



**SAMA  
CONFERENCE  
2019**



**8 - 10 AUGUST 2019  
DURBAN**

**Leadership & Quality  
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Let's close the gap**

# **Gender-based violence: What role for the Health Sector?**

**Sub title here**



# Why the health sector is important

## Intimate partner violence

The health sector, family and friends, and the police are the most common ports of call for South African women seeking help after an incident of violence (Rasool, 2002).

Data from a non-random survey of 1 000 women indicated that approximately 42% of the women in the sample approached health care workers for assistance – compared to the 11% who sought legal assistance.

IPV the form of violence most frequently experienced by South African women – 2016 South African Demographic and Health Survey (SADHS) reported one in five (21%) ever-partnered women nationally had experienced physical violence, and 6% sexual violence, at the hands of an intimate partner.

57% of female homicides in 2009 caused by women's intimate partners - prevalence rate of 5.6 per 100 000, five times that of the global average.

Number of intimate femicides may have increased since then: 2 930 women murdered during 2017/2018 versus 2 639 in 2016/17 (11% increase) over a one-year period. Attempted murders increased by 6.7%. Unknown whether the increase is the result of growing numbers of women being killed by their intimate partners, by strangers, or others.



# Why the health sector is important

## Sexual offences

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Data are dated and limited:

1997 SADHS – estimated that only one in seven (15%) women who had been raped, and also had physical force used against them, having ultimately reported the attack to the police.

2010 Gauteng household survey - 25.3% of the women interviewed had experienced rape in their lifetimes, while 37.4% of men admitted to having perpetrated such violence. Only one in 25 of the women who reported being raped went to the police.

According to SAPS data reported rape declined 14% between 2008/09 and 2017/18 - a decrease in prevalence from 94 people per 100 000, to 70.5 people per 100 000 of the population.

Statistics SA: 138 per 100 000 (2016/17 Victims of Crime Survey) – one of the highest rates in the world.

BUT: 62 074 (13/14), 44 464 (14/15), 29 473 (15/16) **73 842 (16/17)** and 28 596 (17/18)



# Impact on health beyond HIV

## Mental health and IPV

2004 South African Stress and Health (SASH) survey - rape has the strongest association with post-traumatic stress disorder (PTSD). IPV, because of its frequency, was associated with the greatest number of PTSD cases amongst women at population level.

2010 Gauteng survey - PTSD reported by 15.4% of women who had experienced sexual or physical IPV, with 34.2% of women reporting high levels of depressive symptoms. Approximately 10.1% had attempted suicide while 10.8% had suicidal thoughts in the month preceding the survey.

SASH survey - abused women 1.7 times more likely to report ever smoking and 1.9 times more likely to report current smoking. They were nearly twice as likely to report ever drinking and 2.4 times more likely to report regular drinking and non-medical use of sedatives. Lifetime and past-year non-medical use of analgesics almost double.

Analyses of case files for 22 shelters in six different provinces - between 20% and 32% of women either reported, or diagnosed with, schizophrenia, psychosis, bipolar disorder, borderline personality disorder, PTSD, anxiety, and depression and suicidal ideation or attempts, as well as difficulties with substance abuse. These are crude estimates but level of psychological distress among abused women would appear higher than the general population - 12-month prevalence for any disorder in the SASH study was 16.5%.



# Impact on health beyond HIV

## Violence, injury and mental health

### Violence, HIV, poverty and the peri-natal period

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SASH survey reported higher rates of mood and anxiety disorders in women, also categorised as more severe than men's. Other factors proposed as contributing to worsening women's mental health include HIV, motherhood – the peri-natal period in particular – and women's higher rates of poverty.

Six-province shelter studies - between 5% and 34% women arrive with abuse-related injuries ranged from bruising to fractures, and from stab wounds to burn wounds. In a few instances resulting in some degree of physical impairment, including loss of mobility, sight and hearing.

Between 13% and 33% of women accommodated by shelters were also living with HIV.

Varying percentages of women (6% to 18%) pregnant or had children under the age of one year. Overall, 4% of all children in shelters were under one year.

Approximately 64% to 68% unemployed and between 26% to 51% had no access to any income



# Impact on health beyond HIV

## Rape and mental health

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SASH survey found that only experiences of political torture matched or exceeded the severity of rape's effects.

2010 Gauteng-based survey - 28.1% of women raped by non-partners suffered from PTSD, with a quarter of women (25%) reporting attempting suicide.

Non-probability sample of 64 rape survivors seen at one Thuthuzela Care Centre (TCC) in the Western Cape reported 71.7% of the sample to meet the criteria for Acute Stress Disorder at one week post the rape and an almost-identical proportion to meet the criteria for a diagnosis of PTSD at four weeks post-rape. At six months more than half the group (56.8%) still met a diagnosis of PTSD. Only about one-fifth of the group had sought further counselling however.



# Is there a role?

## What policy and legislation say

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*The Domestic Violence Act (DVA), 116 of 1998* – obligates the police to assist applicants to find shelter from their abusive partners, as well as have access to counselling **and medical care**.

*Primary Health Care Package for South Africa* (Department of Health, 2000) - recommended the counselling and referral of survivors of domestic violence.

*The Criminal Law (Sexual Offences and Related Matters) Amendment Act (SOA), 32 of 2007* - provides for services to victims of sexual offences, specifically post-exposure prophylaxis (PEP) to prevent infection with HIV and HIV testing of rape suspects.

*The Health Professions Council of South Africa: General Ethical Guidelines for Reproductive Health* (2012, reissued in 2016) - includes a sub-section specifically addressed to domestic violence and provide practical guidelines around screening patients for such violence.

*National Mental Health Policy Framework and Strategic Plan 2013 -2018* – states that “Certain vulnerable groups will be targeted for specific mental health needs. These include women, children, adolescents, the elderly, and those living with HIV and AIDS.”



# The health sector in practice

## Designated facilities

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Adherence to PEP is low both in sub-Saharan Africa, as well as more affluent countries, with 40.3% of patients globally estimated to complete treatment. South African studies have reported compliance rates of anything from 0% to over 90%, 57%, 66% and between 31.9% to 38.2% in another study.

Can be improved through telephonic follow-up, information leaflets, adherence diaries, home visits, provision of transport costs and food.

265 services in total designated to provide PEP, including 55 Thuthuzela Care Centres. Researchers telephonically interviewed 167, or 63%, of the 265 designated facilities and reported that 7% of the facilities contacted were entirely unable to deal with rape cases and referred patients elsewhere. Thirty per cent of facilities did not have access to social work services and less than half (46%) had a separate area or room whose use was dedicated to rape patients. Eighty-six per cent (86%) of facilities located in hospitals.



# The health sector in practice

## Intimate partner violence

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A range of contextual factors would seem to mitigate against the success of screening as a widespread intervention. Studies have highlighted how nurses' personal experience of domestic violence may act as a barrier to their engaging with patients about domestic violence, while health practitioners' frustration around their inability to 'fix' women's circumstances, or women's perceived unwillingness to act on health workers' advice has also diminished health workers' interest in interventions addressing domestic violence. High workloads and poor referral systems also reduced the effectiveness of health sector responses.

Systematic review suggests screening increased identification of abused women but did not increase the referral of women to support services, nor significantly reduce abuse. Screening did not appear to cause harm to women however. The number of studies examining each of these questions is too small to provide sufficient evidence for or against screening, leading the authors to conclude that universal screening (ie asking every female patient if they have experienced abuse) is currently not justified.



# What appears to mitigate against an effective health sector response

Health sector has developed and tested a number of care and support interventions. These are seldom translated into routine practice however, raising questions about the feasibility of health sector responses – especially when these are not explicitly linked to HIV.

The Department of Health's attempts to address GBV would appear to be under-funded and does not currently seem possible to improve health sector responses without additional resources, be these in the form of NPO workers or researchers.

While there is a willingness and interest in strengthening care and support services to victims of GBV this appears dependent on individual managers either at health facility or province levels. Improvements in the response to GBV are therefore not system-wide but ad hoc, as well as vulnerable to disappearance.

Even so, how could one build the obvious points of connection – with shelters, casualty, emergency medical services, mental health, peri-natal care and HIV are obvious sites of health care where selective screening would be appropriate