Perinatal Mental Health Project

Caring for Mothers. Caring for the Future.

Alan J. Flisher Centre for Public Mental Health

Domestic violence among pregnant women in a low-resource South African setting

Findings from a recent research study

Perinatal Mental Health Project

Alan J Flisher Centre for Public Mental Health
Department of Psychiatry and Mental Health
University of Cape Town
Building B, 46 Sawkins Road
Rondebosch, 7700
Cape Town, South Africa

Email: info@pmhp.za.org
Phone: +27 (0) 21 689 8390
Fax: +27 (0) 86 648 2844
Web: www.pmhp.za.org

https://twitter.com/PMHPatUCT
PerinatalMentalHealthProject

The Perinatal Mental Health Project

The Perinatal Mental Health Project (PMHP) is an independent initiative based at the University of Cape Town. The Project has been operating since 2002 in partnership with the Western Cape Department of Health (DOH). We envision mental health support for all mothers to promote their well-being, and that of their children and communities by developing, evaluating and optimising interventions and tools.

The PMHP provides counselling services at three midwife obstetric units (MOUs) in Cape Town: Mowbray Maternity Hospital, Hanover Park Midwife Obstetric Unit , and False Bay Hospital. At these sites, we screen pregnant women for mental health problems and provide counselling and follow-up for those who are experiencing mental distress or are at risk for distress.

This learning brief: domestic violence in pregnancy

We recently did a research study looking at pregnant women who experience domestic violence in Hanover Park, Cape Town. We looked at the profile of women who reported domestic violence and what factors in their lives were associated with this abuse. We also reviewed the notes that our counsellor had taken with some of the women who received counselling, to get a better understanding of the context of this violence.

Target audience for this learning brief

This learning brief targets any service providers who interact with vulnerable women and children, especially those service providers who work with pregnant women. Such services providers can arise from nongovernmental organisations (NGOs) or civil society organisations. The may be healthcare providers or social service providers.

Domestic violence during pregnancy

Domestic violence is any physical, sexual, psychological or economic abuse that takes place between people who are sharing, or have recently shared a home[1]. In Africa, there is more violence against women than on any other continent [2]. Compared to America, twice as many women In South Africa are killed by their partners [3]. Violence during pregnancy has negative effects for both the mother and the child. Abused women are more likely to delay getting pregnancy care and to attend fewer antenatal visits [4].

The negative physical effects for mother and child can be: low birth weight, foetal death by placenta abrupture, haemorrhage after the birth, foetal fracture, rupture of the uterus and premature labour [5]. The negative psychological effects include: lowered self esteem, depression, anxiety, substance or alcohol misuse. Women experiencing violence are likely to become socially isolated, are less likely to have success in income generating work and are likely to become disempowered to negotiate the challenges in their lives.

The research study site

The PMHP study was conducted at the Hanover Park Midwife Obstetric Unit (MOU). Hanover Park is considered one of the most violent communities in Cape Town, with high levels of poverty, gang-related violence, substance use, and physical and sexual abuse[6]. Less than 20% of the adult population has completed high school[7]. There is high unemployment and incomes are low.

The findings

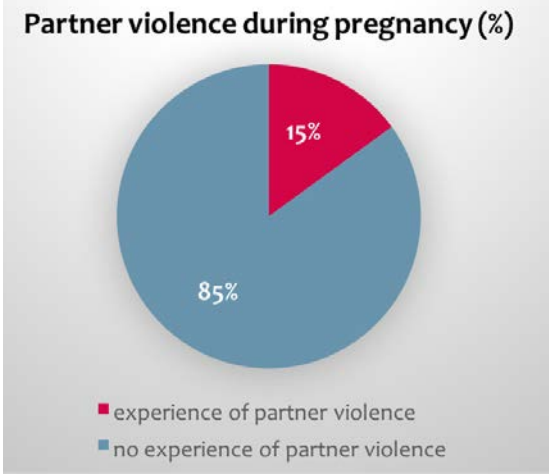


Figure 1 Pregnant women who reported being abused by their partners

A total of 376 women completed the study questionnaires. Most women were in their mid-twenties and were pregnant for the second time. Most women were in a relationship, with about 40% being married.

The average highest level of education achieved was Grade 10 and nearly 60% of the women were unemployed. Of those earning an income, only

5% were earning over R5000 a month. 58 (15%) women reported that they were currently being abused by their partners.

We found that women who were experiencing domestic violence were more likely than those without domestic violence to: have a current mental health problem like depression, anxiety, suicidal thoughts or behaviours, alcohol or drug abuse, have had past mental health problems, have experienced past abuse, not feel supported by their partner, be in a stable but unmarried relationship and were not likely to feel pleased about being pregnant. They were also more likely to be experiencing food insecurity and not have a job.

Figure 2 factors associated with domestic violence during pregnancy

** These mental health problems include depression, anxiety, suicidal thoughts and behaviour, alcohol and drug use*

The counsellor notes

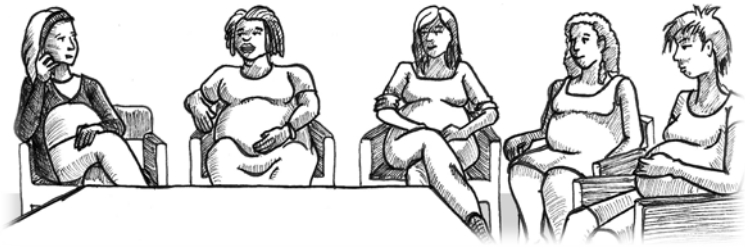
We looked at 95 case notes of women who received counselling for mental health problems. Of these, 31 women experienced domestic violence during their pregnancy. More than half of this abuse (55%) was from someone in the house who was **not** their partner – such as a father, stepfather, uncle, brother, grandmother or brother-in-law. Many of these women experienced abuse from their partner as well. The abuse took different forms. It could be verbal/emotional violence, physical violence, or sexual violence. Some clients experienced all these forms of violence. Also, 38% (12/31) reported a history of abuse.

In addition, the counselling notes showed that:

- alcohol and substance abuse by members of the family were a contributing factor to violence in the home
- experience of past abuse affected current behaviours for the victim of domestic violence
- violence was seen as "normal behaviour" for many of the participants
- many women participated in violent behaviours
- children were negatively affected by violence in the home.

PMHP counsellors' care for women who experience domestic violence

Our counsellors offer non-judgemental support to their clients. This means they show empathy and respect and do not pressure women to leave the abusive relationship. The counsellors recognise that women are most vulnerable to be severly harmed or killed by abusive partners after they leave them. Rather, counsellors listen to their clients' stories, work on improving their self-esteem and draw out examples of capabilities and resilience in the clients' histories. Existing or new social networks are explored for optimising healthy support within the community.



Counsellors talk with their clients about the cycle of violence and this often helps the women to recognise the patterns of behaviour that they experience. They assess what behaviours may trigger the violence and how these may be avoided – i.e. how to think about de-escalating conflict as opposed to engaging in behaviour and conversations that escalate conflict. They try to help the women to assess their safety and that of their children, and to map out a safety plan with people and places they can go to, if they are not feeling safe.

If women are ready and needing to find alternative accommodation, counsellors assist them in thinking about where best they can find a stable situation for themselves and their children, including shelters. Counsellors educate their clients about protection orders, and how to go about obtaining them. They offer referrals to specialist organisations dealing with domestic violence, where partners can also be counselled if they are willing. They discuss sexual health and financial health, and refer them to appropriate agencies, where necessary.

In addition to the practical issues, counsellors work together with women to think about the relationship in the long-term and explore the vision that women have for themselves and their children in the future.

Implications for practice[8]

Healthcare and social service providers at all levels of care are well placed to identify domestic violence and offer appropriate management. Their role is to:

- Ask about domestic violence whenever it is suspected or in high risk women e.g. antenatal, postnatal, mental health and HIV care
- Ensure all documentation is detailed, signed and dated. These may be needed if the woman has to go to court.
- Be supportive and affirming without judgment or pressure
- Ensure comprehensive clinical care, including STI screening and treatment, and contraception
- Develop a safety plan with the woman

- Provide appropriate referrals (shelters, mental health nurse, social service provider, specialist NGOs, emergency care, legal assistance, job skills programme)
- Provide active follow-up and liaison

Recommendations[8]

National, provincial and district health management can help to make this possible by:

- Ensuring domestic violence protocols and standard operating procedures exist and are well communicated and updated at each facility
- Ensuring a broad staff component are adequately trained for working with survivors of domestic violence
- Ensuring and adequate complement of staff are properly trained, supervised and emotionally supported to do this work
- Developing detailed action plans to protect staff from threat or harm.
- Acitvely promoting and developing Intersectoral work to address domestic violence. The Department of Health and the Victim Support Services within the Department of Social Development need to work together to:
    - Develop and maintain working relationships with each other, SAPS, Justice, Crime Prevention and Security, and the NGO sector, from strategic to local level
- Work with communities using participatory approaches, to identify community strengths, mobilise communities and increase their capacity for responding meaningfully to domestic violence.

References:

1. Constitutional Court of South Africa. *Domestic Violence Act 116 of 1998*. Vol 1.; 1998:1-14.
2. World Health Organisation. *WHO Multi-Country Study on Women ' S Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva; 2005.
3. Abrahams N, Jewkes R, Martin LJ, Mathews S, Vetten L, Lombard C. Mortality of Women From Intimate Partner Violence in South Africa: A National Epidemiological Study. *Violence Vict*. 2009;24(4):546-556. doi:10.1891/0886-6708.24.4.546.
4. Heaman MI. Relationships between physical abuse during pregnancy and risk factors for preterm birth among women in Manitoba. *J Obstet Gynecol Neonatal Nurs*. 2005;34(6):721-731.
5. Dutton MA, Green BL, Kaltman SI, Roesch DM, Zeffiro TA, Krause ED. Intimate Partner Violence , PTSD , and Adverse Health Outcomes. *J Interpers Violence*. 2006;21(7):955-968.
6. Western Cape Government. *Report on the Identification of Policing Needs and Priorities in the Western Cape*. https://www.westerncape.gov.za/assets/departments/community-safety/pnps_2012-2013_report_29-08-2013.pdf.
7. Moultire A. Indigenous trauma volunteers: survivors with a mission. 2004.
8. Joyner K, Rees K, Honikman S. *Intimate Partner Violence (IPV) in South Africa: How to Break the Vicious Cycle*.; 2015.