying that child is infected. If he’s abusing you, like shouting at you or beating you … the baby is going to be affected. (Participant 6, 29yrs, 2 days after birth of baby)

4) IPV increases risk for HIV transmission and reinfection, and negatively impacts other health outcomes

In terms of sexual health, many women spoke of not having control over sexual decision-making, and hence having diminished ability to prevent horizontal HIV infection (of partners, or re-infection of themselves), and to implement behaviours related to optimal physical and mental health. Participants described how lack of control led to diminished ability to protect themselves from HIV. For example, partners displayed anger and suspicion when women expressed a diminished interest in sex, and women’s refusal of sex often resulted in an escalation of emotional and/or physical aggression, and/or forced sex. Forced sex can result in tissue trauma that increases transmission of HIV.

> Sometimes he can find me sleeping, and he’ll come inside the house, he expects me to wake up, and make food for him, and lie down and he’s gonna sleep with me even though I don’t want to… If he saw my face is cross, he’s gonna ask, why I’m cross, was there someone else in the meantime while he was not here?… I just do it to satisfy him so he don’t look around. Many people will give you the advice -give to your husband even if you don’t want to ‘cause if you don’t give him sex, he looks around, he has an affair, so you chase the man away yourself…. I have to do it. (Participant 10, 24yrs, 10 weeks pregnant)

Women made a direct link between the “stress” and “sickness” of IPV, and their physical health problems:

> It’s very hard if you’re experiencing abuse because it causes like a sickness. You always have a headache, and you experience lot of pains when you are getting through this abusive thing… you always have a lot of pains in you… If you’re beaten, it will be affecting you inside, inside your body… and I also think it causes high blood pressure and stress. (Participant 4, 22yrs, 24 weeks pregnant)

In terms of mental health, women described experiencing many symptoms which they attributed to the mental "stress" of the abuse, even though many of them expressed an unfamiliarity with depression as a psychiatric disorder. Women spoke of feeling fatigued, having a "tired mind", being forgetful, feeling irritable, angry and sad, and getting tearful. Three participants disclosed that they had felt suicidal in the past.

> Depression… it's where you feel like your mind is always tired, you don't cope, there is a lot of noise, and you feel like shouting… you feel tired all the time, tired of people… you'll think it's them, but it's the things that you keep in mind. (Participant 12, 36yrs, 36 weeks pregnant)

Several women used alcohol as a way of coping with the difficulties and distress in their relationships saying, "*You drink a lot to think about it less… When you drink, then it all goes out, and you won't have to stress yourself so much"* (Participant 4, 22yrs, 24 weeks pregnant). Another woman said:

> I prefer to keep the abuse quiet, and it ended up making me depressed. Some people prefer to share with alcohol. Alcohol is just a friend to share the pain away… to take my mind off things… it's a way to cope. (Participant 11, 28yrs, 28 weeks)

The women who drank alcohol throughout their pregnancy expressed concern about the impact of their drinking on their health, and that of their baby.

5) IPV decreases medical care engagement and access to social support

Across the interviews, participants highlighted several partner-related factors that impacted negatively on their medical care engagement. Women spoke of needing to constantly attend to the needs of their partner to the detriment of their own, often resulting in them not being able to engage in healthy self-care behaviours (for example, partners interrupting their sleep). Partners hampered women's abilities to engage the health system in ways that were vital to maintaining optimal maternal or baby health. The majority of the women told of how their partners isolated them, and interfered with their efforts to get external social support during their pregnancy. In addition, very few women had disclosed their experiences of IPV to their treating doctors/nurses at GSH, and therefore were also not benefiting from a formal support network. The increased engagement with the health care system because of pregnancy, further exacerbated risk of IPV in some cases. One woman recalled how her husband rushed her to hospital when her "water started dripping away" after he had kicked and beaten her. Upon inquiry by the medical doctor, she denied having experienced physical abuse, and told the doctors that a cupboard fell on her. She was admitted into hospital for a few days:

> The doctors said they had to test if the baby is okay. My husband was concerned because he didn't know what was going on. He wanted to know what the actual reason was for them keeping me, but the reason for them keeping me was the blue marks. (Participant 11, 28 yrs, 28 weeks pregnant)

When her husband fetched her, he was confronted about her bruises by the nurse:

> He didn't know because I never undressed in front of him, for him to see. And when I got home, I showed him how he like hit me. I thought it would change his whole attitude, but no. The way he does it now, he does it in a way that you can't see the bruising… I had appointments after that, but since then, he has been stopping me from coming to the clinic (Participant 11, 28 yrs, 28 weeks pregnant)

Another woman recounted deceiving her controlling partner in order to get the opportunity to seek medical care. She was already 36 weeks pregnant, and throughout the pregnancy he had prevented her from attending most of her medical appointments. She resorted to asking one of her friends to phone her house, and pretend it was the hospital informing her of a follow-up appointment, "*I just wanted to find out how it's going with the baby, because I'm anxious now… it's close, I'm almost due. My friend did what I asked her… and so he was like, 'okay, I have to let her go today'"* (Participant 12, 36yrs, 36 weeks pregnant).

In some cases, IPV stigma and shame served as barriers that prevented them from disclosing their experiences of IPV to others, and accessing support. Participants described feeling judged by other women in their community, and many had experienced some form of ridicule or gossip after their experience of IPV was known.

> They won't speak it in words, they will just make signs…Men are not into the gossip issues, it's always women. Maybe they will see your blue eye in the morning in your face, and then they will make signs just laughing at you, looking at you up and down, and then you can see they are busy making fun of it… and you will know it's your issue they're talking about. (Participant 10, 24yrs, 10 weeks pregnant)

Participants also spoke of feeling 'policed' by other women in their communities (e.g. neighbours would become suspicious and curious of their frequent hospital visits). Some commented on how women observed the commitment and family provision offered by male partners – often resulting in jealousy and distrust between the women. For example, one woman was afraid that disclosure of her marital problems could result in other women pursuing her husband. Women were therefore mindful of needing to protect their identities and reputations, and did not necessarily anticipate that other women outside of their family would be sources of support. Other barriers to not disclosing IPV to a friend or family member included concern that the knowledge of IPV would not be kept confidential, as well as fear for their safety should their partner find out about their disclosure.

6) IPV exacerbates HIV shame and stigma, and diminishes HIV care engagement

Many women noted the extra challenges that IPV created for engagement in HIV care and treatment. Many pregnant mothers receive new HIV diagnoses during pregnancy in South Africa because of universal 'opt-out' HIV testing in maternity clinics. It was noteworthy that very few of the women recounted feeling shock and disbelief at receiving their initial HIV diagnosis. The majority had suspected they could be HIV-positive given their partner's history of infidelity, his refusal to use condoms, and/or his past refusal to get tested. Yet, these new HIV diagnoses can present new challenges that exacerbate risk for IPV. Women who experienced emotional abuse in their relationships were further denigrated, ridiculed

and criticised by their partners for their HIV diagnosis, and often blamed for bringing the diagnosis into the relationship. One woman described her experience as follows:

> Sometimes you think, this is the partner who made me HIV-positive so he already knows, and he is not telling me. He wants me to get sick… but your partner is going to say, you're the one who is HIV-positive, and you're the one who made me to be HIV-positive…. All those things your boyfriend said about you, when you look at yourself sometimes you say, maybe he is right… because there is no one to tell, you don't talk to anyone and then you just tell yourself, maybe my boyfriend is right about those things he's saying to me. He said, 'I did you a favour by being with you, no one is going to want you on the street because you are HIV-positive' … No one wants me, so this is the only person who wants me. (Participant 1, 34yrs, 2 days after birth of baby)

Some women attributed the abuse they were experiencing (or the worsening of the abuse) to their HIV diagnosis: "You're still strong, but you know you are HIV-positive, and you are being abused. Maybe you're like me- maybe you are being abused because you're HIV-positive… so you feel very bad" (Participant 7, 33yrs, 36 weeks pregnant). Some women felt reassured by the increased social awareness and understanding of HIV in their communities, including the knowledge that HIV-positive women could have healthy babies. Nevertheless, many had experienced some form of HIV shame and stigma from their family or community as well. HIV, combined with the IPV stigma and shame described above, exacerbated the sense of burden for some women. One woman spoke of the burden and strain of having to come to appointments and engage in her HIV treatment – all in the context of facing abuse at home. Quite symbolically, she refers to the steep hill she has to climb to get to the hospital.

> You're HIV-positive and must come for regular treatments, you must walk up this hill, and then go home and face an abuser… sometimes you don't have the strength to go to the clinic, you don't even feel like taking your medication. You say 'this is who I am' because your boyfriend said you are… So I am who I am, I'm not going to take medication, I'm not going to the clinic, and then you end up sick. (Participant 1, 34yrs, 2 days after birth of baby)

Partner dynamics around IPV adversely affected engagement in HIV care, and HIV treatment behaviours. For example, in cases where women did not disclose their new HIV diagnosis to partners, partners often became suspicious of multiple hospital visits, leading to women missing hospital visits, and not getting their required anti-retroviral (ARV) treatment medication. Some women spoke of avoiding taking their ARV's out of fear of their partner finding out about their HIV status, or experiencing ongoing HIV stigma from their partner.

Despite the impact of IPV on their adherence to HIV-related care, many women described a sense of resilience and resolve that enabled them to have more agency:

> Sometimes you are scared of your partner… maybe you did not tell him, or maybe you did tell him, and he said you are the one who's HIV-positive, and you are not going to take those things (pills) in my house… and then you feel like you are stealing when you're taking your medication. So if you are taking it at eight o'clock, maybe your partner is already at home that time, then you just have to take

> it earlier… You must deal with your health and then leave that abuse. (Participant 2, 26yrs, 12 weeks pregnant)

This resilience was linked to motivations for self-care because of the imminent arrival of a new baby: “My partner doesn’t have a role in me taking my medication, because it’s my life in the end…I have to in order for me to get well and for my baby” (Participant 5, 23yrs, 36 weeks pregnant). Women were motivated to stay engaged in care at all costs in order to protect the health of their baby: “If you are HIV-positive, and you are pregnant, you must, you must protect your child inside you… Your baby didn’t get that thing, that virus you got… You must think about your child” (Participant 3, 28yrs, 31 weeks pregnant).

7) Impact of IPV on motherhood, and children serving as positive catalysts for change

Across interviews, the women expressed worries about the impact of the abuse on their parenting interactions with existing children in the home. An example of the negative impact of IPV on parenting experiences was described by one woman who was concerned about her son witnessing the abuse at home. She recalled one incident when her husband abused her in front of their child:

> And I asked, ‘are you going to hit me’? ‘No I’m just scaring you’… but why must you scare me like that in front of my child here in the house? … The next day my child told my mother exactly what happened, ‘daddy wanted to beat mummy, and mummy was scared and she cried’…. Now I’m wondering… was he thinking about me the whole day being beaten up? But now I’m sending him to Eastern Cape because I think it’s getting hectic for him. (Participant 11, 28yrs, 28 weeks pregnant)

Many participants spoke of feeling guilty over how their emotional distress resulted in them expressing anger, sadness and irritability around their children. The experience of abuse, especially during pregnancy, created in some women, motivation to leave current partners. The impending birth of a new child served as strong motivation for women to leave their relationship after the birth of their baby. One woman described how she planned to leave her husband in order to protect her baby:

> It’s too much for me, I will leave, but when I tell him I will leave him now, he will beg and beg that he will not do it again, then he will do it again after the week’s gone… If it’s not stopping, then I’ll leave. I will not stay, because just think about my child. If I lose my child for the sake of the father, what is the purpose of me saying I’m caring for my child? … Once my baby is born, I think I will leave that man. I don’t want to leave now while I’m pregnant. It’s too late, even if he can change or not, we are going to leave him once my baby is born. (Participant 11, 28yrs, 28 weeks pregnant)

Even if women were motivated to leave abusive partners, participants identified many barriers to physically leaving their relationship, including: concerns regarding their future (“where will I go”), lack of social support, financial constraints, and the hope that the abuse might stop after the baby was born.

Discussion

The central findings of the study point to the complex relationship between IPV and HIV, and how it impacts on pregnancy and health care engagement. The findings show how an experience of IPV jeopardizes women's physical and psychological well-being during pregnancy – resulting in significant anxiety and ambivalence regarding the pregnancy itself, the future health of their unborn baby, and their ability to properly mother their children. For the majority of the women in this study, their current pregnancy was unplanned, and a result of the IPV compromising their sexual decision making and fertility control. The association between IPV and unintended pregnancies has been well established, where the latter can also have adverse outcomes for women's health (Pallitto, Campbell, & O'Campo, 2005). Furthermore, for the women in this study, their experiences of IPV significantly undermined their confidence in their abilities to adequately care for their fetuses and future infants, and protect them from harm.

The results underscore the challenges pregnant women experiencing IPV face in coping with their HIV illness - where the HIV diagnosis itself often elicits further emotional and physical abuse from their partners. The results call attention to how women can be shamed and stigmatised for their HIV-status by their partners in the context of IPV, and how this resultant HIV shame and stigma undermines women's efforts to stay engaged in healthy behaviours and care. Similar to what has been reported in a study with HIV-positive non-pregnant women (Lichtenstein, 2006), several women in this study relayed how their abusive partners actively undermined and controlled their access to treatment and other support systems. Furthermore, IPV worsened some women's HIV-related health through poor adherence, thus underscoring how gender power imbalances pose significant health risks for women.

For the women in this study, the burden of HIV shame and stigma as created by their partners was compounded by significant shame and stigma related to their experience of IPV. As was described in a study with Tanzanian women in general (McCleary-Sills et al., 2016), the women in this study avoided disclosure of IPV due to fear of social consequences - where it was the public naming and speaking of IPV that evoked shame, rather than the perpetration of violence itself. A review of IPV help-seeking literature has found that anticipated-, internalized- and cultural stigma were prominent barriers to help seeking from formal and informal support networks for non-pregnant women who have experienced IPV (Overstreet & Quinn, 2013). For the women in this study, IPV related shame and stigma, compounded by partners shaming women for their HIV illness, resulted in women not disclosing the IPV and/or HIV to others, and thereby becoming increasingly isolated and unable to access social and professional support. This in turn threatened to undermine women's ongoing antenatal and HIV-related care engagement.

The women in this study reported struggling with significant emotional distress, including multiple symptoms of depression. High prevalence rates of antenatal depression have been associated with past-year IPV amongst South African pregnant women (Brittain et al., 2015). Findings from a study with North American pregnant women (n=27) highlighted how the lack of family support, coupled with isolation associated with depressed mood and the forced isolation by the abuser, resulted in disabling mental distress. The authors argue that a

key target of intervention is substantial efforts to connect women with a support network (Rose et al., 2010).

Of concern, maternal depression in South African women has been shown to negatively impact the quality of the mother-infant relationship and the security of infant attachment (Cooper et al., 2009; Tomlinson, Cooper, & Murray, 2005) – factors known to predict favourable child development. The results of the current study bring to attention how the mental distress related to coping with both IPV and HIV during pregnancy may put women and their future attachment and relationship with their infants at risk. IPV during pregnancy has been associated with mother-to-infant bonding failure at 1 month postnatal in a Japanese cohort study (Kita, Haruna, Matsuzaki, & Kamibeppu, 2016).

Although strong evidence of effective interventions for IPV during the perinatal period is lacking (Van Parys et al., 2014), early recognition and subsequent care of pregnant women experiencing IPV may facilitate more positive short- and long-term mental health outcomes (Rose et al., 2010). An intervention based on the principles of interpersonal psychotherapy (IPT) - designed to help pregnant women with IPV improve their interpersonal relationships and social support networks, and master their role transition to motherhood - has demonstrated efficacy in reducing symptoms of depression and PTSD during pregnancy, and PTSD symptoms from pregnancy up to 3 months postpartum (Zlotnick, Capezza, & Parker, 2011). By providing psycho-education, decreasing isolation and enhancing support, women experiencing IPV during pregnancy could be more likely to access appropriate resources (Zlotnick et al., 2011), and be better equipped to make decisions during the childbearing cycle (Rose et al., 2010). The results of the current study point to the importance of further adapting and contextualizing IPV-interventions for HIV-positive pregnant women - in order to address the complex relationship between IPV and HIV. Better understanding the impact of IPV on parental bonding, and what interventions could improve it, is another important area for future research.

The findings from this study are limited by the small sample size. In addition, given that partner-related factors resulted in the loss of follow-up of some women, it’s possible that the experiences of women with more severe IPV were not captured. The number of women screened for IPV in this study approximates the size of the HIV Maternity clinic, and the participant characteristics generally reflect the demographics of the women attending the clinic. Nevertheless, given that the women were seeking care from a tertiary facility, the results may not be generalizable to other HIV-positive pregnant women experiencing IPV, in general, and specifically those accessing other levels of health care in South Africa. A potential barrier was that the interviewer could only converse in English and Afrikaans – thus specifying these languages in the inclusion criteria. Only 4 women were excluded due to language limitations. Although the majority of the participants were Black African women who could converse in English, it is a limitation that they did not have the option of expressing themselves in their home language. Despite these limitations the findings from this study may contribute to a better understanding of how IPV is experienced in the specific context of pregnancy and HIV, and how it may impact on women’s health and engagement in care- including HIV care and treatment. These understandings can in turn be used to

inform caregiving practices, as well as timely clinical interventions, that could mediate the adverse effects of IPV.

Conclusions

The findings from this study contribute new insights into the nature and impact of IPV during pregnancy, how it affects women's experiences of their current pregnancy, their coping with HIV, as well as their expectations for the future. The experiences of the women in this study underscore the compounding burden, shame and stigma of being HIV-positive and experiencing IPV, which is further intensified by the significant challenges and demands of pregnancy – where the pregnancy itself is often an unintended consequence of the abuse. The results draw attention to the challenges women face in navigating disclosure of both HIV and IPV, accessing necessary support, and engaging in both HIV-related and pregnancy-related care in the context of an abusive relationship.

The results point to how the complex intersection of IPV- and HIV-related shame and stigma can lead to non-disclosure, poor health system engagement and lack of social and professional support – – all compounding to make women vulnerable to mental health adversities. These findings have significant implications for women's antenatal and early postnatal care engagement, and thus the critical period of the 'first 1000 days' - where the period from conception to two years are seen as critical in laying the foundations for child health and development. Impaired child development during this period could have negative effects throughout the lifespan, and interventions to manage developmental delays among HIV-exposed infants are lacking. Clearly, intervening with this vulnerable population is important, and of special interest to health care providers. Given that women tend not to disclose IPV in the absence of specific enquiry, health care professionals have an important role to play in its screening and management (Rose et al., 2010; Damra et al., 2015). Perinatal care can offer an opportune time to intervene given that pregnancy is the time at which women are most likely to seek health care services.

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TABLE 1

Examples of interview questions

Experiences and understandings of intimate partner violence:

- What are the different ways in which you have experienced abuse in your intimate relationship? What does the abuse look like?
- How have you come to understand or make sense of the abuse in your intimate relationship?
- What have been your experiences of IPV during your current pregnancy?
- What have been your experiences of disclosing the IPV to others?

IPV during pregnancy:

- How has the IPV impacted on your experience of your current pregnancy?
- Has the abuse changed in any way during your pregnancy? If so, how?
- What are some of your expectations or concerns for your pregnancy and future motherhood?

Impact of IPV on health, coping with HIV and medical care engagement:

- What is it like to live with HIV in the context of the abuse in your relationship?
- What has helped you cope?
- How do you think the IPV during pregnancy has affected your health? This could be your physical, emotional and/or sexual health.
- What have been some of the challenges for you when it comes to staying engaged in your medical care (e.g. attending hospital visits, taking your medication, etc.)?

TABLE 2

Summary of results

	Themes	Main findings
1.	Participant characteristics	● Mean age: 28 years ● Black/African, Xhosa speaking: 67% ● Mixed race, Afrikaans speaking: 33% ● Mean gestation period: 28 weeks ● Married or in a cohabiting relationship: 67% ● Unemployed: 67% ● Current pregnancy unintended: 83%
2.	Experiences of IPV during pregnancy	● IPV experiences included emotional (91.7%), physical (83.3%) and sexual abuse (58.3%). ● Emotional abuse included being degraded, ridiculed, criticised, blamed and insulted, and a range of controlling behaviours. ● Physical abuse included slapping, hitting, punching, kicking and choking, often resulting in need for medical attention. ● Physical and emotional abuse (in particular controlling behaviours) escalated during pregnancy. ● Given threats of harm and/or abandonment, women felt unable to refuse sex.
3.	Impact of IPV on pregnancy experiences	● IPV directly or indirectly resulted in unintended pregnancies, anxiety and ambivalence regarding the pregnancy, and consideration of termination. ● The experience of IPV during pregnancy caused significant emotional distress, and created concern for the safety and well-being of the unborn baby.
4.	IPV increases risk for HIV transmission and reinfection, and negatively impacts other health outcomes	● IPV decreased woman's control in sexual decision-making, and increased risk for HIV transmission and reinfection. ● Diminished interest in sex, or refusal of sex, resulted in escalation of physical and emotional aggression. ● Women associated IPV with multiple somatic symptoms, depression and alcohol use.
5.	IPV decreases medical care engagement, and access to social support	● Partner-related factors interfered with women's medical care engagement, self-care behaviours, and efforts to get social support during pregnancy. ● Increased engagement with health care providers during pregnancy often exacerbated risk of IPV. ● IPV shame and stigma served as barriers to IPV disclosure.
6.	IPV exacerbates HIV shame and stigma, and diminishes HIV care engagement	● An HIV-diagnosis increased risk for IPV, which in turn adversely affected HIV care engagement, and HIV treatment behaviours. ● Abusive partners created HIV shame and stigma for women. ● The compounding burden, shame and stigma of both HIV and IPV isolated women from external support, and created risk for both HIV- and pregnancy related- care engagement.
7.	Impact of IPV on motherhood, and children serving as positive catalysts for change	● Women expressed regret, guilt and concern for how their emotional distress in the context of IPV negatively impacted on their mothering of other children at home. ● IPV during pregnancy motivated women to consider options for leaving their partners in the future.