Violence against women in South Africa

Dr Lerato Langa-Mlambo[1], Dr Priya Soma-Pillay[2]
[1]Fellow: Maternal and Fetal Medicine, Department of Obstetrics and Gynaecology, University of Pretoria, Pretoria, South Africa
[2]Department of Obstetrics and Gynaecology, University of Pretoria, Pretoria, South Africa

Introduction

South Africa is currently experiencing a huge burden of morbidity and mortality arising from violence and injury. In 2000, violence and unintentional injuries combined were the second leading cause of all death and disability adjusted life years (DALY).[1] The first cause being Human Immunodeficiency Viral (HIV) diseases.[1] Interpersonal violence is the leading risk factor after unsafe sex and for loss of DALYs.[1] According to the crime statistics report of South Africa during the 2011/12 financial year there were 777 104 serious crimes arrests and 806 298 in 2012/13.[2] There were 197 877 crimes reported against women in 2009/10 in comparison to 175 880 in 2012/13, a reduction of 11.1%.[2] However, the reviews of evidence for gender based violence has reported that no reduction occurred in the past decade.[3] There are no reliable national data for the prevalence of intimate partner violence (IPV), but the best population based estimates from 1998 identifies a lifetime prevalence of physical violence of 25%.[1-3]

There is growing recognition that violence against women has a large public impact, in addition to being a gross violation of women's rights. According to the Declaration on the elimination of violence against women (General Assembly 48/104), violence against women means any act of gender-based violence that results in, or is likely to result in:

- physical, sexual or psychological harm or suffering to women,
- threats of acts which may cause physical, sexual or psychological harm
- coercion or arbitrary deprivation of liberty, whether occurring in public or in private life, and whether those acts are perpetrated by the State or private persons.[3-8]

Correspondence
Dr Lerato Langa-Mlambo
email: lolo.mlambo@gmail.com

The term "violence against women" encompasses many forms of violence, including:

- violence by an intimate partner (intimate partner violence) and
- rape/sexual assault and other forms of sexual violence perpetrated by someone other than a partner (non-partner sexual violence),
- female genital mutilation
- honour killings or crimes,
- the trafficking of women
- early and forced marriage
- forced pregnancy,
- sexual harassment in the workplace, other institutions and in public places,
- violence condoned by the State and violence in conflict situations.[4-15]

Types of abuse discussed

1. Female genital mutilation

Female genital mutilation (FGM) encompasses all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs whether cultural, religious or other non-therapeutic reasons.[16-18] There are different types of FGM and they include:

Type I – Partial or total removal of the clitoris and or prepuce (clitoridectomy)

Type II – Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision)

Type II – Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning of the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

Type IV – All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising of the clitoris or labia, stretching of the clitoris or labia, cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue

surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.[16-18]

FGM is largely performed on children too young to consent or make informed choices. UNICEF describes FGM as a deeply rooted tradition that is perceived in many societies to be a religious obligation in African and Arab Islamic countries in particular.[16] Many societies are abandoning the procedure as it is said to not be a sin against Islam, but a dangerous procedure with long lasting health consequences.[16-18] The World Health Organisation had estimated that 130 million women have undergone some form of genital mutilation, and some two million undergo the procedure annually.[18]

Health complications of female genital mutilation have been described as the "three feminine sorrows" this includes

- the sorrows on the day of the procedure,
- the sorrows on the night of the wedding when often the woman has to be cut prior to intercourse
- and when the woman gives birth and the vaginal opening is not large enough for a safe delivery.[16]

2. Rape and sexual assault

Gender based violence is prevalent in South Africa and this country has been labelled the "rape capital" of the world by the Human Rights Watch in 2010.[19] In the year 2012 there were 55 201 rape cases reported to the South African Police Services (SAPS).[19] However, there is a problem of gross under-reporting of cases of rape in our country and the South African Police Services estimate that only one in thirty six rape cases are reported.[19]

Rape is defined as the act of sexual penetration with another person without such person's consent as per section 3 of the Sexual offences Act.[20] The term "sexual penetration" replaces the vaginal penetration. Sexual penetration refers to penetration of the vagina, anus or mouth by a penis or the vagina or anus by penis or other foreign object.[20] There is no consent when the sexual act is committed:

- using force or
- intimidation by threats of harm or abuse of power or authority inhibiting a person from indicating his or her unwillingness;
- under false pretences or by fraudulent means;
- or the act is with a particular person who is in fact a different person or such a sexual act is something other than the act; or
- where the person is incapable in law of appreciating the nature of the sexual act because she is asleep, unconscious, or in an altered state of consciousness including the influence of any medicine, drug, alcohol or other substance to the extent that their consciousness or judgement is adversely affected;
- or the act with a child below the age of 12 years, or a person who is mentally disabled.[14,20]

Sexual assault is defined as sexually violating another person without such person's consent. Sexual violation covers a very wide range of behaviours for example contact between the genital organs or anus or female breasts of one person and any body part of another person or animal or object; and contact between the mouth of one person and the genital organs or anus or female breasts or mouth of another person or masturbation of one person by another person.[14,20]

The main distinction between rape and sexual assault is that assault does not include penetrative forms of sex, except the insertion of an object resembling or representing the genital organs of a person or animal into the mouth of another person.[20]

3. Intimate partner violence (IPV)

The definition of intimate partner varies between settings and includes formal partnerships such as marriage, as well as informal partnerships including dating relationships and unmarried sexual relationships.[4] The age of fifteen is set as the lower age range for partner violence and non-partner sexual violence.[4] Intimate partner violence can be physical or sexual. Physical violence is defined as:

- being slapped or
- having something thrown at you that could hurt you,
- being pushed or shoved,
- being hit with a fist or something else that could hurt you,
- being kicked, dragged, or beaten up,
- being choked or burnt on purpose,
- and or being threatened with, or actually, having a gun, knife or other weapon used on you.[4]

Intimate partner violence – sexual violence is defined as

- physically forced to have sexual intercourse when you did not want to,
- having sexual intercourse because you were afraid of what your partner might do
- and or being forced to do something sexual that you found humiliating or degrading.[4]

In some South African studies, more than 40 percent of men have disclosed having being physically violent to a partner, and 40 – 50 percent of women have also reported experiencing such violence.[1] Intimate partner violence is often sexual and emotional, and many women undergo several forms of violence.[1,3] In Soweto, 20 percent of women surveyed in antenatal clinics reported sexual violence by an intimate partner, and 68 percent reported psychological abuse, identified by measures such as threats of violence, controlling of movement, eviction from home, insults and humiliation.[1-2]

Abuse against mothers by their intimate partners is a serious risk factor for child abuse. Children who witness violence between adults in their own homes have been referred to as the silent, forgotten and unintended victims of adult-adult domestic violence. These children have

increased risk of

- post- traumatic stress disorder,
- and also demonstrate emotional and behavioural problems,
- poor school performance,
- low self -esteem,
- nightmares,
- bed-wetting and
- physical health complaints.[7]

In South Africa, in 2007-8, nearly 18 487 homicides were reported by the South African Police Services.[1] The report indicates a decline from 1 147 of female gun related homicides in 1999 to 461 in 2009.[3] Up to 57.7 percent of the tested homicide perpetrators had a high alcohol concentration in their blood.[1] Overall these deaths are associated with the use of firearms and sharp objects. Many women have high concentration of blood alcohol at the time of their deaths, and the men who kill them are similarly intoxicated.[1]

Health effects of intimate partner violence and non-partner sexual violence

Limited sexual and reproductive health control

Global awareness is growing that the role of gender based violence plays an increasing role in the HIV epidemic.[9] The burden of HIV infection disproportionately affects women in Africa and it is estimated that 60% of individuals living with HIV in Africa are girls and women. In the Sub-Saharan Africa, 40% of women living with HIV reside in South Africa.[9-10] There is evidence of an association between IPV and HIV from cross-sectional and prospective studies.[9-13] There is also a lack of understanding of direct and indirect mechanism for the association between IPV and HIV. Direct mechanism includes forced or coercive intercourse and associated physical trauma, which could increase the susceptibility to HIV.[4]

Kouyoumdjian et al.[9] reported that it is the experience of violence and not a particular type of violence which increases the risk of HIV, although there was an overlap in the forms of violence experienced by the women in their study. The association between IPV and HIV tends to be greater for severe forms of violence than with minor forms of violence.[9]

The other important factor is that abused women live in fear of violence, have limited control over the timing or circumstances of sexual intercourse, and limited ability to negotiate safer sex practices, which may lead to low condom usage.[4,9] Partner violence may be also be an important determinant of separation, which in turn increase a woman's risk of HIV if she acquires a new partner.[4] Furthermore, men who are violent against their partners tend to have HIV-risk behaviours including having multiple sexual partners, frequent alcohol use, visiting sex workers, and having a sexually transmitted infections, all of which may increase women's risk of HIV.[4,13]

Women who experience violence may engage in early sexual initiation, anal sex, commercial sex work and unprotected sex with unfamiliar partners.[9] Physically, forced sexual initiation involves friability of vaginal tissue among adolescents contributing to the possibility of HIV acquisition.[10] Globally, forced sexual initiation is highly prevalent, ranging from 5% to 46%, and is associated with HIV risk behaviours including inconsistent or no condom use and multiple partners.[10] Among 26% of women whose first sexual experience was at age 15 years or younger, 22% experienced forced sexual initiation. In addition substance abuse mediated both associations.[9-15]

Of the physically abused women, 41% reported to having anal intercourse. The women who reported forced sex were four times as likely to report inconsistent use of condoms at their last five acts of anal intercourse may also be forced to engage in anal sex.[10]

The psychological stress of violence may affect the susceptibility to HIV through immune suppression.[4,10] Intimate partner violence may be an indirect marker of risk for HIV, as men who perpetrate violence may have higher rates of sexual risk behaviours, which may increase the risk to their partners.[9,10,13] A study by Adam JL et. al. found that some women are not willing to test for HIV if the partner tells her that she is not at risk from him, or is she may not wish to disclose the results to her partner.[12]

The forced sex impacts on the woman's physiological susceptibility to HIV. The local inflammatory response can increase susceptibility to HIV infection in recruitment of target cells to the site of injury, and impairment of the integrity of the mucosal epithelial barrier.[10] Additionally forced or consensual intercourse can cause an increase in CD4+ cells in the cervical epithelium, hypothesized to be a direct result of the exposure of vaginal and cervical cells to seminal fluid.[10] The additional pathway may include the transmission of sexually transmitted infections by an infected abusive partner, which then begins the pathway to increased HIV susceptibility through altering inflammatory response.[10]

The higher rates of adverse reproductive events can be explained by direct consequences of sexual coercion as well as by more indirect pathways affecting contraceptive use, such as sabotage of birth control, disapproval of birth control by preventing use of contraception, or inability to negotiate condom use for fear of violence.[4,14-15] As a result, the women in abusive relationships tend to have unintended pregnancies.[15] The World Health Organisation (WHO) quoted that of the 80 million unintended pregnancies each year, at least half are terminated through induced abortion and nearly half of these take place in unsafe conditions.[4,14-15] Sensitive and stigmatised events, particularly where it is illegal, tend to be underreported.[15]

Maternal and perinatal health concerns

Living in an abusive and dangerous environment marked by chronic stress are important risk factors for maternal health, as well as affecting birth weight.[4,13] The studies reviewed by the World Health Organization found that intimate partner violence was positively associated with low birth weight and preterm birth, but there was no statistically significantly association between intimate partner violence and intrauterine growth restriction.[4,13] The negative outcome of violence during pregnancy pose particular risks to mother and child including increased risk of sexually transmitted infections, miscarriages,

preterm labour, induced abortions, hypertension, stress, and in extreme cases is associated with maternal death.[4,7,13]

Female genital mutilation is associated with increased risk for birth complications, affecting both the mother and child. The potential maternal consequences of FGM include fear of childbirth, increased likelihood of caesarean section, episiotomy, severe vaginal lacerations and fistula formation, difficulty of vaginal examination during labour and even catheterisation of the bladder.[16,18]

Mental Health - depression and suicide

Exposures to traumatic events can lead to stress, fear, isolation, which in turn, may lead to depression and suicidal behaviour. Early life exposure to violence may also play a role in predicting both violence and depression.[4]

After the assault, a rape trauma syndrome often occurs. The acute or disorganization phase may last for days to weeks and is characterized by physical reactions such as generalised pain throughout the body, eating and sleeping disturbances, and emotional reactions such as anger, fear, anxiety, guilt, humiliation, embarrassment, self-blame, and mood swings.[14] The next phase, the delayed or organizational phase is characterised by flashbacks, nightmares, and phobias as well as somatic and gynaecologic symptoms. This phase often occurs in the weeks and months after the events and may involve major life adjustments.[14]

Posttraumatic stress disorder (PTDS) is a long term consequence of assault or violence.[14] PTDS is characterised by a symptom cluster involving re-experiencing the trauma, avoidance, and a state of hyper-arousal. These symptoms may not appear for months or even years after a traumatic experience.[14]

Substance and alcohol abuse

There is a positive association between women's experience of intimate partner violence, rape, and sexual assault and subsequent alcohol use, as well as an association between alcohol use and subsequent intimate partner violence.[4,14] Although the casual relationship between intimate partner violence and alcohol consumption in women is far from clear, there is clear evidence that women with histories of violence consume more alcohol, and conversely, that women who binge drink and consume alcohol in other harmful ways are more likely to report experiences of violence.[4,14] It is possible that both alcohol use and intimate partner violence and sexual assault can be attributed to another underlying issue, such as mental health disorder or another substance use, which can increase women's vulnerability to violence and to alcohol use.[4,14]

Non-fatal and fatal injuries

The direct effects of violence against women are fatal and non-fatal physical injuries. It is estimated that approximately half of women in the United States of America are physically injured by their partners, and that most of them sustain multiple types of injuries.[4] The World Health Organisation reported that the head, neck and face are the most common locations of injuries, followed by the musculoskeletal injuries and genital tract injuries.[4]

Women presenting with injuries due to partner violence may be reluctant to disclose the actual source of the injury, attributing it to some other cause. The data from the World Health Organization found that while on average 48 percent of women experiencing physical intimate partner violence claimed they needed heath care for their injuries, only 36 percent actually sought health care for them.[16] In South Africa, the deaths of men from homicide outnumber those of women by more than 7:1, but the men are predominantly perpetrators as well as victims.[1] In our country, at least half of the female victims are killed by their male intimate partners. In 1999 there was an estimated 3797 homicides of women, which is 24.7 per 100 000; and that is six times higher than the rate worldwide (4.0 per 100 000).[1] In 2007, the National Injury Mortality Surveillance System (NIMSS) suggested that nearly 40 percent of homicides where committed with sharp objects and over a third resulted from gun shots

The potential acute complications of FGM include severe haemorrhage, severe pain, acute and long term urinary and reproductive disorders, clitoral inclusion cysts and keloids, vesico-vaginal fistula, pelvic inflammatory diseases, sepsis, tetanus, and increased susceptibility to hepatitis and blood borne diseases.[16,18] The late gynaecological complications include anorgasmia, dyspareunia, chronic pelvic pain, dysmenorrhoea, recurrent urinary tract infections urinary outflow obstruction, infertility problems. Procedures such as routine cervical screening, evacuation of the uterus following a miscarriage or even a gynaecological examination are also a challenge.

Non communicable and somatoform diseases

These include the symptoms related to cardiovascular disease and hypertension, irritable bowel disease, chronic body aches and chronic pelvic pain.[4] When causes are not found for these diseases or symptoms, then the possibility of abuse should be explored.

Roles and responsibilites of health care workers

The health care providers should routinely screen all women for a history of sexual assault, paying particular attention to those who report pelvic pain, dysmenorrhoea or sexual dysfunction. When performing an examination, one should be aware that some procedures such as breast and pelvic examination and sonography could trigger panic and anxiety reactions. All victims of violence should be screened for substance abuse. Conversely, health care providers should screen those with substance abuse problems for violent abuse. Counselling can help the woman to understand her psychological and physical responses, thereby diminishing her symptoms.[14,15]

The World Health Organization, UNICEF and the Royal College of Obstetricians and Gynaecologists have called for the abandonment of FGM, as this action would benefit societies, families and individuals.[16-18] However health care workers are still likely to encounter these cases and it is essential to be informed of this condition and treat patients with sensitivity. If acceptable to the women defibulation

should be discussed prior to conception, especially if difficult surgery is anticipated.[18] Psychological referral should be discussed with the women as well.[18]

Conclusion

Violence against women is a significant yet avoidable public health problem that affects millions of women regardless of age, economic status, race, religion, ethnicity, sexual orientation or educational background. Individuals subjected to violence suffer emotional, physical trauma and even death. Obstetricians and Gynaecologists are in a unique position to assess and provide support for women who are abused. Opportunities for intervention may take place during the course of pregnancy, family planning, annual examinations, and other women's health visits.

References

1. *Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: prioritising ag agenda for prevention. Health in South Africa 5. Lancet 2009;374:1011-1022.*
2. *An update on progress and achievement in 2012/13. Crime statistics. Last Accessed on 08 April 2014. www.crimestatssa.com/national.php.*
3. *Dunkie KL, Jewkes RK Brown HC et.al. Prevalence and patterns of gender-based violence and re-victimisation among women attending antenatal clinics in Soweto, South Africa. Am J Epidemiol 2004;160:230-9.*
4. *Mayosi BM, Lawn JE, Van Niekerk A, Bradshaw D, Abdool Karim SS, Coovadia HM. Health in South Africa: changes and challenges since 2009. Lancet 2012;380:2029-43.*
5. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization 2013.*
6. *Intimate Partner Violence. Committee Opinion no.518. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:412-7.*
7. *Prevention of violence against women and girls. Commission on the status of women. Fifty-seventh session. March 2013.*
8. *Hedin LW. Physical and sexual abuse against women and children. Curr Opin Obstet Gynecol 2000;12:349-355.*
9. *Fulu E, Jewkes R, Roselli T, Garcia-Moreno C. Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the UN Multi-country cross-sectional study on men and violence in Asia and the Pacific. Lancet Glob Health 2013;1:e187-207.*
10. *Kouyoumdjian FG, Calzavara LM, Bondy SJ, O'Campo P, Serwadda D, Nalugoda Fet.al. Intimate partner violence is associated with incident HIV in women in Uganda. AIDS 2013;27:1331-1338.*
11. *Campbell JC, Lucea MBL, Stockman JK, Draughon JE. Forced sex and HIV risk in violent relationships. Am J Reprod Immunol 2013;69(01):41-44.*
12. *Stockman JK, Lucea MB, Campbell JC. Forced sexual initiation, sexual intimate partner violence and HIV risk in women: A global review of the literature. AIDS Behav, 2013;17(3):832-847.*
13. *Adams JL, Hansen NB, Fox AM, Taylor BB, Janse van Rensburg M, Mohlahlae R. Correlates of HIV testing among abused women in South Africa. Violence Against Women 2011;17(8):1014-1023.*
14. *Russell BS, Eaton LA, Petersen-Williams P. Intersecting epidemics among pregnant women: alcohol use, interpersonal violence, and HIV infection in South Africa. Curr HIV/AIDS Rep. 2013;10(1):103-110.*
15. *Sexual assault. Committee Opinion No. 592. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;123:905-9.*
16. *Reproductive and sexual coercion. Committee Opinion No. 554. American College of Obstetricians and Gynecologists. Obstet Gynecol 2013;121:411-5.*
17. *Momoh C. Female genital mutilation. Curr Opin Obstet Gynecol 2004;16:477-480.*
18. *Adam T, Bathija H, Bishai D, Bonnenfant YT, Darwish M, Huntington D. Estimating the obstetric costs of female genital mutilation in six African countries. Bulletin of the World Health Organization, 2010;88:281-288.*
19. *Female genital mutilation. Green top guideline No. 53. Royal College of Obstetricians and Gynaecologists.*
20. *Gordon SF, Collins A. ''We face rape. We face all things'': Understandings of gender –based violence amongst female students at a South African university. African Safety Promotion J 2013;11(2):93-106.*
21. *Artz L, Roehrs S. Criminal Law (Sexual and related matters) Amendment Act (No. 32 of 2007): Emerging issues for the health sector. CME 2009;27(10):464-7.*

Open access to O&G Forum website

www.ogf.co.za

User ID - inhouse / Password - 2011

O&G FORUM