BREAKING THE CYCLE:
How the intimate partner violence, poor mental health, and HIV syndemics impact parenting practices in South Africa

What we know?

The World Health Organization (WHO) reports that more than 30% of women who have been in romantic relationships have experienced intimate partner violence (IPV) (World health organization,2013). Globally, depression affects an estimated 21–39% of women, and women and girls account for 53% of the total population living with HIV (World health organization; 2022). While extensive research on the Substance Abuse, Violence, and AIDS (SAVA) syndemic has been carried out in the United States, there is still limited evidence on the effects of co-occurring epidemics in low- and middle-income countries (LMICs), particularly among women (Meyer et al. 2011; Singer, 1996). Even less is known about how these overlapping health and social challenges influence parenting.

What is a Syndemic?

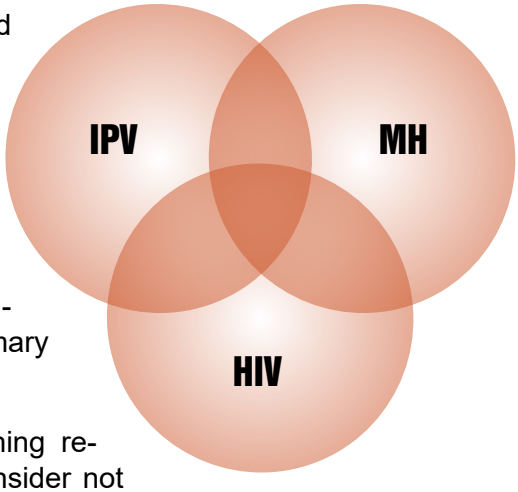
A syndemic occurs when two or more health and social problems interact and worsen each other, creating a greater overall burden than if they occurred separately. In this case, intimate partner violence (IPV), mental health challenges, and HIV combine to deepen harm, especially for women and families (Singer,1996)

Research shows that HIV, IPV, and mental health (MH) challenges disproportionately affect women, particularly those of childbearing age, and each epidemic has been independently linked to negative parenting outcomes. Living with HIV can reduce caregivers' emotional availability and capacity for engagement with children, especially in contexts of poverty and stigma, and lower engagement with children is associated with increased risk of child abuse (American Psychiatric Association,2013). While early studies linked HIV to high parental stress due to stigma and fear of death, recent improvements in treatment and reduced stigma towards people with HIV may have lessened this effect.

Additionally, IPV exposure undermines parenting by affecting mothers' physical and mental health and reducing partner support. This can result in inconsistent parenting practices, ranging from hyper-vigilance to emotional withdrawal or overcontrol (Silima et al, 2024). Similarly, maternal depression is strongly associated with harsh or unresponsive parenting, including increased anger, criticism, and reduced sensitivity to children's needs (Chung et al, 2021; Levendosky et al, 2003).

What did we want to learn?

There is limited research that explores the combined and compounding effects of IPV, MH, and HIV on parenting practices. Most existing studies focus on one or two of these conditions in isolation and do not apply a syndemic lens, missing how these interconnected conditions shape caregiving, parent-child interactions, and risks of child abuse. We sought to address a critical gap by examining how these epidemics, when experienced concurrently, influence parenting among women who are often the primary caregivers in South Africa.



Understanding this syndemic is essential to designing responsive, contextually relevant interventions that consider not only individual health outcomes but also broader family and intergenerational impacts. A syndemic approach also allows us to move beyond siloed interventions and instead inform development of more integrated policy, practice, and community responses.

How did we do the research?

547
Women caregivers

We conducted a quantitative survey with 547 women caregivers of children between seven and 17 years in Mpumalanga. The survey measured lifetime experience of IPV, MH symptoms (depression, PTSD, suicidality), HIV status, and abusive parenting practices (emotional and physical abuse, and neglect). We used multivariate logistic regression and path models to assess the relationships between syndemic exposure and parenting outcomes.

20
Women caregivers

Qualitative interviews were conducted with 20 women caregivers, who had experienced at least two of the epidemics, in-depth interviews were supplemented with arts-based methods

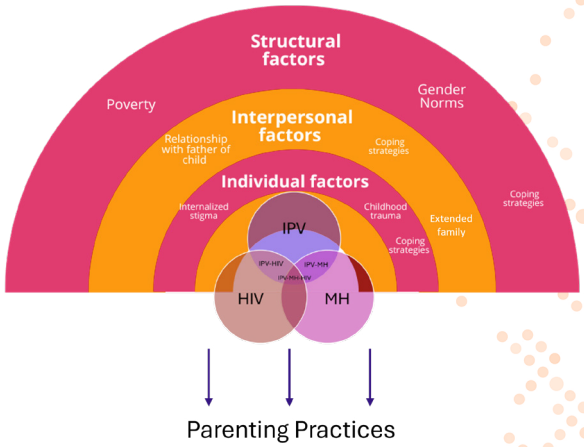
What did we find?

Key Finding 1: IPV, MH and HIV prevalence

Participant Profile	Prevalence (n=547)
Average participant age	40 years
Experienced IPV in the past year	36.4%
Living with HIV	17.6%
Reported common mental health (MH) symptoms	29.2%
Experienced at least two epidemics concurrently	45.8%

Key finding 2: Childhood trauma and structural stressors compound parenting risk

A history of childhood abuse was linked to harsher parenting. This was compounded by poverty, social isolation, and limited access to mental health services.



What did we find? (cont.)

Key finding 3: IPV and MH combined sharply increase parenting risk

Women experiencing both IPV and MH challenges were 3 times more likely to use emotional violence against their children (OR=3.04, 95% CI= 1.86–4,98). When all three conditions (IPV, MH, HIV) co-occurred, the effect was even more pronounced.

"When I was in that abusive relationship, my son would try and speak to me, I would just insult him. I would get pissed off by my partner and take it out on the closest person to me and usually, it was my son he would do a small thing, like spill water, and I would overreact. I realised that the way I was hitting him was not normal. I would take out a lot of pain on him"

(IDI participant with IPV-MH experience)

Key finding 4: Depression and PTSD are the strongest pathways to harsh and inconsistent parenting

Poor MH mediated the relationship between IPV-HIV and parenting. Women reported less warmth, increased frustration, and avoidance of engagement with their children when experiencing depressive symptoms or PTSD.

"I wouldn't want to be a parent if I had a choice. Nothing makes me happy about being a parent [laughs]. To be honest, I just don't find joy in being a parent."

(IDI participant living with IPV-MH-HIV)

Key finding 5: HIV alone did not elevate risk unless combined with IPV or MH

Although HIV deeply affected women's well-being, it only increased parenting risk in the presence of IPV or poor MH, highlighting the importance of understanding these conditions collectively.

"I scold them or hit them with a tree branch. I hit them when they are naughty. I hit them with a stick."

(IDI participant living with HIV-MH)

What should we do?

POLICY AND PROGRAMME IMPLICATIONS

Adopt a syndemic lens and integrate responses across health and social services

Screening for IPV, mental health challenges, and HIV should be routinely embedded within primary healthcare, maternal, and HIV services. Mental health care must be incorporated into IPV and HIV programming, ensuring counselling and psychosocial support are available on-site. Funding and programming should be coordinated across sectors to break down silos and address the intersections of these epidemics.

Strengthen parenting interventions through universal integration of mental health and IPV support

Given the high proportion of women affected by multiple epidemics, all parenting programmes should include support for mental health and IPV to ensure accessibility for all caregivers, not just high-risk groups. Universal access will better protect children and promote positive caregiving.

Break intergenerational cycles through trauma-informed care

Invest in trauma-informed parenting interventions and services that support women caregivers who have experienced childhood abuse, poverty, and social isolation, thereby interrupting cycles of trauma and violence across generations.

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Source:
Silima, M., Christofides, N., Woollett, N., Franchino-Olsen, F. Meinck, F. Beyond Comorbidity: A Syndemic Analysis of Intimate Partner Violence, Mental Health, and HIV and their influence on maternal use of violence among women in South Africa

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BANAKEKELI YOUNG CARERS · THE UNIVERSITY of EDINBURGH · UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG · NWU · erc European Research Council · UK Research and Innovation · GCRF