

**CHARACTERISTICS OF ABUSED WOMEN WHO CONSULTED  
AT DAVEYTON CENTRAL CLINIC: A TWO YEAR REVIEW**

**BY**

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## **DECLARATION**

I Dr. Akingboye Dauda declares that, the work on which this dissertation is based is original research (except where acknowledgement indicate otherwise) and that neither the whole nor part of it has been, is being, or shall be submitted for another degree at this or any other university/institution for tertiary education or examining body.

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Dr. Akingboye M. DAUDA

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Date

# DEDICATION

*To God, Almighty and Late Madam Olanike Dauda (My mum)*

*- "All I have seen teaches me to trust the Creator for all I have not seen."*

*- "Do not go where the path may lead, go instead where there is no path and leave a trail."*

*-Ralph Waldo Emerson (1803 - 1882)-.*

*- "Whenever two ways lie before us, one easy and the other hard,*

*One of which requires no exertion while the other calls for resolution and endurance,*

*Happy is the man, who chooses the mountain path and scorns the thought of resting in the valley,*

*These are the men and women who are destined in the end to conquer and succeed"*

*-Unknown author-.*

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To my foster mum - Mrs. Adeyemi Olufunmilayo, I am highly indebted to you for believing in me.

To my siblings - Comfort, Simbiat, Sikiru and Akintokunbo, I love you ALL!

Finally, to the management, Department of Health, Ekurhuleni region-Chairperson - Dr. Ronel Kellerman, Deputy Chairperson - Dr.Sepuya, Daleen De Beer, Matron Nyoko and all the staffs of Daveyton clinic, I am very grateful.

# ABSTRACT

## *Background:*

The choice of this research topic emanated from my personal experience as Medical Officer at Daveyton central Clinic where I personally attended to an average of three rapes or wife battering cases on a weekly basis and usually many more during festive periods. When compared to my colleagues working in other centres like Pretoria, the prevalence, types and features of the abused women differs which implies that the characteristics might differ from province to province and against this background that the researcher intended to conduct this research.

## *Aims:*

The broad aim of this study is to explore the characteristics of abused women who consulted at Daveyton clinic between January 2008 and December 2009.

## *Methodology:*

Data was collected at Daveyton central clinic which is under Ekurhuleni municipality. A descriptive quantitative study was used based on records of abused women who consulted at the clinic between January 2008 and December 2009. All the files of the women who consulted within the specified period were retrieved and every file with a history of violence against women (VAW) was selected. The analysis was based on the information that were written in the files of the patient by the health workers at the centre.

## *Results:*

The study indicated that the majority of the participants (72 %) were below the age of 30 years. Among the abused women 59.8 % were single. All the women were living in the Daveyton township area. Only five (2%) of the cases had no formal education or stopped at primary school level, while 88.8 % had at least a secondary school education and the rest 9.2 % had tertiary education. About 45.4 % of the cases were unemployed and 14.7 % were students. This gives a total of close to 60.1 % of cases

who are economically inactive and dependent. The rest of the respondents were either in full time (13.9 %) or in part time (25.9 %) employment. At the time of presentation at the centre, more than quarters (29.6 % and 27.6 % respectively) were traumatized or confused, 19.8 % injured and 19.3 % were reserved. Almost half (47.4 %) of the abuse cases were sexually abused, followed by physical abuse at 41.8 % while emotional abuse were 6.3 % and economical abuse were 4 %. Over a half (55.4%) of women abused alcohol, 16.7 % used tobacco and 15 % used illicit drug while 12.8 % of women did not use any form of substances. At the time of presentation at the centre, the following personality traits from abused women were observed; almost 36 % of the abused women were angry, 20.6 % were stubborn and 24.9 % were submissive while 14.8 % were aggressive. Majority of women (63 %) reported abuse yearly. There were more abuse during festive period (67.7 %). About one fifth (18 %) of women were abused during their pregnancy and 82% were not pregnant. 38% of abused women had no child while about 61 % had 1 to 6 children. Two third (61.5 %) of the women were abused by their husband or partners.

Further analysis revealed that age was significantly associated with different types of abuse as younger women (<30 years) were more abused than older women ( $p = 0.011$ ). Marital status was also significantly associated with different types of abuse ( $p = 0.001$ ). This means that single or divorced or separated women were more likely to be victims of sexual abuse. Women's employment status was statistically associated with types of abuse as physical and sexual abuse were more common among women who were unemployed or had part time employment ( $p < 0.001$ ).

Types of abuse was associated with substance abuse as prevalence of physical and sexual abuse were more common among women who took alcohol ( $p = 0.019$ )

It was found that types of abuse and period of reporting were significantly associated as physical and sexual abuse were reported more during festive seasons ( $p = 0.006$ )

Types of abuse was significantly associated with relationship with the perpetrator ( $p < 0.001$ ). This indicated that women were emotionally or economically abused more by father or uncle or where there was more than one perpetrator.

*Conclusion:*

The following characteristics were observed from women who consulted at Daveyton central clinic for abuse; most were between 11-30 years and single (59.8 %). Most of them were economically inactive. It was evident from data analysis that most of them had low level of education (90.8 % - secondary education or lower) and they struggle to get employment. Another characteristic was that 60.1 % of cases were still students or unemployed and therefore depended on their partners for financial support, which in some cases were elderly men. Most of them presented traumatized at the centre and the commonest form of abuse experienced was sexual abuse. Most of the abused women were found angry. Most of them came for consultation during festive periods. This could probably be related to heavy alcohol consumption during these periods.

Key words: Domestic violence, Characteristics of abused women, patterns of reporting.

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## **LIST OF ABBREVIATIONS AND ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
DALY	Disability Adjusted Life Year
DOH	Department of Health
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
MEDUNSA	Medical University of South Africa
NCADV	National coalition against domestic violence
NGO	Non Governmental Organization
MREC	MEDUNSA Research Ethics Committee
RMPH	Research Methodology in Public Health
STI	Sexually Transmitted infections
VAW	Violence against women
WHO	World Health Organization

# CHAPTER ONE

## INTRODUCTION

### 1.1. INTRODUCTION

This chapter presents an introduction as well as background to the study. It starts off with the background of the study followed by the problem statement. The problem will be stated and the researcher will indicate why violence against women (VAW) is a public health problem. The aims and objectives of the study are also presented in this chapter as well as the significance of the study.

### 1.2. BACKGROUND TO THE STUDY

South Africa, a country not at war, faces an unprecedented 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 (DALYs) lost in the country, after HIV/AIDS, with interpersonal violence the leading risk factor (including violence against women), after unsafe sex, for loss of DALYs (Norman et al, 2007).

According to the Women National Coalition of South Africa, more than 1000 women are raped everyday, 1 in every 6 women is regularly assaulted by her partner and at least 4 women are forced to flee their homes because of life threatening situations in the home (Khumalo, 1997). Besides, every twelve seconds in South Africa a woman is a victim of domestic battery (Bohn, 1990). Battered women are defined as women who have suffered one or more episodes of battery from their male partners or ex-partner. Battery includes slapping, kicking, punching, shoving, torture and sexual assault. Women who are physically abused also suffer psychological and emotional battery (Bohn, 1990).

The United Nations defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats or such acts as coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Krug et al, 2002).



There are many forms of violence against women, including sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers or employers); trafficking for forced labor or sex; and such traditional practices as forced or child marriages, dowry-related violence; honor killings, when women are murdered in the name of family honor. Systematic sexual abuse in conflict situations or during political instability is another form of violence against women and the abused are usually left desolate with STDs and unwanted pregnancy after such incidences.

World Health Organization, WHO (2007) defined intimate partner violence (which is a form of violence against women by known perpetrators) as “the range of sexually, psychologically and physically coercive acts used against adult and adolescent women by current or former male partner”. Intimate partner violence is of great concern because it is global, violates fundamental human rights of women, and is a major public health problem. There is no racial, ethnic or socio-economic predictor of abuse, all women are at risk of being abused. An overwhelming 50 % of all women will experience physical violence in an intimate relationship (Bohn, 1990). Women in rural areas may be at increased risk due to social isolation, and cultural traditions and lack of resources which inhibit reporting of domestic violence.

Domestic violence is one of the most pressing social problems in the world with the statistics increasing day by day in Southern African countries (David, 1990). A study of 10 countries found that between 13 and 62 percent of women have experienced physical abuse by a partner over the course of their life time and between 3 and 29 percent of women reported violence within the past year (Bott, Morrison & Ellisberg, 2005). An estimated one of every three women globally is beaten, raped or otherwise abused during her lifetime (Ellisberg *et al*, 2000; Heise *et al*, 1999). A recent study in South Africa (SA) found that a woman is murdered by an intimate partner every six hours. (Mathew, 1996; Abraham, 2000).

Research evidence shows that women who experience domestic violence tend to suffer psychological effects such as low self esteem, depression and post traumatic stress disorder (Renvoize, 2002). According to Hutchings (1998), domestic violence is the infliction of physical pain brought about slaps, punching, biting and hair pulling.

Abused women are not living the same life as non- abused women (Buzawa and Buzawa, 2002).

Renvoize (2002) believes that there are high numbers of women who are abused by their husband or spouses and these women continue to think that situation will improve and do not report this to officials. Kirkwood (1999) argues that battered women tend to be autistic. Loneliness has been observed from battered women all over the world. Some women are lacking in knowledge; they do not know that being violated is synonymous to being abused. Kleint (2001) believes that women who have experience violence tend to be disturbed emotionally.

According to Roy (1999), women who have children claim that their partners abuse them and tend to extend the violence to their children. These women indicated that one particular child is more likely to be a victim of violence. Some women claim that their husband's violent behaviour had made them to become hesitant in having more children and the issue of birth control receives much more consideration. The family which is characterised by violence will produce emotional unstable children (Kalmuss, 1984).

Rape is just one of the numerous violence against women (VAW). It was also reported that Political violence, also a form of violence against women was more rampant in KwaZulu-Natal province of South Africa than most other provinces (Human Right watch, 1995). It can then be inferred that the prevalence of violence against women and the characteristics of abused women varies according to individual province. It is against this background that the researcher intends to conduct His research.

Daveyton Central Clinic is located in Daveyton which is a township in the Ekurhuleni Metropolitan Municipality, Gauteng Province, South Africa. It was established in the year 1956, just two years after the establishment of the township itself making it the oldest clinic in the town. Majority of Daveyton residents are unemployed and as a result seeking health care at public health care institution because of their inability to afford the high health care cost at private health care institutions. That means that the Government has to undertake such a heavy responsibility of providing free health

care to them via Daveyton clinic. Hence, majority of Daveyton inhabitants consult at Daveyton clinic which gives a good contact point for the conduct of this research.

### **1.3. PROBLEM STATEMENT AND RATIONALE:**

Concern about the problem of violence against women is growing. It is highly imperative to analyze insights into every aspects of physical and sexual violence. Although, it is recognized that a summary of the available evidence cannot address all relevant issues, but an attempt to achieve a detailed account of characteristics of victims will be made in this research. Violence (physical, sexual or emotional abuse) against women is found at a higher rate globally and is given a priority for an elaborate intervention by the WHO (Garcia-Moreno, 2002).

Finding out the specific forms of abuse experienced by women in situations of domestic environment will help abused women to be aware of such forms of abuse as knowledge is power. Interventions directed at the victims of violent crimes experiencing psychological distress is important to assist with immediate consequences such as injury, income loss and adjustment to disability and to prevent longer-term negative sequelae such as those associated with post-traumatic distress which is usually associated with severe abuse. Identifying the various emotions expressed by women who had experienced domestic violence will raise awareness of such behaviours. Sharing the experiences that helped abused women to emerge out of the abusive relationships would help raise awareness to other women who find themselves in the same predicament. The first national femicide study found that four women are killed by an intimate partner everyday in South Africa (Mathew,1996).

Most victims of battering do not use medical facilities as a resource for problems related to domestic violence (Appleton, 1980). Therefore, determining what women do when experiencing domestic violence will help other women who are reluctant to report domestic violence to be courageous enough to take actions themselves. Few physicians screen their patients for violence in the home (Sugg, 1992; Parson, 1995). Victims of battering rarely volunteer a history of abuse when they are seen in a medical setting (Friedman, 1992). At some point, however, many victims of domestic violence will call attention to their problem and seek help!

In addition, the World Health Organization found that 10 % to 69 % of women from developing and industrialized nations have been assaulted by a partner and called for more nations to support intimate partner violence research and interventions in their populations (Krug, 2002).

#### **1.4. RESEARCH QUESTIONS**

What type/types of abuse are the women experiencing?

What is the nature of the relationship between clients and the perpetrator?

How many times have the clients consulted at the clinic?

What is the relationship between the victim's demographic profile and the frequency of abuse?

#### **1.5. AIM**

The broad aim of this study is to describe the characteristics of abused women who consulted at Daveyton clinic between January 2008 and December 2009.

#### **1.6. RESEARCH OBJECTIVES**

To identify types of abuse experienced by the women.

To identify the type and nature of relationship with perpetrator.

To determine the number of reports by the client.

To explore associations between demographics and frequency of abuse.

#### **1.7. SIGNIFICANCE OF THE STUDY**

Finding out the specific forms of abuse experienced by women in situations of domestic environment will help abused women to be aware of such forms of abuse. Identifying the various emotions expressed by women who have experienced domestic violence will raise awareness of such behaviours. Determining what women do when experiencing domestic violence will help those women who are reluctant to report domestic violence take actions themselves. Sharing the experiences that helped abused women to emerge out of the abusive relationships would help raise awareness to other women who find themselves in the same predicament. Enquiring about services available to assist abused women will help

raise awareness to other abused women who find themselves in the same situation in their communities.

## **1.8. METHODOLOGY**

Data was collected at Daveyton central clinic which is under Ekurhuleni municipality. A descriptive quantitative study was used based on records of abused women obtained who consulted at the clinic between January 2008 and December 2009. All the files of the women who consulted within the specified period were retrieved and every file with a history of violence against women (VAW) were selected. The analysis was based on the information that was written in the files of the patient by the health workers at the centre.

## **1.9. REPORT OUTLINE**

This report comprises of chapters 1 to 5. Chapter 1 is the introductory chapter and it therefore contains the introduction to the topic of VAW, problem statement, aims, objectives, research questions, significance of the study and methodology.

Chapter 2 is the literature review chapter and it cited and explains previous works that has been done in this field. Chapter 3 is the methodology chapter and it also contains ethical considerations. Chapter 4 revealed the result of the data analysis and chapter 5 the conclusion and the implications of the research findings.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1. INTRODUCTION**

In this literature review, I will attempt to review current and previous studies of authors relevant to my area of study. Research studies that have contributed to the field in manner similar to my own dissertation are cited. Literature about types of abused experienced by women in situation of domestic violence, characteristics expressed by women who experienced domestic violence and strategies that abused women have used to help themselves.

Violence against women was defined as any act of gender based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats or such acts as, coercion or arbitrary deprivation of liberty, whether in public or in private life. Violence against women is also considered as an obstacle to the achievement of the objectives of equality, development and peace (Keizire, 1995; Jewkes et al, 2001).

#### **2.2. TYPES OF ABUSE EXPERIENCED BY WOMEN IN SITUATIONS OF DOMESTIC VIOLENCE**

The World Health Organization (WHO) multi-country study on women's health and domestic violence showed that the lifetime prevalence of physical or sexual partner violence, or both, varied between 15 % and 71 % in 10 countries. Violence (physical, sexual or emotional abuse) against women is found at a higher rate globally and is given a health priority for intervention by the WHO (WHO, 2007).

##### **2.2.1. *Sexual abuse***

Numerous studies have already demonstrated that sexual assault in childhood and adolescence is widespread particularly amongst women (Corey & Leslie, 1997; Lechner, Vogel & Garcia-Shelton, 1993). In 2001, more than 15,000 women were sold into sexual slavery in China and these figures shows that violence against

women is a global phenomenon and not just an African problem! In an Australian study by Mazza et al (1996), the prevalence of physical violence was 28 %, emotional violence 20 % and 30 % for sexual violence making sexual violence the commonest in this study population. According to Jewkes et al., (2001), Sexual abuse was also said to be commoner in abusive relationships. According to these reports one third and one half of all battered women are raped by their partners at least once during their relationship. Any situation in which force is used to obtain participation in unwanted, unsafe, or degrading sexual activity constitutes sexual abuse. Forced sex even by spouse or intimate partner with who consensual sex occurred is an act of aggression and violence!

According to Onyejekwe, C.J. (2004), In the United States only, a woman is battered every 15 seconds and 700,000 are raped every year. In India, studies have found that more than 40% of married women were reported being kicked, slapped or sexually abused for reason such as their husbands' dissatisfaction with their cooking or cleaning, jealousy and a variety of other motives such as disputes over dowries. At least 60 women were killed in domestic violence in Kenya in 1998-1999 and 35 % of women in Egypt reported being beaten by their husbands. In North Africa, 6,000 women were genitally mutilated each day and it was also stated that the life time prevalence of experiencing physical violence from a current or ex-husband or boyfriend was 24.6 % and 9.5 % had been assaulted in the previous year in the three provincial study in South Africa (Jewkes, et al.,2001).

### **2.2.2. Physical abuse**

Physical violence and its threat are ugly and means of securing control or dominance (Koos & Goodman, 1994). It is almost certain that violence is multi- dimensional that is, a violent episode is caused by a combination of factors rather than any single factor operating in isolation, and for example a man who believes strongly that the man should be the head of the household will be threatened by loss of work, particularly if the wife is employed. The relationship between drinking and violence is a path that must be treaded with great caution as causal relationship has not been well established in literatures (Krug et al., 2002). However, it has been documented that heavy drinking men may be so focused on their own sexual arousal and feelings of entitlement that they miss or ignore messages intended to convey the woman's

lack of interest thereby inflicting serious physical and sexual assault on their victims(Steele & Josephs, 1990).

### **2.2.3. Emotional Abuse**

The abusers make the victim to feel worthless. They withheld money from the abused, constantly called her names, humiliated and isolate them from friends and family. Threatened to kill her or actually attempted to (Mazza et al, 1996). Then they take full control of the victim's lives. They make these women feel guilty and blame themselves for the wrong they did then play with their emotions to do whatever the abuser wants. This was said to be the most severe form of abuse but yet the most unnoticed violence (Friedman, 2003).

### **2.3. CHARACTERISTICS EXPRESSED BY WOMEN WHO HAVE EXPERIENCED DOMESTIC VIOLENCE.**

Numerous studies have already demonstrated that sexual assault in childhood and adolescence is widespread particularly amongst women (Corey & Leslie, 1997; Lechner & Vogel, 1993; Kenny, et al., 1997).

Danish studies during 1975 and 2001 have dealt with the characteristics of the victims and of the assaults, some of those studies covered rapes or attempted rapes reported to the police and medically examined. Others with notification but without a medical examination, or medically examined victims without police-reports were also documented (Balvig, 1991; Worm, 1997).

Wright and Kariya (1997), studied the Characteristics of female victims of assault attending a Scottish accident and emergency department, however features like obstetric and educational status were excluded and it was more of comparism to their male counterpart.

In several studies from developing countries, it is found that violence is associated with poverty, low socio-economic status, alcohol and substance abuse (van der Straten et al, 1996; Jewkes, Levin & Penn-Kekana, 2002). However they do not include the characteristics of the abused women and the studies were done at provincial level.



At least 60 women were killed in domestic violence in Kenya in 1998-1999 and 35% of women in Egypt reported being beaten by their husbands. In North Africa, 6,000 women were genitally mutilated each day and it was also stated that the life time prevalence of experiencing physical violence from a current or ex-husband or boyfriend was 24.6 % and 9.5 % had been assaulted in the previous year in the three provincial study in South Africa (Jewkes, et al.,2001). However, there has not been any study done at township level, although there are suggestions which have not been confirmed that the prevalence of violence against women is high throughout South Africa, this study will be done at township level-Daveyton. This study will also report the characteristics of victims as opposed to perpetrator.

This study is focusing on the characteristics of victims of VAW at township level and will consider other likely characteristics which have not been fully examined by previous researchers like obstetric status of the abused women, substance abuse and time of the day.

### **2.3.1. Age**

A similar study done in Liberia by WHO revealed the age range of the abused to be between 8 to 95 years (Omanyondo, M.O. 2005). A woman's age is thought to affect the likelihood that she will experience domestic violence. Researchers argues that as a woman ages, she often grows in social status as she becomes not only a wife, but a mother, and perhaps a more economically productive or socially influential member of her community, thus older women are less likely to report current experience of abuse than young women (Fernandez, 1997; McClusk, 2001).

### **2.3.2. General Health Conditions**

Violence experienced by women results in significant morbidity and in some cases, mortality. The experience of sexual abuse as a child has been linked to later development of psychological disorders, drug abuse and dependence (Mullen et al, 1988). Domestic violence has health effects beyond the acute injuries; battered women are more likely to suffer from somatic complaints, anxiety and depression, pelvic pain, and sexual and gynaecological problems. They also use health services more often than women not subjected to domestic violence. Violence against women

has a serious consequences for women's health and well being ranging from fatal outcomes such as homicide, suicide, and AIDS related deaths to non-fatal outcomes such as physical injuries, chronic pain, syndrome gastro-intestinal disorders, gynaecological problems, unwanted pregnancy, miscarriages, low birth weight of children and sexual dysfunction (Bott, Morrison & Ellsberg, 2005). The World Bank estimates that at global level, the damage and costs to health from violence against women aged 15-44 years is comparable to that posed by other risk factors and diseases such as AIDS (World Bank, 2009).

According to World Health Organisation (WHO, 2004), in a multi-country study on women's health and domestic violence against women, women who have experienced violence by a partner have: Worse general health, more symptoms of ill health such as pain and bad memories, more suicidal thoughts and attempts, more induced abortion and miscarriages. Other dominant effects of Violence against women include:

Unintended pregnancy: Women who experience IPV have difficulty using family planning effectively. They are more likely to use contraceptive methods in secret, be stopped by their abusive partner from using family planning, and have a partner who refuses to use a condom. These women also experience a higher rate of unintended pregnancies, have more unsafe abortions, and are more likely to become pregnant as adolescents (Garcia Moreno, 2002).

### **2.3.3. Maternal and child impacts**

Abuse during pregnancy poses immediate risks to the mother and unborn child, and also increases chronic problems such as depression, substance abuse, bleeding, lack of access to prenatal care, and poor maternal weight gain (Campbell, Garcia – Monero & Sharps, 2004). Children of abused women have a higher risk of death before reaching age five and violence during pregnancy is associated with low birth weight babies (Valladares et al, 2002)

#### **2.3.4. STIs/HIV**

Forced and unprotected sex and related trauma increase the risk that women will be infected by STIs and HIV. It was reported in the literature that the prevalence of STIs among women who have experienced violence is at least twice as high as in women who have not (Kishor, Sunita & Johnson, 2004). Recent data have shown a strong correlation also between IPV and HIV. A 2008 report on married women in India reveals that women who have experienced both physical and sexual IPV have HIV infection prevalence four times greater than non-abused women (Silverman et al, 2008). A new study from South Africa shows that relationship between power inequity and intimate partner violence increase the risk of HIV infection in young South African women (Jewkes et al, 2010) and in Tanzania young women, ages 18-29, who have been abused by a partner have been found to be ten times more likely to be HIV-positive than women who have not been abused (Maman et al, 2002).

#### **2.3.5. Socio – economic status**

Within relationships, male control of wealth and decision-making and relationship instability are strongly associated with abuse (Heise et al, 1999). The social and economic costs of violence against women are enormous and have ripple effect throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities, and inability to care for themselves and their children (WHO, 2004).

Education has shown to be a source of empowerment for women facilitating their ability to “gather and assimilate information, manipulate and control the modern world and interact effectively with modern institutions” (Kishor, 2000; Malhotra & Mather, 1997). It hypothesize that women with higher education have greater resources to draw upon in times of need, such as when dealing with a violent partner, hence women with higher education experience less violence.

Status inconsistency theories see violence as resulting from resource imbalance among family members where resources include both material and non-material (such as education and prestige) assets. Patriarchal norms typically imply that men will have more resources than women, and the empowerment of women can upset

this balance. Women can experience violence when patriarchal norms are threatened by resource imbalance in favor of women, which over time can generate stressors within the family (Gelles, 1993).

Internationally studies have shown that women who are economically independent are much less likely to be abused by male partners (Counts & Campbell 1990). Preventing women from working is both a form of abuse and reduces women's ability to resist other abusive acts.

Similar to education, women who are engaged in paid employment are hypothesized to have more say over financial and other household matters than women who are not active in the labor market (Malhotra & Mather, 1997).

### **2.3.6. Number of children**

It was once thought that women with many children were at increased risk of abuse. Research now indicates, however, that domestic abuse increases women's risk of having many children by limiting their ability to control the timing of sex and the use of contraception (Ellsberg, et al. 2000). The relationship between violence and the number of children a woman can be conceptualized such that when there are more children in the household, there is less income per capita, insufficient resources may lead to exacerbated level of stress for the head of the household, which may lead to violence in some instances, hence the more the children the greater the likelihood of violence (Martin *et al*, 1999). According to multi-country domestic violence study by WHO, results showed that women with no children have the lowest rates of ever – experience of violence, and in most countries women with five or more children have the highest likelihood of experiencing violence(WHO, 2007).

## **2.4. EFFECTS OF ABUSE**

### **2.4.1. Intergenerational effect**

The intergenerational transmission of violence is one of the most often studied explanations of partner violence. Through intergenerational transmission process children learn how to behave both by experiencing how others treat them and by observing how their parents treat each other. According to Stith et al (2000), in a

meta-analytic study, found that growing up in an abusive family is positively related to becoming involved in a violent marital relationship.

#### **2.4.2. *Psychological Factors***

Many women consider the psychological consequences of abuse to be even more serious than its physical effects. The experience of abuse often erodes women's self-esteem and puts them at greater risk of a variety of mental health problems, including depression, post-traumatic stress disorder, suicide, and alcohol and drug abuse.

#### **2.4.3. *Depression***

Depression is becoming widely recognized as a major health problem resulting from abuse worldwide (Ustun, T.B.1999). Women who are abused by their partners suffer more depression, anxiety, and phobias than women who have not been abused, according to studies in Australia, Nicaragua, and the USA (Cascardi et al, 1995, Ellsberg et al, 1999 & Danielson et al, 1998). Among women of ages 15 to 49 in Nicaragua, for example, battered women were six times more likely to experience emotional distress, as measured on an international mental health scale, than were other women. Physical abuse was the single most important risk factor for emotional distress in this study, accounting for roughly 70 % of mental health problems among women. Sexual assault in either childhood or adulthood is also closely associated with depression and anxiety disorders (Cascardi et al, 1995). They also asserted that, the most likely to lead to psychological disorders are sexual abuse occurring before age seven or eight, abuse by more than one perpetrator, abuse that includes genital or anal penetration, and abuse that is frequent or continues over a long period of time.

#### **2.4.4. *Post-traumatic stress disorder (PTSD)***

Many abused women experience PTSD, an acute anxiety disorder that can occur when people go through or witness a traumatic event in which they feel overwhelming helplessness or threat of death or injury. The symptoms of PTSD include mentally reliving the traumatic event through flashbacks, or "flooding"; trying

to avoid anything that would remind one of the trauma; becoming numb emotionally; experiencing difficulties in sleeping and concentrating; and being easily alarmed or startled.

Rape, childhood sexual abuse, and domestic violence are among the most common causes of PTSD in women. The chances that a woman will develop PTSD after being raped are between 50 % and 95 %, according to studies in France, New Zealand, and the US (Darves-Bornoz, 1997). He also found out that the psychological effects of being raped were comparable to the effects of being tortured or kidnapped.

#### **2.4.5. *Suicide***

Gillespie and Lupton (2002) argue that some of these women decide to end their lives because they cannot go on living like that; that is they cannot stand the pain of being abused day in and day out. Barnett and Parrin (2005) believe that these abused women try to please their husbands in every way they can think of. For some women the burden of abuse is so great that they take their own lives or try to do so. Studies from a number of countries, including Nicaragua, Sweden, and the US, have shown that domestic violence is closely associated with depression and subsequent suicide (Darves-Bornoz, 1997; Cascardi et al,1995; Ellsberg et al,1999 & Danielson et al,1998). Battered women who develop PTSD appear to be most likely to try suicide. Women who have experienced sexual assault either in childhood or as adults are also more likely to attempt suicide than other women. The link is strong even after controlling for such individual risk factors as women's sex, age, and education and for presence of PTSD symptoms and psychiatric disorders.

#### **2.4.6. *Alcohol and drug use***

Victims of partner violence and women that were sexually abused as children are more likely than other women to abuse alcohol and drugs, even after controlling for such other risk factors as prior use, family environment, or parental alcoholism (Heise, Ellsberg, & Gottemoeller, 2008). In a survey among women seeking primary care, those who had been abused by their partners within the previous year were three times more likely than those not recently abused to be drinking large amounts

of alcohol and four times more likely to be using drugs (Mc Clusky,2001). Domestic violence undermines children's well-being and conflict between parents frequently affects their young children. Children who witness marital violence face increased risk for such emotional and behavioural problems as anxiety, depression, poor school performance, low self-esteem, disobedience, nightmares, and physical health complaints. Such children are also more likely to act aggressively during childhood and adolescence (Ellsberg et al, 1999).

## **2.5. WHAT WOMEN CAN DO WHEN EXPERIENCING DOMESTIC VIOLENCE**

According to Johan (1994) most abused women are reluctant to report the abuse to the prosecutor and other professionals who are trying to help them and end the abuse because they love the man. This may sound strange to people who are not experiencing this love. Perhaps in some cases it is almost like obsessive compulsive live interest, in which the fear of losing the man is much more frightening than the abuse to which one has become conditioned. The abused women know that this kind of thinking is not logical, yet victims of domestic violence tend to think this way. Until the abuse tends to get so severe or so frightening or so threatening that the victim realizes she had to end it or risk of losing her life or killing the abuser. According to Manor (1999), the only foolish part is for the victim of abuse to think that the abuse will end and she is taking some sort of steps to reform the abusers attitude and behaviour. Dobash and Dobash (1992) believes that the fear of loneliness, the belief that one is unable to help oneself, the dependency on the abuser and the fear of being rejected is so overwhelming that even the abuse seem tolerable. Victims of abuse think about many times when their abusive males were affectionate, loving and caring. These good times get so elevated in their memories and the bad times get buried deep within their subconscious minds. Such thinking enables the abused women to continue to tolerate the abuse without even thinking of reporting the abuse to the police. Ending the relationship may sound like impossible task. Sometimes it comes about as part of the progression of the bad relationship. In other words for how long psychologically and emotionally, can make the person feel affection towards the man that has battered, ridicule isolated verbally attacked and destroy ones' soul. Renvoize (2002) states that abused women can do something for

themselves like leaving the abusers and take control of their lives. A victim may suddenly realize that her abusive man does not love her. While this is devastating it is part of the process of recognizing that the relationship is on the skids and is to sink unless effective measure is done to repair it. Maybe ending the love will result from a victim's exposing herself to various help groups and individuals in the community willing and able to work with her.

Dulton (1992) believes that the most important first step for the victim of abuse in taking an action to end their abuse is to expose their abuse, by telling somebody about it. This is to report the abuse to someone who can act or do something about it e.g. police, social services, and a friend. The victims of domestic violence are vulnerable and helpless.

Women living with violence often develop coping strategies they use to protect themselves. It is important that they identify and acknowledge their strengths and what they can do to keep themselves safe. Many women living with violence have a safety plan around what they will do if they feel threatened. Here are some things they can do.

#### **2.5.1.     *Make a safety plan***

If a woman is living with violence, safety is a key priority. The period soon after leaving a violent partner can be a dangerous time. So too can staying with an abusive partner. Making a safety plan can be helpful as it allows them to think through how to best protect themselves. Their plan may include who to call or where to go if they feel threatened. If they can, have money, phone numbers and important documents accessible to you if they have to leave in a hurry. They may consider having a bag packed with items such as clothing, medication, toiletries, children's toys and a spare set of keys. If they have children it is important that they know what to do.

#### **2.5.2.     *Developing a Safety Plan***

Health care providers can help women protect themselves from domestic violence, even if the women may not be ready to leave home or report abusive partners to



authorities. When clients have a personal safety plan, they are better able to deal with violent situations. Providers can review these points and help each woman develop her own personal safety plan: Identify one or more neighbours you can tell about the violence, and ask them to seek help if they hear a disturbance in your home. If an argument seems unavoidable, try to have it in a room or an area that you can leave easily. Stay away from any room where weapons might be available. Practice how to get out of your home safely. Identify which doors, windows, elevator, or stairwell would be best. Have a packed bag ready, containing spare keys, money, important documents, and clothes. Keep it at the home of a relative or friend, in case you need to leave your own home in a hurry. Devise a code word to use with your children, family, friends, and neighbours when you need emergency help or want them to call the police. Decide where you will go if you have to leave home and have a plan to get there (even if you do not think you will need to leave). Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he is demanding to calm him down. You have the right to protect yourself and your children. They must also be reminded that they do not deserve to be hit or threatened

## **2.6. INQUIRING ABOUT ABUSE**

Caring professionals, relatives and friends feel an obligation to make a sensitive inquiry of their friends or even stranger in some cases to find out whether the person might be abused. Kleint (2001) states that a word of warning is that one should expect to deny that she is being abused.

### **2.6.1. *First response***

Karmen (1990) say that it is absolutely critical that whoever the victim tells about the abuse show sympathy, make it clear that he or she believes the victim no matter how bizarre or horrible the details of the abuse are. Abuse victims maybe more likely to tell strangers casual acquaintances about the abuse than family members and close friends. The professionals or casual acquaintances should not be surprised if the person who tells them about the abuse has not told her family members or friends.

### **2.6.2. The Police**

Dobash and Dobash (1992) see that all police officers need to be effectively trained in appropriate handling of domestic violence cases preferably by a team involving a police officer, prosecutor and staff member from a domestic abuse centre. Kleint (2001) the training of the police officer given in this area should be extensive and should involve guest speakers, experts and most certainly domestic abuse victims to tell of their experiences. The training must aim to make officers sensitive to the experiences of domestic violence victims and go beyond teaching them when and how to make a mandatory arrest.

### **2.6.3. Approaching a victim of domestic abuse to offer help**

Viano (1992) stated that in every case it is important that the person, who offer help develop some sort of rapport with the victim, gains trust and does not violate the trust. The one who wishes to help someone whom he or she believes might be a victim of domestic violence must exhibit a demeanour which is supportive, friendly, trustworthy and reliable for instance if you are a medical doctor and the nurse suspects that the person has lied to you about how she revived an injury seen as bruises, broken bones and black eyes. The approach may be to contact the victim with the fact that her story does not match the physical injury that you are treating and ask if she is the victim of domestic violence in a sensitive way. At such time, the victim needs to know that she will have at least a support while trying to regain control of her own freedom and future.

Some signs may indicate that someone is experiencing domestic and family violence. They may:

- seem afraid of their partner or always be very anxious to please them
- stop seeing you, other friends or family and become isolated
- become anxious or depressed, unusually quiet or may lose confidence
- be denied adequate care if they are an older person or a person with a disability and the person caring for them is abusive
- have a partner who is jealous and possessive and accuses them of being unfaithful

have a partner who continually phones or texts to check on them when away from the house

have physical injuries (bruises, sprains or cuts on the body) and may give unlikely explanations for these injuries

finish phone calls when their partner comes into the room

be reluctant to leave their children with their partner

say their partner or carer gives them no access to money, makes them justify every cent that is spent or makes them hand over their money.

Your help can make a difference.

The way you respond to someone experiencing domestic and family violence is really important and can make a difference. If your response supports and encourages them to talk about the situation, they may feel stronger and more able to explore their options and make decisions. Your friend or family member may not be aware that what they are experiencing is domestic and family violence and that it is illegal.

Do not be surprised if your friend or family member denies there is a problem, rejects your support or becomes defensive. They may be afraid to tell you or scared of worrying you if they tell you about the abuse. When approaching someone experiencing domestic or family violence, it is helpful if:

They are alone and it is safe for them to speak.

You approach them in a sensitive, respectful and caring way, for example, by saying: "I am worried about you because I've noticed you have been unhappy lately" to start the conversation.

You respect their decision if they do not want to talk about the domestic violence – they may be afraid of talking about it or ashamed, or they may not be ready to admit to being abused. It may take some time for them to feel comfortable and safe to talk about their situation.

Following are some examples of what you might say to someone experiencing domestic or family violence:

“I don’t think it is okay for anyone to treat you like that”

“I believe everyone deserves to be treated with respect, especially by those who say they love us and care for us”

“I’ll be here for you if, and when, you are ready to talk”.

Respect their right to make their own decisions. When the person being abused is ready to talk, it is important to listen to them without making a judgement and to take the issue seriously. It is also important to respect the decisions they make and help find ways for them to become stronger and safer. Even if you do not agree with their decisions, you should respect their right to make their own decisions. Listen to what they have to say, this is one of the most important things you can do. Remember that they are confiding in you and may have kept this problem a secret from others. Encourage them to understand that they have a right to a life free from abuse. Focus on how they are feeling and how they are coping with the domestic and family violence. For example, you could ask: “How have you been managing? How is their behaviour affecting you?”. Be open and show you believe what they are telling you. People who are abused are more likely to minimise the abuse and to make excuses for the person abusing them than they are to exaggerate. Many people who use abusive behaviour can appear caring and charming but this does not indicate the kind of person they may be behind closed doors. Many are only abusive to their partner or family members and not to other people. Some victims of domestic and family violence may not see themselves as being abused. They may accept it as a normal part of their life or may not be able to see a way out of the situation. Let them know the domestic and family violence is not their fault. No one deserves to be abused. You could say things like: “The way you are being treated is wrong – it’s abuse” or “People feel angry but everyone has a choice in how they respond to the situation. Anger is not an excuse for domestic violence”. Focus on their safety and their children’s safety; if children are involved let them know you are worried about their safety (and their children’s safety) by making statements such as: “I am really afraid for your safety”.

## **2.7. MEANS OF ASSISTANCE AVAILABLE TO ABUSED WOMEN IN THE COMMUNITY**

According to Dulton (1992), having someone to talk to is exceedingly important to abused women. One does not however always expect that the person approached will be willing to listen, but she is extremely grateful when someone does. Kirkwood (1999) stated that when battered women do reveal their private troubles to a friend, relatives or neighbours they usually seek for emotional support from a sympathetic listener and marital assistance in the form of temporary refuge. The response of this request usually is sympathetic. Most of those approached are willing to listen to abused women and many will give a few hours or overnight refuge.

### **2.7.1. *Educational, occupational and economical resources***

The level of education, job skills employment, experience and current employment are all important resources that may make a difference in the abused women ability to respond effectively to the violence against her. Many women do not have the economic resources to continue on their own, from the time they leave the shelter. The availability of low cost transitional housing is typically quite scarce in most communities (Malhotra and Matter, 1997).

### **2.7.2. *Police restraining order***

Roy (1999) stated that police restraining order is one of other assistance that abuse women can turn to, to stop violence against them. By reporting the violence to the police may be the first step to take away the misery the abuse women seems to suffer from. The need to go to police station to report what has happened to them, so that they can get restraining order against their abusers.

### **2.7.3. *Shelters***

According to Kirkwood (2000) providing shelter is another form of assistance that other women can use. However, it should be borne in mind these women are not supposed to stay for long time. They are expected to stay for not more than two to three weeks. Because of the temporary nature of these shelters coupled with

unemployment of the abused women, they may end up going back to their husbands.

#### **2.7.4. Support groups**

Kleint (2001) believes that sometimes it is better to know that one is not alone when encountering problems at home. Most women tend to turn to support groups to get support, and some advice to handle the similar problems that other women used to help themselves in order to solve a similar problem. Some of women claim that the support groups that are in their communities are really helping them. Due to these supports groups, these women tend to be assertive and make things better at home.

#### **2.7.5. Social support**

Social and emotional support from the others may play a significant role. In both battered women's ability to respond to the violence against her, and in terms of the psychological impact of the violence itself. Social support also creates a sense of belonging and affiliation (Kleint, 2001).

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.1. INTRODUCTION**

This chapter outline the study's research design, the selection of participants and how they were sampled, the setting of the study and the analysis of data. It also gives an overview of research instrumentation and the training of the research assistant. Issues of ethical consideration are explained. It ends by explaining the processes of data collection processes and data analysis.

#### **3.2. THE STUDY DESIGN**

This is a descriptive quantitative study where records of abused women who consulted at Daveyton Clinic were reviewed. Data was collected retrospectively.

#### **3.3. STUDY POPULATION**

All records of abused women who consulted at Daveyton Clinic between January 2008 and December 2009 were reviewed. According to the centre register women who visited the centre during this period were about 15,000. The desired sample size was 380. However, only 251 records were reviewed.

#### **3.4. STUDY SETTING**

The study was conducted in Daveyton central clinic which is located at in Daveyton town. Daveyton is a big town located under Ekurhuleni Metropolitan Municipality, Gauteng Province, South Africa . The centre operates from 08h00 to 16h30 during week days during this period but is being operated on a 24hrs basis.

#### **3.5. SAMPLING PROCEDURE**

The researcher retrieved all the files of women who consulted during the said period. All the files for the patients with the diagnosis in question and falling in the period under review were collected, reviewed and the needed information extracted. The

sample size was therefore all the files of the abused women and all were included in the study.

### **3.6. DATA SOURCES**

The hand written information in files of victims of violence that consulted in Daveyton clinic between January, 2008 to December, 2009 were reviewed. Data included the following variables: victim age, education, marital status, employment status, substance use and so on. The participants were between the ages of 11–50 years. The data collection technique used the available information in patient's file. Data abstraction form was developed and used (see appendix 1). The researcher chose this method of data collection because she was mindful of the sensitivity of the topic, time and the psychological effect that the interview could have to the participants.

**Inclusion criteria:** All files of the victims of 'violence against women' that consulted at Daveyton clinic between the specified periods were included in the sample population. Those who consulted and were later referred to other hospitals for specialized or further management were also included. Also included were the signs and symptoms patient presented with on consultation date, the file number per consultation to find out the numbers of times the patient had consulted, the diagnosis, the treatment given and so on.

**Exclusion criteria:** This included the files of victims of 'violence against women' prior to January 2008 and after December 2009 that consulted at Daveyton clinic. Victims who consulted at other hospitals were also excluded as it may prove difficult to obtain access to their files.

### **3.7. ETHICAL CONSIDERATION**

Confidentiality in reviewing records of abused women was maintained by using numerical identification of files and presenting aggregate, not individual data. Research proposal was presented to the Research Committee of the School of Health Care Science at University of Limpopo MEDUNSA Campus.

Permission was also sought from the regional department of Health. This was done by a written letter of permission stating the nature of study, the time lines, and the



way the files and the collected data will be handled, as well as the significance of the study to the clinic and Daveyton Township as a whole.

As with most quantitative research by secondary data analysis, this research is also plighted with the inability to obtain informed consent from the patient.

The data were handled with care in a confidential and anonymous manner which is the sole reason names and surnames were not included in the data. File numbers were used in order to avoid violation of patient privacy and anonymity. No person other than the researcher was given access to the patient files. Data was collected within the hospital environment and patients' files were not taken out of the hospital premises. Data collection, recording and reporting were not linked to the identification of patients but to the institution. Data collection instruments remained under lock and key and will be destroyed after the publication of the report. The report of the research will be sent to the regional health department, research and ethics committee of department of health and University of Limpopo.

### **3.8. DATA COLLECTION TOOLS**

The demographic and clinical data of all abused women who visited Daveyton Central clinic were collected. Data abstraction form developed by the researcher was used (-Appendix 1).

### **3.9. DATA COLLECTION**

The data collection technique uses available information in patient's files. Data abstraction form was developed and used.

### **3.10. DATA RELIABILITY**

Reliability will estimate the consistency of my measurements, or more simply the degree to which the tool which in this case is the data abstraction form determines issues the same way each time it is used under the same conditions with the same subjects. The same data abstraction forms were used to asses all cases; this ensured complete reliability of the tool when comparing cases as data abstraction form will report exact information given by patient.

### **3.11. DATA VALIDITY**

The researcher worked in this clinic and so understands the sensitivity of violence against women. There was a vigorous literature review about violence against women (VAW). The supervisor - Ms Mathilda Mokgatle–Nthabu assisted the researcher, hence confident about the use of VAW terminology.

### **3.12. DATA ANALYSIS**

After data collection, the responses were transferred into codes for data entry. Data were entered into a Microsoft Excel spreadsheet programme and thereafter imported to SPSS 12.0.1 for analysis. The researcher found it appropriate for analysing quantitative data. Analysis included frequency distribution according to place, age, marital status, education, employment, abuse type and substance use. The variables were classified as demographic data and clinical data which include presentation at the centre, type of abuse, substance abuse, frequency of reporting, and time of reporting, obstetric status, disabilities, number of children, relationship with the perpetrator and occupation of the perpetrator.

### **3.13. LIMITATIONS OF THE STUDY**

Daveyton Clinic is not the only health care facility available around Daveyton. There is also Far East Rand hospital which is a level one hospital and also manages victims of violence.

As with most quantitative research by secondary data analysis, this research is also plighted with the inability to obtain informed consent from the patient.

Finally, the problem of missing information as some health worker did not fill in all the needed variables.

## CHAPTER 4

### DATA ANALYSIS AND RESULTS

#### 4.1. INTRODUCTION

This chapter presents the results of the statistical analysis of the collected data and is presented according to the objectives of the study which are:

To identify types of abuse experienced by the women.

To identify the type and nature of relationship with perpetrator.

To determine the number of reports by the client.

To explore associations between demographics and frequency of abuse.

#### 4.2. SOCIO-DEMOGRAPHIC PROFILE OF THE ABUSED WOMEN

The results are presented in frequency tables and graphs for descriptive analysis.

A total of 251 female came to the hospital because of abuse. Four women's age were not recorded. Majority of the women (72.8 %) were 30 years or younger (Figure 1). The average age of the women was 26.55 years (SD = 8.8 yrs). More than half (59.8 %) of the women were single (Figure 2), majority of them (88.8 %) had secondary education (Figure 3), and almost half of them (45.4 %) were unemployed (Figure 4) and (Table.1).

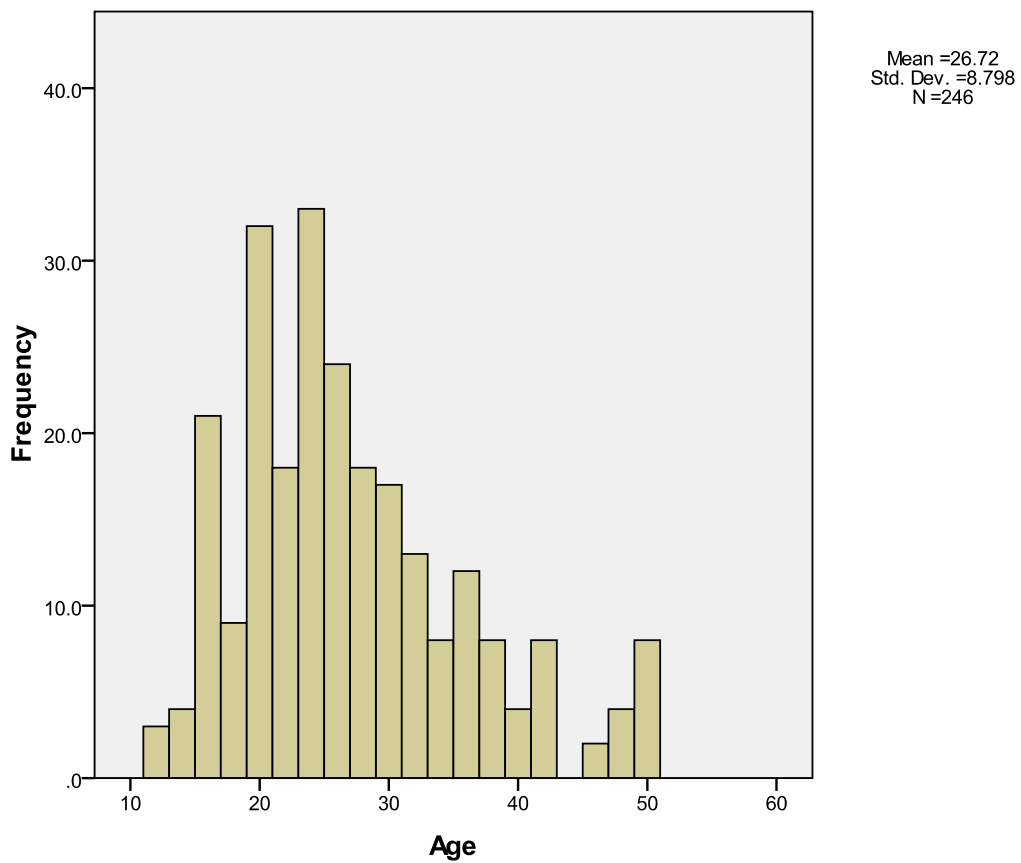
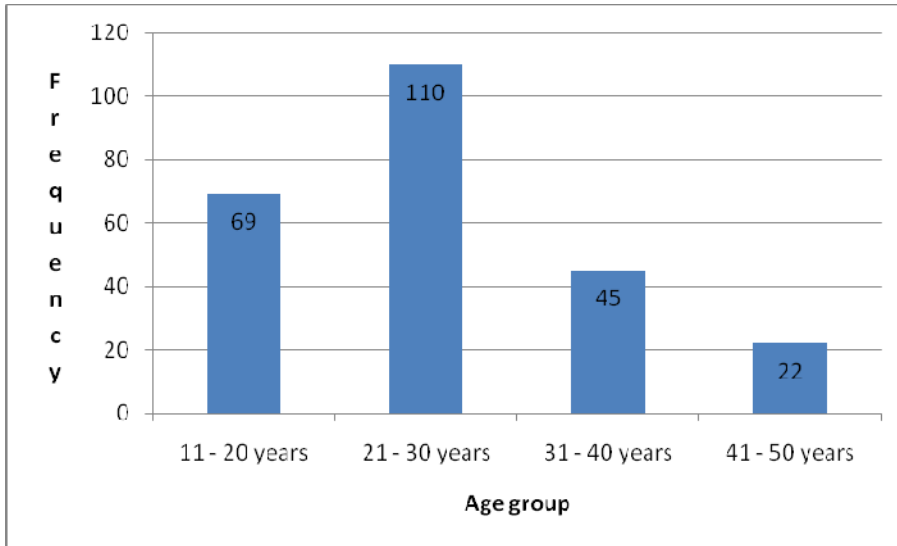
**Table 1: A summary of Socio-demographic information of the abused women attending Daveyton Clinic.**

Variables	Frequency	Percent
<b>Age group</b>		
11 - 20 years	69	28.0
21 - 30 years	110	44.7
31 - 40 years	45	18.3
41 - 50 years	22	8.9

Mean age (SD)	26.55 yrs (8.8 yrs)	
<b>Marital status</b>		
Single	150	59.8
Married	25	10.0
Divorced	41	16.3
Separated	35	13.9
<b>Education</b>		
High school	223	88.8
Tertiary	23	9.2
Other	5	2.0
<b>Employment status</b>		
Student	37	14.7
Part time employment	65	25.9
Full time employment	35	13.9
Unemployment	114	45.4

#### ***4.2.1. Age distribution of abused women***

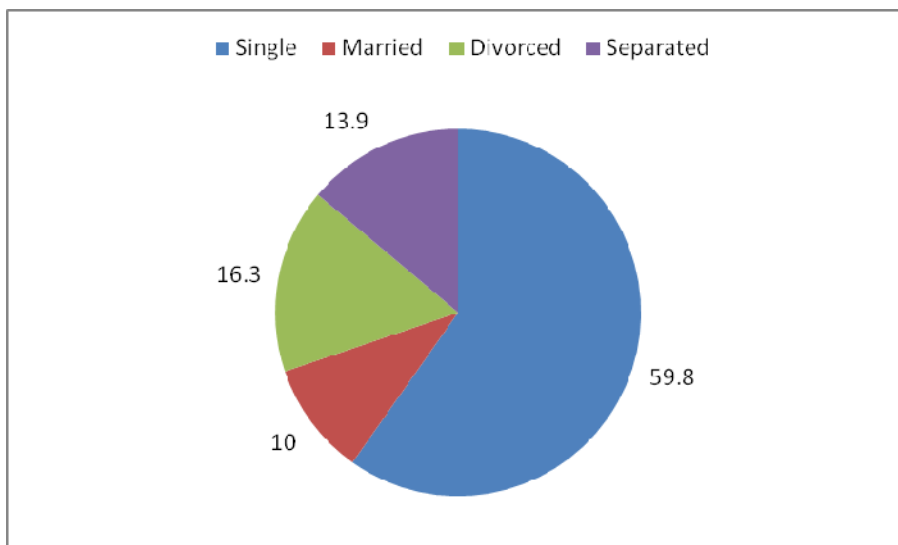
About 28 % of the respondents were between the ages of 11-20 years, 44.7 % were between the ages of 21-40 years (Highest), 18.3 being between the ages of 31-40 year and about 8.9 % being in the age range of 41-50 years. The mean age was 26 years.



**Figure 1: Frequency distribution of age group of the participants (Bar chart & Histogram).**

#### **4.2.2. Marital status of abuse women:**

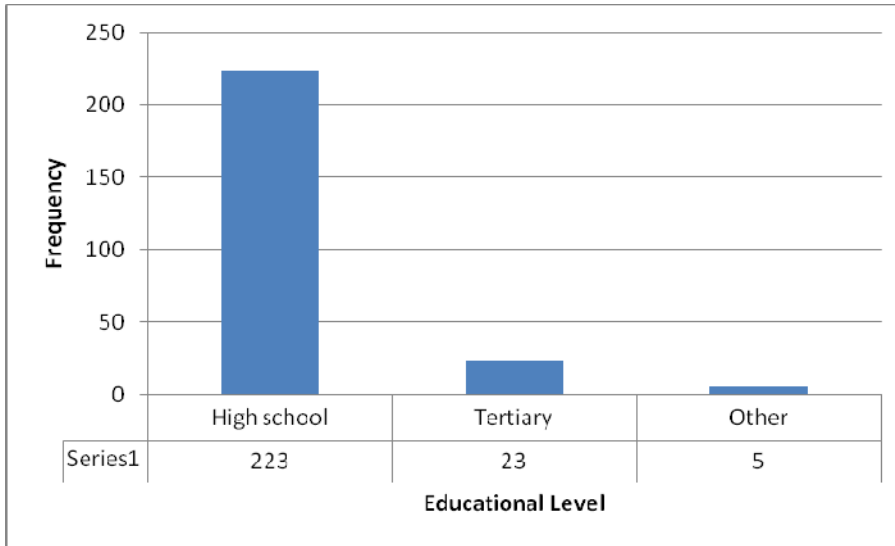
Most of them were single 59.8 % while 10 % were married, 16.3 % divorced and 13.9 % were separated.



**Figure 2: Marital status of the abused women**

#### **4.2.3. Educational level of abused women**

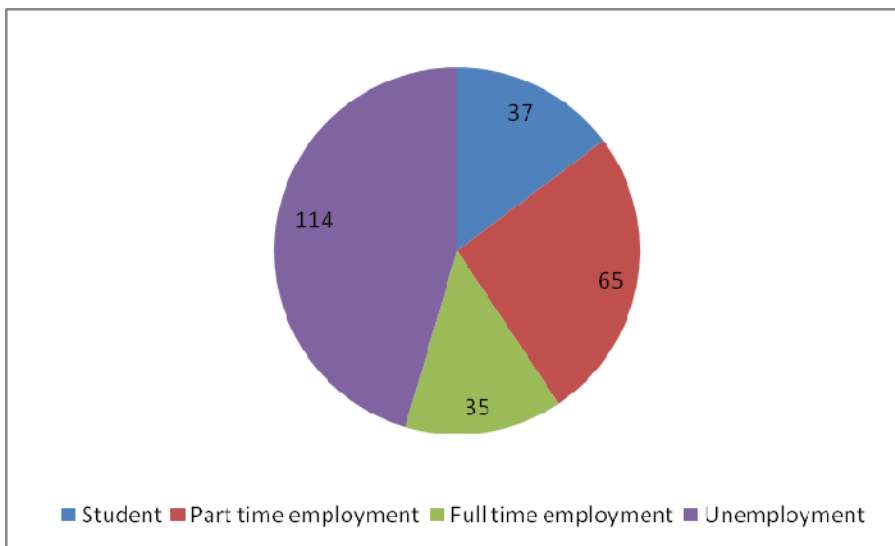
Only five of the cases had no formal education while close to 88.8 % (223) had at most a secondary school education and the rest 9.2 % (23) had tertiary education.



**Figure 3: Education level of the respondents**

**4.2.4. Employment status of the study sample**

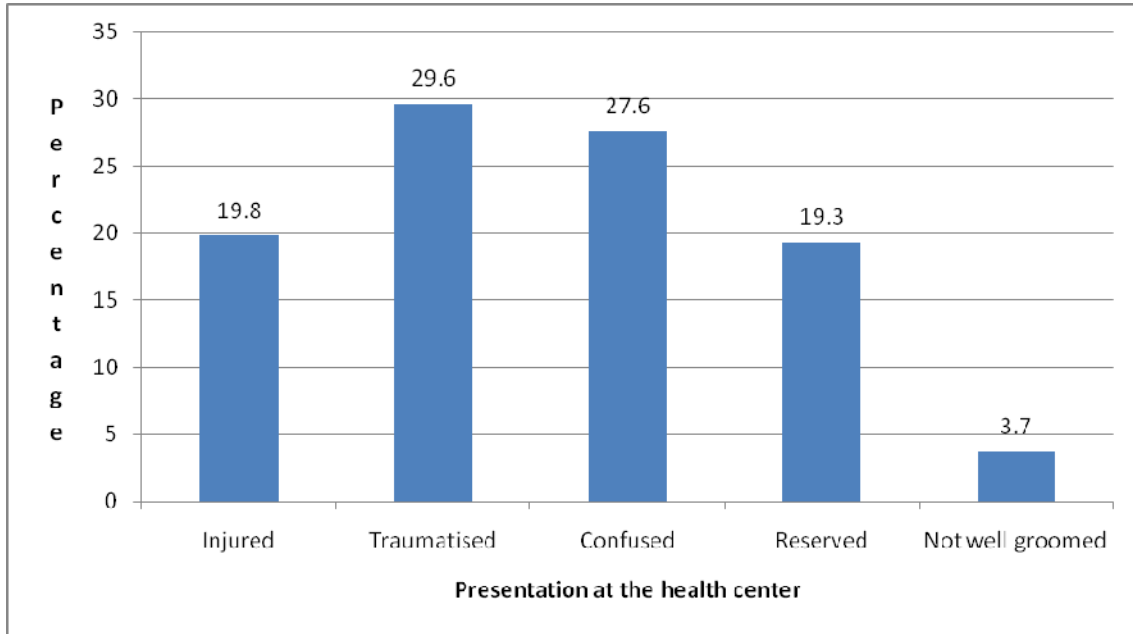
About 45.4 % (114) of the cases were unemployed and 14.7 % (37) were students. This gives a total of close to 60 % (151) of cases who were economically inactive. The rest of the respondents were either in full time (13.9 %) or in part time (25.9 %) employment.



**Figure 4: Employment status of the abused women who attended the health centre**

### 4.3. PRESENTATION AT THE CENTRE:

At the time of presentation at the health centre, more than quarters (29.6 % and 27.6 % respectively) were traumatized or confused (Figure 5).

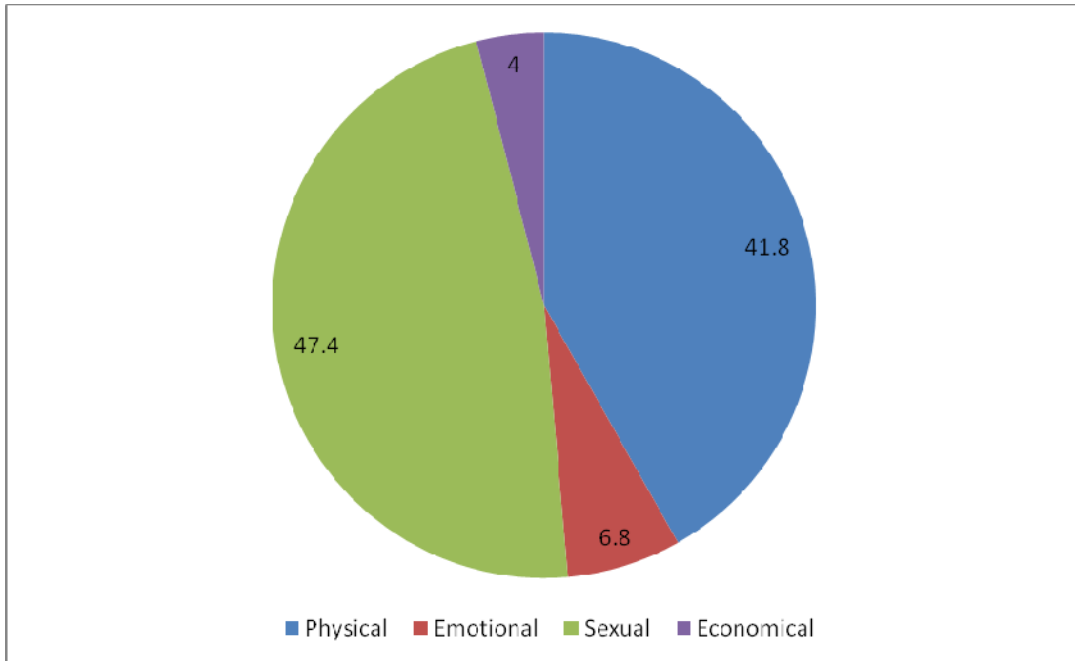


**Figure 5: Women's presentation at the health centre after being abused**

### 4.4. DISTRIBUTION OF TYPES OF ABUSE EXPERIENCED BY WOMEN

Figure 6 shows different types of abuse experienced by women attending the health centre. Regarding types of abuse, about half of them (47.4 %) experienced sexual abuse and another 41.8 % experienced physical abuse.

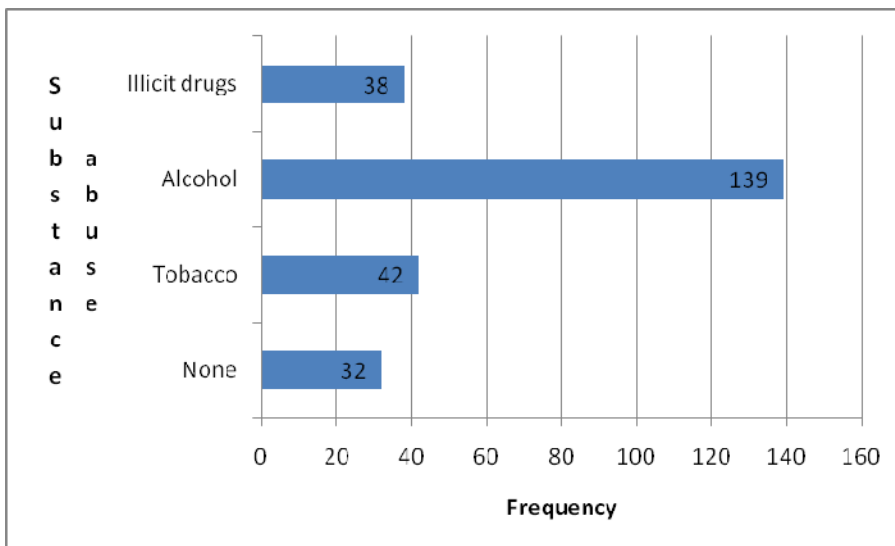




**Figure 6: Types of abuse experienced by women attending health center (%)**

#### 4.5. DISTRIBUTION OF SUBSTANCE ABUSED BY ABUSED WOMEN

Figure 7 shows the distribution of substance uses among the abused women. Among the abused women, more than half (55.4 %) abused alcohol.



**Figure 7: Distribution of substance abused by abused women attending the health centre.**

#### 4.6. EMOTIONAL STATUS OF ABUSED WOMEN

Sixty two abused women's emotional status was missing. Considering emotional status of the women, more than a third (35.4 %) were angry followed by submissive (24.9 %) (Table 2).

**Table 2: Emotional status of abused women attending the health centre**

<b>Emotional status</b>	<b>Frequency</b>	<b>Percent</b>
Anger	67	35.4
Stubbornness	39	20.6
Submissive	47	24.9
Aggressive	28	14.8
Over sensitive	8	4.2

Regarding frequency of reporting of abuse, 63.6 % reported their abuse yearly and one tenth (10.1 %) reported weekly (Table 3).

#### 4.7. FREQUENCY OF ABUSE:

**Table 3: Frequency of reporting of the abused women attending the health centre**

<b>Frequency of reporting</b>	<b>Frequency</b>	<b>Percent</b>
Weekly	13	10.1
Monthly	34	26.4
Yearly	82	63.6

#### 4.8. REPORT AND TIME OF REPORTING

Table 4 summarizes periods and time of reporting of the incidences. Almost half of them (48.6 %) had missing information regarding frequency of reporting. Those who had information available, among them more than two-thirds (67.7 %) of the abuse reported during the festive season and more than half (59.8 %) was reported at night.

**Table 4: Period and time of reporting of the abused women attending the health centre**

<b>Period of reporting</b>	<b>Frequency</b>	<b>Percent</b>
Festive season	170	67.7
Non-Festive season	81	32.3
<b>Time of reporting</b>	<b>Frequency</b>	<b>Percent</b>
Morning	27	10.8
Day	74	19.5
Night	150	59.8

#### 4.9. OBSTETRICS STATUS AND NUMBER OF ABUSED WOMEN

About one fifth (18 %) of the women reported that they were abused during their pregnancy. Also more than half (54.2 %) were intellectually disabled. More than a third (38.7 %) of the abused women had no children (Table 5).

**Table 5: Obstetric status of the abused women attending the health centre**

<b>Obstetric status</b>	<b>Frequency</b>	<b>Percent</b>
Pregnant	44	18.0
Non-Pregnant	201	82.0
<b>Number of children</b>	<b>Frequency</b>	<b>Percent</b>
0	72	38.7
1	36	19.4

2	46	24.7
3	21	11.3
4	7	3.8
6	4	2.2

#### 4.10. WOMEN'S RELATIONSHIP WITH THE PERPETRATOR AND PERPETRATORS DEMOGRAPHIC INFORMATION

More than half (54.8 %) of the women were abused by their partners and almost a fifth (17.0 %) were abused by others (Table 6). Majority of the perpetrators (81.3 %) were either unemployed or had non-formal job. Almost half (49.6 %) of the perpetrators were between the ages of 31 and 50 years (Table 7).

**Table 6: Women's relationship with the perpetrator and perpetrators demographic information**

Relationship with perpetrator	Frequency	Percent
Husband	16	6.6
Partner	132	54.8
Uncle	26	10.8
Father	5	2.1
More than one perpetrator	21	8.7
Others	41	17.0

**Table 7: Occupation and age of perpetrators**

Occupation of the perpetrator	Frequency	Percent
Unemployed	66	41.3
Formal	30	18.8
Non-formal	64	40.0
Age of perpetrator	Age	Percent

10 - 30 years	50	37.0
31 - 50 years	67	49.6
51 years or more	18	13.3

#### 4.11. ASSOCIATIONS BETWEEN DEMOGRAPHIC VARIABLES AND TYPES OF ABUSE

##### 4.11.1. Association between age and types of abuse

Age was significantly associated with different types of abuse as younger women (<30 years) were more abused than older women ( $p=0.011$ ) (Table 8).

**Table 8: Associations between age and types of abuse**

Age group	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
11 - 20 years	30	4	35	16.661	0.011
21 - 30 years	35	13	62		
31 - 40 years	26	5	14		
41 - 50 years	14	0	8		

##### 4.11.2. Association between marital status and types of abuse

Marital status was also significantly associated with different types of abuse ( $p=0.001$ ). This means that single or divorced or separated women were more likely to be victims of sexual abuse (Table 9).

**Table 9: Association between marital status and types of abuse**

Marital status	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
Single	71	4	75	19.552	0.001
Married	10	5	10		
Divorced or separated	24	13	34		

**4.11.3. Association between employment status and types of abuses**

Table 10 shows the association between employment status and types of abuses. Women's employment status was statistically associated with types of abuse as physical and sexual abuse was more common among women who were unemployed or had part time employment ( $p < 0.001$ ).

**Table 10: Association between employment status and types of abuse**

Employment status	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
Student	18	0	19	28.507	<0.001
Part time employment	23	0	42		
Full time employment	11	8	11		
Unemployment	53	14	47		

**4.11.4. Association between substance uses and types of abuse**

Types of abuse was associated with substance abuse as prevalence of physical and sexual abuse was more common among women who took alcohol ( $p = 0.019$ ) (Table 11).

**Table 11: Association between substance uses and types of abuse**

	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
Substance abuse					
Tobacco	23	5	14	11.742	0.019
Alcohol	61	12	66		
Illicit drugs	6	5	22		

**4.11.5. Association between period of reporting and types of abuse**

It was found that types of abuse and period of reporting were significantly associated as physical and sexual abuse were reported more during festive seasons ( $p=0.006$ ) (Table 12).

**Table 12: Association between period of reporting and types of abuse**

Period of reporting	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
Festive season	79	9	77	10.291	0.006
Non-Festive season	26	13	42		

**4.11.6. Association between relationship with the perpetrator and types of abuse**

Types of abuse was significantly associated with relationship with the perpetrator ( $p<0.001$ ). This indicated that women were emotionally or economically abused more by father or uncle or where there was more than one perpetrator (Table 13).

**Table 13: Association between relationship with the perpetrator and types of abuse**

Relationship with perpetrator	Type of abuse			Chi-Square value	P value
	Physical	Emotional or Economical	Sexual		
Husband	7	0	9	45.085	<0.001
Partner	66	0	61		
Father or Uncle	13	10	8		
More than one perpetrator	19	11	32		



## **CHAPTER FIVE**

### **DISCUSSION, CONCLUSION AND RECOMMENDATIONS**

#### **5.1. INTRODUCTION**

The purpose of the study was to examine characteristics of abused women, who consulted at Daveyton Central Clinic.

In this chapter results are discussed and analysed under the following headings: demographic data which consist of age, marital status, educational status and employment status and clinical data which consist of presentation at the centre, type of abuse, substance abuse, frequency of reporting, period of reporting, time of reporting, obstetric status, disabilities, number of children relationship to the perpetrator and occupation of the perpetrator.

#### **5.2. DISCUSSION**

Demographics and clinical data are clearly discussed here below:

##### ***5.2.1. Demographic Data***

###### ***Age group***

This study shows that the majority of respondents were under the age of 40 years and most of them 44.7 % being between ages 21-30 years (Figure 1). This is consistent with earlier findings that older women are less likely to report current experience of abuse than young women (Fernandez, 1997; McClusk, 2001). This appeared to apply in the study conducted at Daveyton. Older women do not report abuse probably because of the financial dependency and security; even if abuse is identified by the neighbors they do not want to report it as they don't want to interfere with other people's business.

###### ***Marital status***

Among the abused women most of them were single 59.8 % while about 30 % were either separated or divorced and the rest were married(Figure 2). According to Renvoize, 2002 there are high numbers of women who are abused by their husband or spouses, and these women continue to think that situation will improve or become normal because their partners love them, and therefore do not report this to police. However this situation does not apply to Daveyton as most reported cases were single.

### ***Educational level of abused women***

A look at educational level reveals that only 5 (2 %) cases had no formal education or stopped at primary level, 88.2 % (223-majority) had secondary education and 9.2 % (23) had tertiary education. This is in line with status inconsistency theories which see violence as resulting from resource imbalance among family members where resources include both material and non material (such as education and prestige etc) assets. Even those educated up to secondary level are not good candidates for employment therefore they fall under the list of imbalanced resource (researcher's opinion).

### **Employment status of the study sample**

About 45.4 % (114) of the cases were unemployed and 14.7 % (37) were students. This gives a total of about 60 % (151) of cases who are economically inactive. The rest of the respondents were either in full time (13.9 %) or in part time (25.9 %) employment. These findings support what has been hypothesized in previous studies that women who are engaged in paid employment have more say over financial and other household matters than women who are not in active labour market (Malhotra and Matter, 1997). In several studies from developing countries, it is found that violence is associated with poverty, low socio-economic status, alcohol and substance abuse (Van der Straten et al, 1996; Jewkes, Levin & Penn-Kekana, 2002)

### **5.2.2. Clinical data**

#### **Presentation at the centre**

At the time of presentation at the health centre, more than quarters (29.6 % and 27.6 % respectively) were traumatized or confused (Figure 5).

The rest were either injured (19.8 %), reserved (19.3 %) or not well groomed (3.7 %). These findings are keeping with what was said in literatures on VAW concerning the effect of domestic violence on women's general health condition: that is, it has a serious consequence for women's health and well being ranging from fatal and non fatal outcomes that include manifestations of mental, physical, and reproductive health outcomes and negative health behaviors (Heise et al., 1999)

### ***Type of abuse among women***

The study shows that the most common form of abuse was sexual 47.4 %, followed Physical 41.8 %, then emotional 6.8 % and economical 4 % (Figure 6). This is not in line with previous studies which documented that physical was the commonest form of abuse (Jewkes et al, 2002).

### ***Substance abuse***

A look at substance abuse by abused women revealed that more than half (55.4 %) abused alcohol, 15 % were on illicit drugs, 16.7 % used tobacco while 12.7% did not use any form of substance.

### ***Emotional status of abused women***

The results indicated that most of the respondents were angry 35.4 %. Stubborn cases were 20.6 %, 24.9 % were submissive while 14.8 % were aggressive and only 4.2 % oversensitive. Dulton (1992) believes that anger is most common among abused women. Anger is commonly directed to husband or boyfriend. This anger is prolonged and in some cases may be directed to society, police or family members for not helping when the victim is crying for help. According to Viano (1992), the wife that is abused is always ashamed, embarrassed, and angry about what is happening to her.

### ***Frequency of reporting of the abuse by the women attending the centre***

The study shows that 13 cases (10.1 %) included in the study reported weekly, 34 (26.4 %) reported abuse only monthly, and (82) 63.6 % reported yearly.

### ***Period of reporting abuse by the study sample***

A look at the period of reporting reveals that majority of women 67.7 % reported their abuse during festive period while 32.3 % of the women reported during non-festive period (Table 4.4). This may due to the effect of excessive alcohol consumption during yuletide period.

### ***Time of reporting***

The study shows that the 59.8 % of women reported during the night, 19.5 % and 10.8 % reported during day and morning respectively.

### ***Obstetric condition of women during the abuse***

The results indicated that at least 18 % of the women were abuse during pregnancy and 82 % when they were not pregnant. Several review of relevant literature (Heise *et al.*, 1999; Campbell, 2002) emphasizes the linkage between the experience of domestic violence and both fatal and nonfatal outcomes for women and their children. Fatal outcome related to domestic violence for women can result directly through homicide or indirectly through suicide and maternal or AIDS related mortality. Non fatal outcomes include manifestations of mental, physical, and reproductive health outcomes, and negative health behaviours (Heise *et al.*, 1999). Abused women's reproductive health is also compromised through much high rates of gynaecological problems, HIV, sexually transmitted infections (STIs), miscarriages, abortions, unwanted pregnancy and low birth weight (Campbell, 2002).

### ***Number of children among abused women***

A look at the number of children among abused women revealed that 72 (38.7 %) had no children, 19.4 % of them had one child and 24.7 % had two children, 11.3 % had 3 children, 3.8 % had four children and 2.2 % had 6 children. This is not in

keeping with the literature as several studies indicate that the risk of experiencing violence is positively associated with women's number of children (Ellsberg, 1999; Martin *et al.*, 1999). The relationship between violence and the number of children was conceptualized as when there are more children in the household, there is less income per capital, insufficient resources may lead to exacerbated level of stress for the head of the household, which may lead to violence in some instances, hence the more the children the greater the likelihood of violence (Martin *et al.*, 1999). According to multi- country domestic violence study results shows that women with no children have the lowest rates of ever – experiencing violence, and in most countries women with five or more children have the highest of ever – experiencing violence.

### ***Relationship between women and their perpetrator***

The study shows that most abuse were perpetrated by partners (54.8 %), others, usually unknown persons (17%), uncle(10 %),husband (6.6 %),more than one perpetrators (8.7 %) and father (2.1).

### ***The occupation of the perpetrator***

The results indicated that of those who mentioned their perpetrators occupation, about 18.8 % were involved in formal employment and 40 % were non-formal employment. About 41.3 % were unemployed.

### ***Age of perpetrator***

About 49.6 % of the perpetrators were between 31-50 years old, 37 % were between 10-30 years and 13.3 % were more than 50 years old.

## **5.3. ASSOCIATIONS BETWEEN DEMOGRAPHIC VARIABLES AND TYPES OF ABUSE**

Age was significantly associated with different types of abuse as younger women (<30 years) were more abused than older women ( $p=0.011$ ) (Table 4.7).This can also be ascribed to power/resources imbalance as the older a woman becomes, the

more likely is she to be responsible and be gainfully employed (Researcher's opinion).

Marital status was also significantly associated with different types of abuse ( $p=0.001$ ). This means that single or divorced or separated women were more likely to be victims of sexual abuse, than a married woman.

Women's employment status was statistically associated with types of abuse as physical and sexual abuse was more common among women who were unemployed or had part time employment.

Types of abuse was associated with substance abuse as prevalence of physical and sexual abuse was more common among women who took alcohol ( $p=0.019$ ). When an individual is drunk she is more likely to be dis-inhibited, irrational and aggressive.

It was found that types of abuse and period of reporting were significantly associated as physical and sexual abuse were reported more during festive seasons ( $p=0.006$ )

Types of abuse was significantly associated with relationship with the perpetrator ( $p<0.001$ ). This indicated that women were emotionally or economically abused more by father or uncle or where there was more than one perpetrator.

#### **5.4. RECOMMENDATIONS**

The researcher recommends the following:

##### **5.4.1. Policy Makers**

Government especially Department of Health, as the first contact for injured victims should be fully involved in domestic violence eradication e.g. establish a directorate for domestic violence.

There is a need to accelerate poverty alleviation programs in Daveyton and similar areas. Programs that will empower women with skills so that they can enter the job market should be pursued. The government with the help of the private sector and international donors need to come up with programs that will empower women with

skills and employment opportunities. A poverty alleviation program, which will result in women being able to have sustainable jobs, is urgently needed.

The response to domestic violence is typically a combined effort between law enforcement, social services and health care. All these services play an important part in bringing domestic violence into public view which will lead to its ultimate eradication.

Social norms that support and condone violence need to be changed. Awareness campaigns family and community level to overcome barriers to women seeking formal help.

Medical professionals working in areas such as casualty, HIV/AIDS, maternal health, and mental health should be trained to identify domestic violence victims.

A special trauma unit for the victims should be established for counselling, treatment and rehabilitation.

#### **5.4.2. General Populace**

##### ***How to Promote Nonviolent Relationships Wherever You Are***

Everyone can do something to promote nonviolent relationships.

##### ***Health workers can:***

Educate themselves about physical, sexual, and emotional abuse and explore their own biases, fears, and prejudices.

Provide supportive, nonjudgmental care to victims of violence.

Ask clients about abuse in a friendly, gentle way.

##### ***Leaders of reproductive health programs can:***

Establish policies and procedures to ask women clients about abuse.

Establish protocols that clearly indicate appropriate care and referral for victims of abuse.

Promote access to emergency contraception.

Lend facilities to women's groups seeking to organize support groups and to hold meetings.

***Community and religious leaders can:***

Urge understanding, compassion, and concern for victims of violence.

Challenge religious interpretations that justify violence and abuse of women.

Make their houses of worship available as temporary sanctuary for women in crisis.

Provide emotional and spiritual guidance to victims of abuse.

Support the efforts of abused women to leave relationships that put them at risk.

Integrate discussions on healthy relationships and alternatives to violence into religious education programs

***The mass media can:***

Respect the privacy of victims of rape by not printing their names without their permission.

Avoid sensationalizing cases of violence against women; place events in their proper context, and use them as an opportunity to inform and educate.

Provide free airtime or space for messages about gender violence and announcements of available services.

Reduce the amount of violence portrayed on television.

Develop socially responsible radio and television programming that depicts equitable and nonviolent relationships between men and women.

Develop programming that creates public dialogue about sexual coercion, rape, and abuse.

***Parents can:***

Refrain from arguing in front of their children.

Teach their children to respect others and themselves.

Encourage the health, safety, and intellectual development of their daughters as well as their sons, and encourage their self esteem.



Avoid hitting their children; use nonviolent forms of discipline instead.

Teach children nonviolent ways to resolve conflicts.

Talk to their children about sex, love, and interpersonal relationships; emphasize that sex should always be consensual.

## **5.5. CONCLUSION**

The following characteristics were observed from women who consulted at Daveyton Central clinic. Most women 54.8 % were single and they were either having steady relationships or co-habiting. Some of them also had children. Most of them were unemployed or student and economically inactive. Even those of them that were lucky enough to have job, it was on part-time basis. It was evident from data analysis that most of them had low level of education (88.8 % secondary education) and they struggle to get employment. Another characteristic was that 14.7 % of cases were still students and therefore depended on their partners for financial support, which in some cases were elderly men. Most of them presented traumatized at the centre and the commonest form of abuse experienced was sexual abuse. Most of the abused women were found angry. Alcohol abuse was common among the abused women. Most of them reported abuse at the centre during the festive period and at night probably because of excessive alcohol consumption.

It was also evident that there was a relationship between obstetric status and abuse as some of them were abused during pregnancy. The researcher associated this with social and cultural practises where women cannot have sex during pregnancy. The social and economic costs of violence against women have detrimental effects in their communities and society in general. Abused women suffer isolation, inability to work, lack of self confidence, lack of participation in societal activities, and limited ability to care for themselves and their children.

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## APPENDICES

### APPENDIX 1: DATA ABSTRACTION FORM.

**Study Title: Characteristics of Abused Women who consulted at Daveyton Central Clinic: A two year review**

Number	Variable	Victim
1.	<b>Age(Years)</b>	
2.	<b>Marital Status</b>	
	Single	
	Married	
	Divorced	
	Separated	
3.	<b>Education( Highest Completed)</b>	
	8	
	9	
	10	
	11	
	12	
	Tertiary education	
	Other	
4.	<b>Employment status of victim</b>	
	Student	
	Par time employment	
	Full time employment	
	Unemployed	
5	<b>Type of employment of victim</b>	
6.	<b>Presentation at the Centre</b>	



	Injured	
	Traumatized	
	Confused	
	Reserved	
	Not well groomed	
7.	<b>Type of abuse</b>	
	Physical	
	Sexual	
	Economical	
8.	<b>Substance abuse</b>	
	Tobacco	
	Alcohol	
	Illicit Drugs	
9.	<b>Emotional states</b>	
	Anger	
	Stubbornness	
	Submissive	
	Aggressive	
	Over sensitivity	
10.	<b>Frequency of Reporting</b>	
11	<b>Period of Reporting</b>	
12.	<b>Time of Reporting</b>	
	<b>Morning</b>	
	Day	
	Night	

13.	<b>Obstetric status</b>	
	Pregnant	
	Non Pregnant	
14.	<b>Disabilities</b>	
	Physical	
	Intellectually	
	Psychiatric	
15.	<b>Number of Children</b>	
16.	<b>Relationship with the Perpetrator</b>	
	Husband	
	Partner	
	uncle	
	Father	
	More than one perpetrator	
	Others	
17.	Occupation of the Perpetrator	
18	Age of the Perpetrator?	

**APPENDIX 2: PERMISSION LETTER TO THE CLINIC MANAGER REQUESTING FOR PERMISSION TO COLLECT DATA FOR RESEARCH ON CHARACTERISTICS OF ABUSED WOMEN WHO CONSULTED AT DAVEYTON CENTRAL CLINIC.**

Dr. Akingboye M. Dauda,

P.O. Box 27039,

Sunnyside, Pretoria,

South Africa.

12-06-2010

The Clinic Manager,

Daveyton Central clinic,

Emtilweni Street, Daveyton,

Ekurhuleni,

South Africa.

Dear Sir/Ma,

I, Dr.Akingboye Dauda, a medical practitioner and currently conducting research for my Masters of Public Health (MPH) dissertation at the University of Limpopo, hereby humbly request for permission to gain access to female patient's files who consulted between January 2008 and December 2009 only.

The title of my research is the Characteristics of abused women who consulted at Daveyton Central Clinic: A two year review. These include any information in the patient's personal medical files, and information pertinent to the treatment while the

patient was under the care of Daveyton Central Clinic during the time period stipulated above. Again, this is for the sole purpose of research undertaken by myself only and that all information abstracted will be destroyed at the end of the research work.

Thanking you for the anticipated favorable response sir/ma.

Yours faithfully,

Dr. Akingboye M. Dauda

Signature of Researcher

Date of Signature

### **APPENDIX 3: PERMISSION LETTER TO REGIONAL HEALTH DEPARTMENT**

Dr. Akingboye M. Dauda,

P.O. Box 27039,

Sunnyside, Pretoria,

South Africa.

12-06-2010

The Director,

Ekurhuleni department of health,

South Africa.

Dear Sir/Ma,

I, Dr.Akingboye Dauda, a medical practitioner and currently completing my Masters of Public Health (MPH) dissertation at the University of Limpopo, hereby humbly request for permission to gain access to female patient's files who consulted between January 2008 and December 2009 at Daveyton central clinic.

The purpose of this request is only for research purpose for the topic: Characteristics of abused women who consulted at Daveyton Central Clinic: A two year review. These include any information in the patient's personal medical files and information pertinent to the treatment while the patient was under the care of Daveyton Central Clinic during the time period stipulated above. Again, this is for the sole purpose of research undertaken by myself only and that all information abstracted will be destroyed at the end of the research work.

Thanking you for the anticipated favorable response sir/ma.

Yours faithfully,

Dr. Akingboye M. Dauda

Signature of Researcher

Date of Signature

**APPENDIX 4 : MREC CLEARANCE CERTIFICATE.**

**APPENDIX 5: EKURHULENI RESEARCH ETHICS CLEARANCE CERTIFICATE.**



**APPENDIX 6: DATA COLLECTION CONFIRMATION SHEET.**

