Intimate partner violence: Are we ready for action?

'Everyone is entitled to freedom and security of the person, which includes the right … to be free from *all forms of violence*, from either public or *private* sources (Article 12, Bill of Rights, Chapter 2, Constitution of the Republic of South Africa, 1996) (author's italics).

Documenting, quantifying, intervening in and preventing interpersonal violence is a leading global public health challenge of this decade.[1] Apart from HIV/AIDS, TB and malaria – where violence arguably plays an exacerbating role – what other disease process claims more than half a million lives annually, generating a burden of 'approximately 1400 deaths a day, the equivalent of three long-haul commercial aircraft crashing every single day'?[2] Yet even death may not be the most sensitive measure of the profound impact of interpersonal violence on the lives of individuals, communities, societies, nations, regions and our very humanity. With interpersonal violence occurring anywhere that humans function, both publicly and privately – at home, at work, in the streets, markets and cinemas, and on the battlefield – this social problem poses an increasing threat to the quality of our lives and the planet. The urgency of confronting this issue cannot be clearer.

In this month's *SAMJ* two articles address intimate partner violence (IPV),[3,4] a sub-set of interpersonal violence that primarily targets women, is deeply rooted in the gendered nature of human relationships, and is largely perceived as invisible to public scrutiny. They are a welcome addition to the gender-based violence literature. Their themes expand our knowledge and understanding of this complex and vexing health and human rights issue and should also galvanise us into action.

Abrahams and colleagues[3] provide compelling evidence to support continued gun control efforts in this country. They synthesised data from six South African studies to examine the use of firearms by intimate partners to kill, rape, maim and intimidate women, as well as turn such weapons on themselves in acts of murder-suicide. Calculating the rate for intimate femicide (women killed at the hands of their current or former husbands, boyfriends or lovers) with a firearm, using data from a 1999 national retrospective homicide study (the year before Parliament passed the Firearms Control Act (2000) and several years before its full implementation), the authors establish a deadly baseline. Nearly 31% of women who died from gunshot injuries were killed by their intimate partners. In South Africa, where every 6 hours a woman is killed by her intimate partner,[5] it is not surprising that the population rate of 'females shot and killed by their intimate partners … is higher than the overall USA rate of females killed by shooting [i.e. all-gun mortality, not just at the hands of their intimate partners], which [itself] was the highest among 25 high-income countries where firearms are widely available'. The inter-generational consequences of such gun violence are staggering.[6] We are reminded that 'a gun in the home is more likely to be used against a family member than in providing protection' and that working men in Cape Town who as children witnessed the abuse of their mothers were 'three times more likely to be arrested for illegal gun ownership as adults', constituting an excess '30% of illegal gun possession [that] would not have occurred … had [there] been no childhood exposure to domestic violence'. Those who *legally* own firearms are even more lethal: '91.5% of murders followed by suicide would not have occurred were it not for legally owned guns', and '… legally owned firearms are the main risk factor for murder of intimate partners'.

Gass and colleagues[4] conducted secondary data analysis to determine the impact of IPV on health. The South African Stress and Health Study (SASH), a population-based, nationally representative mental health survey conducted in conjunction with the World Health Organization World Mental Health Survey Initiative from 2002 to 2004, asked respondents about the presence and frequency of *physical violence* (in this context, pushing, grabbing, shoving, throwing something, slapping or hitting) in their current or most recent intimate relationship. Hypothesising from the international domestic violence literature that South African women experiencing IPV would report poor physical and mental health, engage in risky health behaviours (such as unprotected sex, smoking, alcohol and other substance use) and possibly seek out health care services to at least the same degree as non-abused women, they examined three sets of risk factors: health-risk behaviours, health-seeking behaviours and chronic physical illness.

The results are consistent with findings from other domestic violence studies, with 31% of the SASH cohort reporting IPV in their most recent marriage or cohabitating relationship. While there are statistically significant associations between IPV and the use of tobacco, alcohol and cannabis and the non-medical use of sedatives and analgesics, women in the SASH sample did not report chronic health problems to the same degree as abused women elsewhere. Ironically, however, women experiencing IPV accessed a 'disproportionate share' of health care services, being '1.5 times more likely to have visited a doctor and nearly twice as likely to have visited a traditional healer in the past 12 months'. This leaves many questions unanswered about the nature of those interactions and whether or not they result in appropriate detection, intervention and referral. Limitations are acknowledged in demonstrating the chronic health effects of IPV, including lack of a consistent definition for IPV,[7] screening for physical violence only (not sexual, emotional/psychological, threats or stalking), restriction of asking about a current relationship and not about activity across a lifetime, the degree of trust or willingness to disclose abuse to a SASH interviewer, and South African women's potentially limited access to and understanding of health care services.

These two studies could surely guide the translation of research findings into coherent policy and practice for IPV, especially support for gun control legislation and including substance abuse interventions in programmes for victims and perpetrators[8] of domestic violence. Yet it is more than likely that we will carry on with business as usual and wait for media news of the next family violence tragedy or the next study to enlighten us even further. I have followed this literature closely and bear grim witness to the fact that for more than 10 years these and many other authors have published scores of peer-reviewed articles, documenting and explaining the consequences of our failure to act to contain IPV. They write eloquently and with restraint, sidestepping the diatribe that collusion with patriarchal systems could well merit – given that it is pathology so deeply entrenched, socially acceptable, and responsible for shaping how we view this problem. For any other disease process as costly in financial and human measures we would demand answers, find cures, and disseminate evidence about interventions. What is it about IPV that fails to test our patience?

The human rights obligations of health professionals have been outlined.[9-11] The violation of the right to freedom and security of the person is so basic a prerequisite to health that IPV must be seen as a direct call to action; physicians must become advocates to break the silence and end the complicity that endangers our patients' lives.

However, how is this possible when we ourselves may be victims or survivors, perpetrators or purveyors? This requires that we open up some of our own vulnerability, step out of our comfort zones, and consider our own roles in maintaining social norms that nurture such destruction.*

This is not an easy task: '… the subject of family violence may be too uncomfortable in the physician's own life because 12 to 15 percent of physicians have witnessed domestic violence in their childhood or experienced physical abuse by an intimate partner at some point in their lives'.[14] Similarly, South African researchers have found that health care workers who treat IPV patients are themselves subject to the same, if not higher, rates of violence in their personal lives.[15,16] Imagine how this affects the services provided. Christofides and Silo[15] report no difference between nurses who personally experienced either physical or emotional abuse and those who had not in the *identification and management* of domestic violence, but found that those who reported their own or a friend or family member's experience with IPV had a higher *quality of care* score, which could be due to their ability to identify and empathise with victims. In contrast, stating that health care workers '… are women and men first – and as such, experience the same cultural values … as the clients they are expected to counsel and treat', Kim and Motsei[16] underscore the gender-bound constructs we operate within, that extend from our personal to our professional capacities.

The literature indicates that women mostly welcome being asked by their health care providers about experiences of IPV, whether in the context of universal screening or case-finding. It is prudent to inquire about the presence of a weapon in the home, as firearms pose the most serious threat to survival. Identification, documentation, appropriate referral and testifying in court are effective ways of using our medical skills. On a policy level, inter-sectoral collaboration is required to develop and test the efficacy of interventions, with multi-pronged efforts by police, the judicial system, media and entertainment, housing, mental health, faith communities, social services, substance abuse networks, HIV/AIDS organisations, men's groups, women's groups, youth groups, disability rights, the private sector (including the breweries), educational institutions, government, sports associations and health systems. We do not always act, despite knowing a lot from professional and personal circumstances. We see, but often turn away, effectively leaving IPV in the shadows. The *SAMJ* articles substantiate the imperatives for action against IPV. We must decide whether we can rally the personal and political will to take the next steps.

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References

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva: World Health Organization, 2002.
2. Butchart A, Phinney A, Check P, Villaveces A. Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health. Geneva: World Health Organization, Department of Injuries and Violence Prevention, 2004.
3. Abrahams N, Jewkes R, Mathews S. Guns and gender-based violence in South Africa. *S Afr Med J* 2010; 100: XXX (this issue).
4. Gass, JD, Stein, DJ, Williams, DR, Seedat, S. Intimate partner violence among South African women. *S Afr Med J* 2010; 100: xxx (this issue).
5. 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 2004: 5. Cape Town: Medical Research Council, 2004.
6. Abrahams N, Jewkes R. Effects of South African children's having witnessed abuse of their mothers during childhood on their levels of violence in adulthood. *Am J Public Health* 2005: 95(10): 1811-1816.
7. Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2001. www.cdc.gov/ncipc/pub-res/ipv_surveillance/intimate.htm (accessed 20 August 2010).
8. Stein DJ, Williams SL, Jackson PB, *et al*. Perpetration of gross human rights violations in South Africa: association with psychiatric disorders. *S Afr Med J* 2009; 99(5): 390-395.
9. London L, Baldwin-Ragaven L. Human rights obligations in health care. *CME* 2006; 24(1): 20-24.
10. de Gruchy J, Baldwin-Ragaven L. Serving nationalist agendas: health professionals and the violation of women's rights – the case of apartheid South Africa. In: Tong R, Anderson G, Santos A, eds. Globalising Feminist Bioethics: Cross-cultural Perspectives. Boulder, CO: Westview Press, 2001.
11. Baldwin-Ragaven L, de Gruchy J, London, L, eds. An Ambulance of the Wrong Colour: Health Professionals, Human Rights and Ethics in South Africa. Cape Town: University of Cape Town Press, 1999.
12. WMA Statement on Violence and Health. Adopted by the WMA General Assembly, Helsinki 2003 and reaffirmed by the WMA General Assembly, Seoul, Korea, October 2008. www.wma.net/en/30publications/10policies/v1/index.html (accessed 20 August 2010).
13. WMA Statement on Family Violence. Adopted by the 48th General Assembly Somerset West, Republic of South Africa, October 1996 and editorially revised at the 174th Council Session, Pilanesberg, South Africa, October 2006. www.wma.net/en/30publications/10policies/f1/index.html (accessed 20 August 2010).
14. Rodriguez MA, Bauer HM, McLoughlin E, Grumbach K. Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians. *JAMA* 1999; 282: 468-474.
15. Christofides NJ, Silo Z. How nurses' experiences of domestic violence influence service provision: study conducted in North-West province, South Africa. Nurs Health Sci 2005; 7(1): 9-14.
16. Kim J, Motsei M. 'Women enjoy punishment': attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. Soc Sci Med 2002; 54(8): 1243-1254.

*The World Medical Association (WMA) has repeatedly called upon national medical associations to develop more systematic and unified approaches to deal with interpersonal violence. It recently reaffirmed two statements which address the health consequences of violence: the WMA Statement on Violence and Health and the WMA Statement on Family Violence.[12,13] The first acknowledges that although 'doctors can be victims of violence in the workplace or other settings … [and] involved in committing acts of violence or neglect … in some settings they have contributed as a profession to the prevention of violence'. The statement puts forward eight areas for action: advocacy, data collection, medical training, prevention, co-ordination of victim assistance, research, social example and policy-making. As for family violence, national medical associations must 'intensify and broaden their efforts to address the universal problem of family violence'.