

# Intimate Partner Violence (IPV) in South Africa: How to break the vicious cycle

CPMH

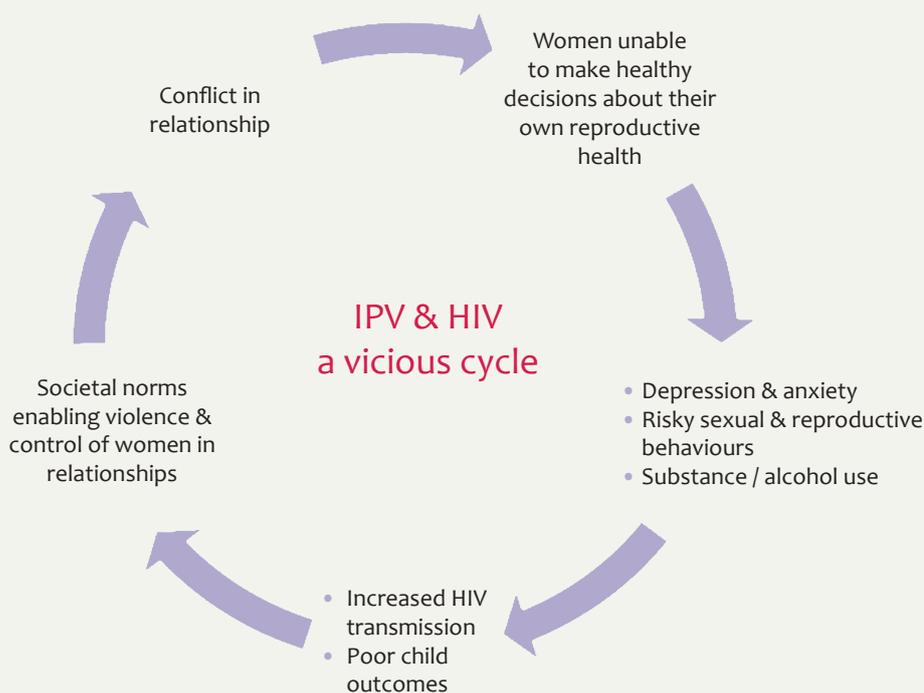
Policy Brief

November 2015

Dr Kate Joyner, Dr Kate Rees and Dr Simone Honikman

## The challenge

Half of women murdered in South Africa are killed by their intimate partner. Our country has reported the highest rates of such murders in the world.<sup>1</sup> However, the devastating physical, mental and social consequences of this problem are mostly hidden. There is very strong evidence that intimate partner violence (IPV) exists in a vicious cycle with HIV, mental illness, poor reproductive health, poor childhood development and chronic disease, and leads to numerous injuries, disability and death.<sup>2,3</sup> Abused women are twice as likely as non-abused women to report physical and mental health problems.<sup>4</sup> This problem is costly since women in abusive relationships make greater use of health and other services.



## A window of opportunity

IPV survivors are often hesitant to disclose their situation, due to stigma. Many have had bad experiences with service providers who fail to detect their problem or deny that it exists. Health and social services provide windows of opportunity to identify and respond to this violence constructively. Simple actions from several sources can, together, operate to prevent the consequences of IPV and establish social norms against IPV.

Intimate Partner Violence is any behaviour within a current, ex- or would-be intimate relationship that causes physical, psychological or sexual harm to either partner.

Examples include:

**Physical violence:** punching, kicking, burning

**Emotional (psychological) abuse:** insults, constant humiliation, intimidation, threats of harm, or threats to take away the children

**Sexual violence:** forced sexual intercourse and other forms of sexual coercion

**Controlling behaviours:** isolating one's partner from friends and family, monitoring their movements, or restricting access to financial resources, employment, education and health care

Alan J Flisher Centre for Public Mental Health  
a collaboration between the University of Cape Town and Stellenbosch University



Caring for Mothers  
Caring for the Future



Western Cape  
Government

The Western Cape Departments of  
Health and Social Development

## Cultural and social norms that can support violence

Cultural and social norms are highly influential in shaping behaviour in intimate relationships. Norms can protect against violence or support and encourage the use of it. Most IPV is perpetrated by men. The murder of a woman by her partner is the most extreme consequence of IPV.

In South Africa, a woman dies in this way **every eight hours**.<sup>5</sup> Working with men and boys through group education combined with community outreach has shown efficacy in reducing use of violence against women and girls. Note that multi level interventions work better than single level interventions, and that these need to focus on transforming harmful gender roles.<sup>6</sup>

## Violence during pregnancy

In South Africa, studies have shown that 36-40% of pregnant women experience physical IPV, while 15-19% experience sexual IPV.<sup>7,8</sup> In this vulnerable population, IPV is associated with a range of physical and mental health consequences for the mother including pregnancy loss, depression and post-traumatic stress disorder.<sup>9</sup> In South Africa, the mortality rate attributed to IPV is the highest globally and is double that of the United States.<sup>10</sup> For the infant, there are increased risks associated with preterm delivery and low birth weight.<sup>11,12, 13</sup>

## Violence against women is everyone's business.

At this crucial stage in our developing nation, the health and social development sectors are able to step up to their role as advocates for the vulnerable in society, and set norms for addressing these problems.

Doing nothing perpetuates the violence.

## What can be done?

IPV prevention and responding holistically to survivors are key to providing comprehensive care in our context. This requires that for each point of entry for women, standard operating procedures are established, implemented and audited. All actors in the health and social development system need to have a defined role to play, embedded in their job descriptions.

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

- Ask about IPV whenever it is suspected or in high risk women e.g. antenatal, mental health and HIV care
- Provide detailed, signed and dated documentation
- 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

**National, provincial and district health management** can provide the enabling environment for this to take place.

Their role is to:

- Ensure IPV protocols and standard operating procedures exist and are well communicated at each facility
- Ensure a broad staff component are adequately trained for IPV work
- Ensure staff are adequately supervised and emotionally supported for IPV work
- Ensure staff such as mental health, HIV and emergency care providers have indicators relating to IPV included in their performance agreements
- Ensure indicators for IPV are included in routine monitoring
- Develop detailed action plans to protect staff from threat or harm

**Intersectoral work** needs to be promoted and developed to address IPV adequately.

The roles of the **Department of Health** and the Victim Support Services within the **Department of Social Development** include:

- Developing and maintaining working intersectoral relationships with each other, SAPS, Justice, Crime Prevention and Security, and the NGO sector, from strategic to local level
- Working with communities using participatory approaches, to identify community strengths, mobilise communities and increase their capacity for responding meaningfully to IPV

# Entry points



## Child health

- Violence in the home has serious negative impacts across the life-cycle, especially for children.
- Children should not necessarily be removed from the home when their carers experience IPV. The family should be supported and provided with appropriate care and referrals.

I felt she\* cared... then I could feel there is someone who cares for me... That day I was done with her\* I felt like a brand new person. I had courage, a lot of courage to go on.

## Maternal health

- About 1 in 3 women attending maternity services in SA will be experiencing domestic violence.<sup>7</sup>
- IPV causes antenatal and postnatal depression and anxiety.<sup>14</sup>
- Brief interventions for IPV can improve pregnancy outcomes.<sup>15</sup>
- All women in maternal care should be asked about experiences of IPV and providers should show concern and follow response protocols.

I was a wreck, but when I left her\* office I could face the world again. She\* taught me things about myself I did not know. My problems were not solved straight away, but I can now notice what I did not notice before and I feel better about myself as a person.

## Mental health

- Women experiencing IPV should be assessed for symptoms of depression, anxiety and post-traumatic stress disorder.
- IPV often leads to alcohol and substance abuse, which in turn can lead to further partner violence.
- Primary care mental health nurses are an important resource for women identified with IPV.
- Mental health nurses should be adequately equipped to care holistically for IPV survivors and this should be part of their job description and performance agreement.

## Emergency care

- Routine enquiry about IPV is best practice when managing injuries.
- Thorough notes should be taken, with legal issues in mind
- The following should be carefully documented:
  - Events leading to the injuries
  - Use of weapons
  - Name of abuser and relationship to client
  - Verbatim quotations where appropriate
  - Type of injuries, e.g. bruise, abrasion, laceration
  - Location and size of old and new injuries
  - An opinion as to whether the injuries are consistent with the history of abuse
  - Note if there appears to be inconsistency between the injuries and explanation (there may be reluctance to confirm abuse)
  - Signature of provider on every page and name in block letters
  - Date of entry

When I was done talking to her\*, everything was alright again. She\* understood me and I understood her... It went very well. We spoke like people who knew each other... when I was in conversation with her\*, everything disappeared from me.

Remember that you are less likely to be called to court if documentation is complete and legible.

## Conclusion

The Departments of Health and Social Development are ideally placed to assume a leadership role in addressing the national crisis of IPV. Numerous opportunities exist to integrate appropriate care within existing service delivery platforms and programmes such as the Justice, Crime Prevention and Security cluster. Meaningful intersectoral collaborations could strengthen impact, prevent violence, and promote community wellness.

Clear policies and standard operating procedures for responding to IPV are a requirement for sustained, quality implementation. However, also required, is a will to respond to this pervasive human rights abuse affecting the health of our communities.

## References

1. Mathews S, Abrahams N, Martin LJ, Vetten L, Van Der Merwe L, Jewkes R. Every six hours a woman is killed by her intimate partner: a national study of female homicide in South Africa. MRC Policy Brief. Pretoria: Medical Research Council & Centre for the Study of Violence and Reconciliation:2004. Available from: <http://www.mrc.ac.za/policybriefs/woman.pdf>
2. Devries KM, Mak JY, Bacchus LJ, Child JC, Falder G, Petzold M, Astbury J, Watts CH. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Med* 2013;10:e1001439.
3. Ellsberg M, Jansen HAFM, Heise L, Watts CH, García-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet* 2008;371:1165–1172.
4. World Health Organization. WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva, World Health Organization, 2005. Available from: [http://www.who.int/gender/violence/who\\_multicountry\\_study/summary\\_report/summary\\_report\\_English2.pdf](http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf)
5. Abrahams N, Mathews S, Jewkes R, Martin LJ, Lombard C. Every eight hours: intimate femicide in South Africa 10 years later! MRC Policy Brief. Pretoria: Medical Research Council:2012. Available from: <http://www.mrc.ac.za/policybriefs/everyeighthours.pdf>
6. Fulu, E., Kerr-Wilson, A., 2015. What works to prevent violence against women and girls evidence reviews Paper 2: Interventions to prevent violence against women and girls. Available from: <http://www.whatworks.co.za/documents/publications/15-global-evidence-reviews-paper-2-interventions-to-prevent-violence-against-women-and-girls/file>
7. Mbokota M, Moodley J. Domestic abuse -an antenatal survey at King Edward VIII Hospital, Durban. *S Afr Med J* 2003;93(6): 455–457.
8. Hoque ME, Hoque M, Kader SB. Prevalence and experience of domestic violence among rural pregnant women in KwaZulu-Natal, South Africa: original research. *South Afr J Epidemiol Infect* 2009;24: 34–37.
9. Howard LM, Oram S, Galley H, Trevillion K, Feder G. Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLOS Med* 2013;10(5):e1001452.
10. 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.
11. Taillieu TL, Brownridge DA. Violence against pregnant women: prevalence, patterns, risk factors, theories, and directions for future research. *Aggress Violent Behav* 2010;15: 14–35.
12. Covington DL, Hage M, Hall T, Mathis M. Preterm delivery and the severity of violence during pregnancy. *J Reprod Med* 2001; 46(2):1031–1039.
13. Murphy CC, Schei B, Myhr TL, Du Mont J. Abuse: a risk factor for low birth weight? A systematic review and meta-analysis. *CMAJ* 2004; 164(11):1567–1572.
14. Ludemir AB, Lewis G, Valongueiro SA, de Arújo TVB, Araya R. Violence against women by their intimate partner during pregnancy and postnatal depression: a prospective cohort study. *Lancet* 2010;376(9744):903-10.
15. Kiely M, El-Mohandes AAE, El Khorazaty MN, Gantz, MG. An integrated intervention to reduce intimate partner violence in pregnancy. *Obstet Gynecol* 2010;115(2):273-283.
16. Rees K, Zweigenthal V, Joyner K. Implementing intimate partner violence care in a rural sub-district of South Africa: a qualitative evaluation. *Glob Health Action* 2014;7:24588.
17. Wagman JA, Gray RH, Campbell JC, Thoma M, Ndyababo A, Ssekasanvu J, Nalugoda F, Kagaayi J, Nakigozi G, Serwadda D, Brahmbhatt H. Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *Lancet Glob Health* 2015;3(1):e22-e23.
18. Turan JM, Hatcher AM, Odero M, Onono M, Kodero J, Romito P, Mangone E, Bukusi EA. A community-supported clinic-based program for prevention of violence against pregnant women in rural Kenya. *AIDS Res Treat* 2013: 736926.

Dedicated to the memory of a pioneer of public mental health in Africa, the Alan J Flisher Centre for Public Mental Health (CPMH) is the first of its kind on the African continent, and is a joint initiative of the Department of Psychiatry and Mental Health at the University of Cape Town (UCT), and the Department of Psychology at Stellenbosch University (SU).

The CPMH conducts high quality research on public mental health, and uses evidence for teaching, consultancy and advocacy to promote mental health in Africa. This is in recognition of the need to prioritise mental health on the public health agenda; to develop professional mental health capacity; and to develop policy, service and legislative frameworks to scale up systems of mental health care in Africa.

www.cpmh.org.za

*The views expressed are those of the authors, and not necessarily those of the CPMH or any of its funders.*

*Special thanks to Wessel van den Berg - Sonke Gender Justice, for his contribution.*

**Perinatal Mental Health Project** is an independent initiative based at the University of Cape Town, located within the CPMH. The PMHP actively addresses the challenges associated with gender based violence, teen pregnancy, HIV, substance misuse, refugee status and early childhood development through its clinical engagement with vulnerable women and their families, through training of staff that interact with these women, through research projects and advocacy work.

Alan J Flisher Centre for Public Mental Health (CPMH)

Department of Psychiatry & Mental Health, University of Cape Town, South Africa 7700

Tel +27 (0) 21 689 8390

Email [info@pmhp.za.org](mailto:info@pmhp.za.org)

Tweet @PMHPatUCT

Web [www.pmhp.za.org](http://www.pmhp.za.org)

# ENABLING ENVIRONMENT

Intimate Partner Violence prevention and responding holistically to survivors



Multiple entry points for effective intervention

## DEPARTMENTS OF HEALTH AND SOCIAL DEVELOPMENT

### WORK WITH COMMUNITIES

Identify community strengths, mobilise communities and increase their capacity

Use participatory approaches

### INTERSECTORAL RELATIONSHIPS

Improve and maintain relationships from strategic to local level  
(SAPS, DoE, NGO sector, media, faith-based groups and youth centres)

## NATIONAL, PROVINCIAL AND DISTRICT MANAGEMENT

### STAFF

Adequately train & supervise

Support emotionally

Protect from threat or harm

### PROTOCOLS AND SOP\*

Develop and communicate clearly at each facility

### INDICATORS

Include in staff performance agreements

Include in routine monitoring

## HEALTHCARE AND SOCIAL SERVICE PROVIDERS

### APPROPRIATE MANAGEMENT

Provide detailed documentation  
Provide comprehensive clinical care  
Develop a safety plan with the woman  
Provide appropriate referrals  
Provide active follow-up and liaison

### IDENTIFY IPV

Ask about IPV when suspected

Support and affirm without judgement

\*STANDARD OPERATING PROCEDURES

# CASE STUDIES

There are a number of examples of effective interventions against IPV in low resource settings.

They focus on community awareness and participation.

## Case 1

Safe Homes and Respect for Everyone (SHARE) Project, Uganda

This project used multiple activities to mobilise the community and prevent violence and HIV. The activities included: advocacy sessions with community leaders and policy makers; capacity building with health care providers, police, social workers and others; appointment and training of community volunteers as ambassadors and the formation of community action groups; distribution of learning materials and special events.

In addition, peer groups were formed for young people. A men's and boy's training programme was conducted. HIV counselling protocols were modified to include inquiring about and managing IPV.

HIV counsellors were trained accordingly and support groups for HIV positive women were initiated. These initiatives reduced physical and sexual IPV as well as HIV incidence.

See reference 17

## Case 2

A programme to prevent and mitigate the effects of gender based violence in pregnant women, Kenya

A pilot of a health-services based IPV intervention for pregnant women included capacity building in health care providers, strengthening of intersectoral linkages and community awareness activities, especially amongst men.

Community and traditional leaders participated in a skills-building workshop and mapped out community resources.

All clinic staff, including community health workers, were trained on IPV, gender, human rights and HIV.

They were provided with risk assessment and referral tools. All pregnant women were then screened for IPV. Community volunteers assisted women to access services. The pilot was found to be acceptable and feasible, and shows promise in intervening for IPV as well as primary prevention.

See reference 18