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Abused Women's Experiences of Help-Seeking from Health Services

ABSTRACT: This chapter argues that women survivors of domestic violence do not seek out health professionals to disclose abuse or to seek help to deal with abuse specifically. This is largely because they do not see them as a valuable solution to dealing with the abuse. It would seem that some abused women in this study had no notion of how health professionals can assist in resolving domestic violence concerns. This could be due to a lack of knowledge of the role of these professionals in domestic violence or to their actual experiences of inappropriate responses by them. Nevertheless, health services are critical to assisting abused women since they often present at these settings, even though they may not disclose abuse.

INTRODUCTION: Medical personnel are often the first point of professional contact for abused women (Hochfeld, 1995; Hoff, 1989; Jewkes et al., 1999; Rasool, 1995; Rasool et al., 2002). Whilst women may not necessarily disclose domestic violence to medical professionals, they do however seek medical assistance for injuries, psychosomatic complaints, suicidal feelings and for antenatal care when pregnant. The first contact with healthcare providers is critical in detecting, intervening and preventing abuse. They can provide women with options for seeking help and refer women to social services, which are critical to preventing further abuse and in some cases even death. Medical professionals' identification of domestic violence and referral of abused women to social services for further assistance are fundamental to helping women escape domestic violence.

Exploring abused women's experiences with health services is imperative since domestic violence has implications both for health (Williamson, 2000, p. 12) and psychosocial problems (Campbell, 1992; Evans, 2011; Heise & Garcia-Moreno, 2002; Plichta, 2004). This chapter considers the views and experiences of abused women with regard to health services in South Africa. Health services could refer to primary, secondary and tertiary medical services delivered by government and private providers. However, the healthcare professionals women usually referred to in this study were doctors and nurses. Based on in-depth qualitative interviews with 17 abused women living in shelters in Johannesburg and Cape Town, this chapter will illustrate that women do not see health services as points of disclosure for abuse. However, abused women frequently make contact

with health services, which provides an ideal opportunity for the detection, intervention and prevention of domestic violence. In many cases, these opportunities are missed. Women's experiences with health institutions need to be read within the context of health provision in South Africa. A brief overview of the health sectors in South Africa is discussed to provide a context for understanding abused women's experiences with these sectors; it is, however, by no means a comprehensive account.

THE HEALTH AND WELFARE CONTEXT IN SOUTH AFRICA

The development of health services in South Africa is fragmented because of its roots in South Africa's apartheid history. Post-apartheid, a social democratic approach to health and welfare, as embodied in the Reconstruction and Development Programme (RDP) (ANC, 1994), was adopted. Health and welfare services were restructured to be more equitable to address the historical backlogs in services and to make them more accessible and appropriate in meeting the needs of the majority of the population (Patel, 2005). A shift away from remedial services was proposed in order to find a better balance between remediation, primary prevention and promotion within a developmental paradigm (Patel, 2005). A mixed economy of health and social service provision prevails, with public provision for those who cannot pay for services and private provision for those with resources. In addition, a pluralist model of service provision exists where services are provided by an array of providers, including government, non-government (NGO), development agencies, civil society groups and private institutions (Patel & Hochfeld, 2008).

The delivery of efficient and effective health services to the majority of the population remains an enormous challenge (Harrison, 2009). Public health services provide poor quality care and spending remains low in comparison with the private health sector and in relation to health needs. There are also insufficient healthcare professionals in the public sector and their morale remains low (Harrison, 2009). Despite these enormous challenges, some of the post-apartheid achievements in the health sector are free hospital care for those who cannot afford to pay and the expansion of primary healthcare and district level services (Harrison, 2009). Moreover, specialist medico-legal services to deal with rape have been developed in some areas. However, the provision of free healthcare in South Africa is not as expansive and neither is the quality of care as advanced as the services provided by the National Health System (NHS) in the UK, for instance. The gains made by the South African healthcare system continue to be plagued by an inefficient, inequitable and bureaucratic system, which is ill-equipped to meet the huge demand.

Hence the governments support for a National Health system in South Africa.

The response of health and social service professionals to abused women therefore needs to be understood within the context of the complex institutional conditions prevailing in the provision of health and social welfare services in South Africa (see also chapter (if the chapter that was presented by colleague at conference is written for book we can cross ref to it) For more detail on the South African health system). It is important to note that when referring to health services, I am referring sometimes to the professionals who deliver services and at other times to the service-delivery systems within which they operate. These are two sides of the same coin; they impact on each other and on the possibilities of women receiving an effective and efficient service. However, service users do not often differentiate between professionals and the system as a whole. The latter are typically referred to interchangeably by service users. The majority of respondents made use of public health services, e.g. a hospital or a local clinic in the area where they live, with only a few women utilising private general medical practitioners working in local communities. Before discussing the findings of the research with regard to help-seeking from health services, a brief outline of the methodology and a description of participants will be provided.

METHODOLOGY

An exploratory qualitative study was conducted with 17 abused women utilising in-depth interviews that lasted between 2-3 hours. Non-probability, purposive sampling was utilised to access survivors of woman abuse. A purposive sample was selected to identify women who have disclosed and sought help on numerous occasions for woman abuse, since the purpose of the study was to understand help-seeking patterns. The sample was also a volunteer sample, since shelter workers approached adult women living in shelters who were over the age of 18, and who have experienced woman abuse in a heterosexual intimate partner relationship, to ask them if they were willing to participate, and women self-selected. Woman abuse refers to the physical and/or emotional violence by an intimate male partner (i.e. husband, partner, or boyfriend), as reported by the women. All the names utilised in the chapter are pseudonyms. Whilst representational generalisation is not possible since a small sample was utilised, inferential generalisability is possible since thick descriptions (Geertz, 1993) of the narratives are provided. Hence readers can independently evaluate the validity of the claims being made. Analysis of the data was based on an approach to life-history

analysis as outlined by Mandelbaum (1973) in conjunction with guidelines provided by Rubin and Rubin (2005) and Denzin (1989). The data was entered into ATLAS.ti for coding and organising. A description of the women interviewed follows.

The women interviewed, came from all over South Africa even though interviews were conducted in two cities. Almost an equal number of women were employed (8) and unemployed (9). The women were evenly spread among the age groups, ranging from 19 to 46. The majority of women interviewed had a high school education and were married. All of the women had children. Hence, in many respects the women interviewed were quite diverse, however most came from middle to lower income communities. This is reflected in their use of public health services, with very few of the women utilising private health services. Irrespective, it seems that utilising health services for abuse was not something that occurred to women, as illustrated below. The next section highlights how women did not think about using health services as an option for dealing with abuse, before discussing women's actual experiences with health services.

Lack of Disclosure to Health Services- *Rehana:* What can they do? … They can't do anything.

Evidence from the interviews suggests that in general women do not think about using health services as a resource in abusive relationships, even though they are preoccupied with thoughts of escaping. This means that they may think of where else they could live, but not necessarily about using formal services. Rita highlights:

> You know you don't so much think of going and asking for help, you just think of, "if I could go out of the situation, what can I do?"…I thought about it lots of times. I wanted somebody to talk to but didn't know who and how.

Few make deliberate attempts to seek help from health services specifically to deal with domestic violence.

Participants perceive the role of healthcare professionals as relating to standard medical concerns, as outlined in the next part of this chapter. They do not think of health service professionals as an option for dealing with abuse, as survivors do not have a conception of how they can help them. Women in a study conducted in the UK (Bacchus, Mezey, & Bewley, 2002, p. 14) similarly "expressed uncertainty as to whether domestic violence was a valid problem to take to their doctor, or whether the doctor would be interested or able to help them."

My discussion with Paulina shows that she did not see healthcare providers as an option for dealing with abuse. When I asked her, “And you never ever told the nurse, the doctor....?”, *Paulina replied, “* No, I never told them. You know, I thought, for me there is no help there”. Similarly when I asked Irene, “What about doctors and nurses, do you feel you can tell them?” she said, “No, what can they do”. This indicates some women’s beliefs that healthcare professionals would have been unable to help them had they thought of disclosing abuse. Another participant, Anna, not only believed that the medical professional would be unable to help her, she also felt that they would respond judgementally. Anna states, “In my mind I thought they would criticise me and say you are young why did you do this? I didn’t think they could help me”. Hence, going to a medical person for help to deal with the abuse did not seem a sensible option for some survivors, and in general there seems to be a lack of knowledge or understanding about the potential role healthcare professionals can play in cases of woman abuse. Whilst some women have utilised health services, they are unaware of the role they can play in domestic violence situations. Women are dubious about the efficacy of these services in dealing with domestic violence, because of the way in which they perceive the role of health providers.

Abused Women’s Experiences with Healthcare Providers

It would seem that abused women do not seek out health services as a point of disclosure for domestic violence, but they do utilise them to deal with three commonly identified medical concerns, namely when injured, pregnant or suicidal. This part of the chapter will discuss the responses of healthcare providers to women when they seek help for these three medical concerns. Healthcare providers may be the first point of professional contact for women survivors of abuse in many contexts (Hoff, 1989; Mick, 2006). This is not surprising since abuse can result in a range of medical conditions. Physical “injuries sustained during episodes of violence are only part of the damage to victims’ health. Physical and psychological abuse (have also been associated with)back pain, pelvic pain, gynaecological, disorders, gastrointestinal disorders, problem pregnancies, sexually transmitted diseases (STDs), headaches, central nervous system disorders, and heart or circulatory conditions” (Evans, 2011). Women could also seek help at emergency units, primary healthcare facilities, gynaecological services, psychological and psychiatric services (Davidson, King, Garcia, & Marchant, 2001). In South Africa, it is estimated that 3.5 million people “seek medical assistance for non-fatal injuries each year, of which half are due to interpersonal violence” (Harrison, 2009, p. 11). The nature and quality of interactions

with healthcare providers as well as the respondents' lack of knowledge about the role of medical personnel, determine women's decisions to disclose or not. It is within these interactions that healthcare professionals can play a profound role in detecting and referring women who experience domestic violence to social services.

Help-Seeking for Injury

The Centers for Disease Control and Prevention (CDC, 2005) reports that domestic violence causes more than 2 million injuries and approximately thirteen hundred deaths in the USA annually. A study of three provinces in South Africa also confirms high levels of injuries as a result of domestic violence (Jewkes et al., 1999). Jewkes et al. (1999, p. 15) explains that "the very high proportions of abused women who reported being injured and seeking medical attention suggests that their partners are either often very brutal or that more minor forms of physical violence (e.g. slaps) were greatly underreported".

Some of the women interviewed did not seek help for abuse, despite resultant injuries. A South African survey indicated that less than half of the women had sought help for severe injuries after woman abuse (Rasool et al., 2002). Lisa's narrative indicates that despite a stab wound she did not consult health services because of a lack of financial resources: "Last month he stabbed me in the head. I went to the police… I never went to doctors or nurses for injuries. No money for train fare". Despite her head injury as a result of a stabbing, Lisa did not seek medical assistance, because of the inaccessibility of health services. Patel and Hochfeld (2008) confirm that in South Africa, lack of funds to pay for transport is a significant barrier to accessing social services.

Irene, similarly, did not seek help from health services:

> *Irene:* There was nothing I could do…He just hit me like this, "you bitch, you bitch"… It carried on for about 2 hours until I was blue.
>
> *Shahana:* Did you think of going to a Doctor when you got injured?
>
> *Irene:* No, it was only bruised.

Irene minimised the abuse, which resulted in the non-utilisation of services in her situation. Nita was also severely beaten by her partner, but her partner's family did not take her for medical treatment and they did not take care of the wound after the injury happened. She relates:

> *Irene:* And one night …we had an argument but I can't remember about what and hy vat a vase and slat my kop with a vase (he took a vase and hit me on my head). I feel blood…

Shahana: And did you go to the doctor?

Irene: His mother… she took me to her room and let me sleep, she didn't even make it clean or look at it. She just locked her door.

Shahana: And that night what did she do?

Irene: I sleep in her bed because I was afraid to go out. The next morning I stand up early, wash and his sister come and she cleaned the wound for me.

Nita's mother-in-law did not clean her wound or take her for medical help. In-laws, in particular, seem to collude with the abuser, since they want to protect their sons at the expense of the women they are abusing (for an extensive discussion of the role of informal systems in domestic violence see Rasool, 2012).

In some instances women consult doctors for medical conditions unrelated to the abuse. In the course of these encounters, they sometimes disclose the abuse, but find the response of health practitioners inadequate. Catherine explained that the doctor expressed shock when he learnt about the abuse, but he did nothing to explore the abuse or refer her for help, despite the obvious seriousness of the injury.

Catherine: I was for three months in the hospital, not for injuries but for something in my… throat.

Shahana: Did the nurses or doctors ask you if you were being abused?

Catherine: No they didn't ask me, I showed them where he hit me. They ask me "what is that…behind your back" because he hit me with a wire. I told them I was hit with a wire.... by my husband.

Shahana: And what did they say?

Catherine: They were only shocked, "Ha, oh Catherine". That was it; he didn't ask me how [he can] help me.

Shahana: So, they didn't tell you about a counsellor, they didn't tell you about the police?. Nothing!

Catherine: No, they didn't tell me anything.

The unresponsiveness of healthcare providers, as demonstrated above, is a major deterrent to women disclosing abuse. This was also apparent in studies in the U.S., where it was found that 80% of women who told their physicians that they were abused by a male partner in an intimate relationship were not referred to other service providers (Kurz & Stark, 1988). Evans (2011) confirms that in "a recent poll, one-third of U.S.

physicians surveyed said that they don't record patients' reports of domestic violence and 90% don't document whether patients are offered information or other support. One-third of physicians surveyed admitted that they did not feel confident about counselling patients who reported intimate partner violence". Similar evidence exists in South Africa, confirming that when women presented at a local clinic in an urban township, they were treated mainly for their physical injuries, with little attention to their emotional and future safety needs (Motsei, 1993).

In a few situations, women did seek help from health services soon after abuse if there were severe injuries, but chose not to disclose the source of injuries. Rehana, for example, ended up at a public hospital in Cape Town, twice after abuse, but she decided not to disclose the abuse because of her love for the abuser. She relates what happened on the first occasion:

> The first time I ended up in hospital was 5 years after marriage [1992]. He took his fist and hit me. My teeth got stuck in my lip I had to go to Jooste for stitches. …I was bleeding. My friend took me to Jooste. The Nurse asked me, "What happened". I said, "I was in a physical fight with a girlfriend". She said "Am I sure? This time of the morning?" The doctor asked and I said the same thing. I always used to cover up for him. Maybe I loved him. I thought it was going to be forever. I never thought of looking for someone else. I was 16 [when I married].

Protecting partners because of continued love for them is one reason women cited for non-disclosure of abuse, despite severe injuries (Rasool, 2013). In the previous scenario, Rehana's friends witnessing the abuse took her to the hospital immediately after the incident. At a later stage, she ended up in hospital again for injuries, she relates:

> He hit my stomach…in my gut... I collapsed and then a little bit of blood came out of my mouth. I was shocked, I said to him "but why this, what did I do wrong?" He said, "I'm having an affair with this guy", I said, "what guy?" because I was totally confused, and while I'm lying there asking all these questions… my stomach was so sore and he hit my face against the brick.

This time, despite injuries, and the abusers family witnessing the abuse, they did not take her for medical help immediately. Rehana had to secretly call a friend the next day to take her to the public hospital. Women do not always go to the hospital immediately after they are injured. In this case, the presence of the abuser and the lack of support and protection provided by her in-laws resulted in her not getting medical help. Nevertheless, her friend took her to the hospital the next day and Rehana was fortunate to

have been treated by the same healthcare provider who recognised her. The provider tried to explore the issue again, but she continued to protect her husband:

> The same story I lied again… by coincidence I was running into the same nurse and she said, “you again… but you don’t look like a violent person”. I said, “Sometimes things get out of hand”. She laughed. I knew she thought I didn’t get in a physical fight, this must be my husband. She didn’t say that… but I could see the way she looked at me. I said “you know people they can’t handle their drinks… they get out of hand”. I don’t think they believed me that time because I could see, they didn’t say anything …they can’t tell me I’m lying... but I said I got in a fight again with a friend. Same thing I lied over and over.

Although the healthcare provider tried to pursue the issue, the respondent denied it. In this case Rehana cites love as the reason for protecting her partner by not revealing the abuse.

In certain cases, refusal to disclose abuse makes it difficult for professionals to assist women to deal with abuse. However, appropriate training of healthcare professionals may increase the likelihood of disclosure by women. This assistance could include something as simple as providing the survivor with a list of resources she could use when she feels comfortable to reach out for help at a later stage. Research in other contexts indicates that, “Training and education of healthcare workers has a positive impact on identification and possibly on assessment and referral of women” (Davidson et al., 2001, p. 120). A South African study (Harrison, 2009) suggests that the existence of trained and specialist services increases service usage. If healthcare providers are trained in detection and intervention in domestic violence, this could lead to abused women being helped earlier in the abuse cycle.

Furthermore, the discourse around privacy prevents women from seeking help as illustrated extensively in Rasool (2012). Nita, for example, suggested that she was not one to speak about abuse. So in her first experience with a health professional after abuse, she did not disclose:

> *Nita:* Three years ago, he was sticking me with the knife. He just started it out of the blue. Dan steek hy vir my [then he stabs me] at my great grandmother’s house. I ran away to his mother’s house. His mother [sister and brother-in-law] took me to the hospital.
>
> *Shahana:* Did the doctors and nurses ask you what happened?
>
> *Nita:* One of the nurses asked. Ek is nie een wat somer praat nie [I am not one to just speak]

Shahana: What did you say?

Nita: Nothing.

There is a powerful discourse in communities that suggests that women should not discuss their private affairs in public, since it could lead to a negative perception of the victim, though not necessarily of the perpetrator. As Promise says, “I didn’t want other people to see it, to make a mockery out of me”. This comes out clearly in the perceptions women have of how the doctor might see them if they disclose the abuse. When I asked Lisa if she felt comfortable talking to healthcare professionals about abuse, she said, “I wonder what they will think of me”. This is further connected with the privacy, secrecy and embarrassment expressed by the respondents (Rasool, 2012). The non-responsiveness of professionals served to further reinforce the survivor’s feelings of shame if they were to talk about the abuse.

These discourses in communities are so pervasive and powerful that they may not only deter women’s help-seeking, but also impact on the attitudes of service providers who are part of these communities. Research in the UK led Williamson (2000, p. 18) to conclude that “[healthcare providers] considered domestic violence to be a personal problem in which they had no right to intervene”. A powerful example of how this silence and lack of intervention in domestic violence extends to community service providers was illustrated in a study conducted by Artz (1999, p. 124) in South Africa, where she revealed that nursing sisters in two community centres “were initially hesitant to even talk about domestic violence or even acknowledge it as a problem, for fear of our discussions getting back to other community members”.

Despite the negative scenario referred to above, a few women received appropriate and effective professional care following a referral. Nita explains what this meant to her:

> Two years ago when I was sick I went to a private doctor. I was getting panic attacks. They sent me to the hospital because I was getting sicker. I told the doctor. He told me to go to hospital. There I spoke to the social worker and she sent me to [a psychiatrist]. I spent two years with this [psychiatrist]. I was really comfortable talking to her about everything. She makes me feel so good. She’s always accepting me.

The intervention Nita received from the psychiatrist in the public health system assisted her to feel cared for. Hence, effective referrals at a time when the survivor is probably open to receiving help, could result in positive outcomes.

In another situation, Lisa received a positive response from a healthcare provider, so much so that she returned to the provider for assistance. However, the response on her return was unhelpful and hence an opportunity for assisting a survivor was lost:

> *Lisa:* I took the baby into the clinic... The nurse saw my face was blue. She asked “why?” I told her the baby’s father did it. The nurse gave me phone numbers. I told his [other] girlfriend [about this]. She told him about the numbers. He asked for it and she took it out. He said, “You work with the police”. He said, I’m dirty. I mustn’t do that because he hates the police.
>
> *Shahana:* Why didn’t you call the numbers given by the nurse?
>
> *Lisa:* Because for a few days he was not beating me. Also maybe because his girlfriend told him about the numbers. The nurse said I must go and talk to her. [When I went back] She wasn’t there. [I found her and] went and told her I want to see her. She said she’s still on a break, I must wait. I waited but then had to go back home again because my baby needed milk.

In this scenario above, the nurse in the first instance responded well by detecting abuse and providing the woman with a list of resources to contact. Unfortunately, the circumstances that followed did not support her with accessing the services required. First the informal resource Lisa reached out to, led to her being chastised. Second when she go back to the nurse she was not available. Unfortunately this opportunity was lost, through no fault necessarily of the service provider.

Women’s encounters with healthcare professionals provide them with an opportunity to detect, intervene and prevent abuse. The above narratives show that in some cases professionals ignore the abuse, resulting in missed opportunities to intervene. This may be due to inadequate knowledge about how to intervene appropriately or it may be due to negative social attitudes and practices with regard to intervening in domestic violence in South Africa (Hochfeld, 1995; Rasool, 1995). A lack of financial resources was an important deterrent in South Africa to women seeking medical assistance, particularly for what they may consider relatively minor injuries (Abrahams et al., 1999; Rasool et al., 2002). Rehana above was lucky since she had informal support systems and financial resources to assist her in obtaining medical help. In many cases, women in South Africa leave their injuries to heal or use home remedies (Abrahams et al., 1999). It is therefore critical that when abused women do consult healthcare professionals for domestic violence, the professionals are able to respond effectively by detecting the abuse and

referring service users to appropriate services before the abuse intensifies and injuries become brutal and even fatal.

Help-Seeking when Pregnant

Many women have contact with health services at some point during their pregnancy. This is similar for abused women in this study. It has been shown internationally that pregnancy is a time when women are particularly vulnerable to abuse, or is a time when abuse intensifies (Evans, 2011; Gazmararian et al., 2000; Williamson, 2000). In this regard, Williamson (2000) argues that women in face a greater risk from violence during the time of pregnancy. Figures in the US indicate that abuse during pregnancy is a serious concern with intimate partner violence occurring in approximately 4% to 8% of pregnancies (Gazmararian et al., 2000). This is particularly associated with unplanned pregnancy. More than 300,000 American women experience intimate partner violence during their pregnancy each year.

Similarly, a study by Dunkle et al. (2003) in Soweto (a township south-west of the city of Johannesburg, in South Africa) found that in the 12 months prior to the study, 30.1% of pregnant women reported physical or sexual abuse and 21.8% reported experiencing more than one incident of abuse. The lifetime prevalence rates were even higher, with 55.5% of pregnant women reporting physical or sexual abuse by a male partner at least once during their life and 42.8% reported having had more than one abusive incident over the course of their life (Dunkle et al, 2003). Pregnancy therefore provides an ideal and critical opportunity for healthcare providers to screen, intervene effectively and prevent further abuse.

My own evidence included cases where women were injured as a result of abuse during pregnancy and utilised a healthcare provider, as was evident in Lisa's case:

> The night before [I gave birth] he was beating me… I was having blue marks all over my body and my hand was thick. The next morning four o'clock I started with pains and I went through…to Somerset [hospital]. I gave birth… past one in the afternoon.

A couple of hours after being beaten up Lisa gave birth at a public hospital. Whether this was a pre-term birth due to abuse is unclear. However international research has indicated that battering can lead to miscarriage, preterm labour, low birth weight, or other injury to the developing foetus (Evans, 2011).

My discussion with Paulina indicates that she miscarried during the period of abuse:

> *Paulina:* In 1994 I was pregnant… I had a miscarriage…at five months.
>
> *Shahana:* Was it is because he was beating you?
>
> *Paulina:* No, maybe it was because of stress, I really don't know what happened.

Although Paulina did not directly attribute the miscarriage to abuse, but rather stress from the abuse, studies have indicated that miscarriage is one of the common consequences of abuse (Evans, 2011; Williamson, 2000). Stress is also a consequence of living in a violent situation (Evans, 2011; Gondolf, 2002).

In most of their interactions with healthcare providers, pregnant women do not reveal that they have been abused. When I asked Lisa if she actually went to the hospital for injuries as a result of the abuse during pregnancy, she said:

> *Lisa*: No I didn't, I just gave birth.
>
> *Shahana:* So you went to give birth. Did they ask you about your injuries?
>
> *Lisa:* No they didn't ask me, they didn't ask me. No one asked me, they just asked me why I'm so blue. I said, "No I'm having a fight". I didn't want to say…
>
> *Shahana:* So you didn't tell them…
>
> *Lisa:* What happened to me…No I didn't!

Whilst Lisa was asked 'why she is blue', Lisa's response indicates a sense of frustration that no-one really asked her for the details about how her injuries occurred. Whilst Lisa did not indicate who she fought with, she did provide some information. If healthcare providers had done a sensitive and thorough screening for domestic violence, she may have been inclined to reveal more. Williamson (2000, p. 18) indicates with respect to the UK, that when healthcare providers were questioned about being unresponsive or partially responsive to abused women, they said that the patients were "'evasive', 'purposively vague' and 'inconsistent'". This resulted in medical staff stigmatising abused women and they resorted to 'blaming the victim' in domestic violence situations which ultimately led to non-intervention. This indicates that medical staff are unaware of the complex dynamics of abuse and the impediments to women disclosing abuse and seeking help.

Similarly, an opportunity for screening during pregnancy was missed in Irene's case. Irene had been abused during pregnancy but had never disclosed the abuse to a doctor. I asked her, "What about when you gave birth, or when you went for check-ups during pregnancy did the doctor ever ask you anything?" She replied, "Because it was a State hospital, it was just a kind of someone feel your stomach and then go". This is particularly true in public health facilities where pressures of high numbers of service users within a context of poor working conditions exacerbates attitudes of non-intervention, as well as a tendency to stigmatise victims of domestic violence (Jewkes, 1999).

In some cases, women are willing to speak about the abuse, but frequently the circumstances do not make it easy for women to do so and healthcare providers do not ask about injuries that are commonly known to be associated with abuse. A study in the UK indicated, "Very few women voluntarily disclosed domestic violence to a healthcare professional and even fewer were asked directly about domestic violence" (Bacchus et al., 2002, p. 10). Warshaw (1989, p. 51) suggests that when a medical general practitioner in the context of her research does not acknowledge when a woman patient has been abused, they "inadvertently recreate the abusive dynamic between themselves and their patients". This is clearly illustrated in an interview with Shamima who delivered prematurely as a result of abuse, but still the healthcare provider did not explore the circumstances surrounding the premature birth of her child:

> *Shamima:* The beating started when I was still pregnant with my first boy. It stopped completely a month before I was hospitalized for high blood pressure. Labour started at six months. My water broke at six and a half months. The child died at three weeks.
>
> *Shahana:* Did the doctors ask?
>
> *Shamima:* No.

So, even in extreme situations such as this, there was no antenatal screening for abuse. The reluctance of medical personnel to address the issue of abuse with pregnant women is clearly a theme that emerged in interviews. Research in the UK has similarly indicated that although "women are more likely to experience abuse during pregnancy, either as a first incident of abusive behaviour or the escalation of violence already present within the relationship, healthcare professional still appear reluctant to address the issue" (Williamson, 2000, p. 14).

Pregnancy provides the ideal opportunity for healthcare professionals to detect and intervene in woman abuse because women inevitably present for antenatal screening, which was probably the case for most women in this study as every single one of the women interviewed have children.

Inappropriate responses or ignoring abuse are missed opportunities that could have serious consequences for women and their unborn babies which reinforces their belief that there is not help to deal with domestic violence.

Help-Seeking for Psychosomatic Complaints or Attempted Suicide

Medical personnel are potentially also confronted with abused women when they present at health facilities with psychosomatic illnesses including women who are suicidal as a result of abuse. Psychosomatic complaints include stomach aches, headaches, depression, anxiety, post-traumatic stress disorder and so on (Evans, 2011; Sharps et al., 2001). Sharps et al. (2001, p. 374) say that "cross-sectional and cohort studies have shown clinically significant increases in depression, anxiety, somatisation, and posttraumatic stress disorder among abused women". Evans (2011) in the UK confirms that abuse is linked "to mental health problems, including depression, anxiety, antisocial behaviour, low self-esteem, inability to trust men, fear of intimacy, and post-traumatic stress disorder... Women who have experienced [intimate partner violence] also have an increased risk of substance abuse [and] suicide."

The World Health Organization's (WHO, 2005) international study of 24,000 women in ten developed and developing countries indicates that women who experience domestic violence have more than double the risk of poor health and mental health problems than women who are not abused. Despite the horrendous emotional and psychological abuse and trauma experienced by the women interviewed in this study (see Rasool, 2011 for more details), abused women do not necessarily think of healthcare professionals when looking for assistance. Annela said:

> If it was physical it would be easy to run to nurses and doctors… This was more social and private. If you are speaking against yourself there is no point in going …I'm not suffering from any wounds.

Annela felt that because she did not have any physical injuries she could not consult a healthcare provider because there would be no physical evidence of abuse.

Other respondents disclosed that they ended up in hospitals after having attempted suicide. My re-analysis of the raw unpublished data from the 1999 South African National Survey on Violence against Women indicates that both women who contemplated suicide and those who actually attempted suicide after physical abuse consulted a medical professional. When women attempt suicide, it is vital that healthcare workers detect

domestic violence through screening and thereafter intervene appropriately by referring them to specialist psychiatric and social services. A study conducted by Kurz and Stark (1988, p. 253) in the US confirms the importance of this, since there are high levels of suicide attempts by abused women. They reported, “one-sixth of battered women attempted suicide at least once… The risk of attempted suicide becomes five times greater for battered than non-battered women only after the onset of an abusive injury”.

Bongi, for example, attempted suicide several times and ended up in hospital on two occasions. But in none of these instances was there screening specifically for abuse. Evidence from a Cape Town study points to the reluctance of healthcare workers to explore issues of domestic violence with women because they felt it was too sensitive, they thought it unnecessary, or they indicated that they were too busy to ask (Jacobs, Steenkamp, & Marais, 1998).

In Bongi’s case, the first time she ended up in hospital when attempting suicide was while she was pregnant, she relates:

> *Bongi:* Everyone was suspicious while I was pregnant because when I was seven months pregnant I slit my arm. Three weeks before the child was born [the perpetrator] said he didn’t love me anymore and he was having an affair with a 15 year old – a child. I went into an anxiety attack that night, I started shaking, breathing heavily, [I was] nauseous. I wasn’t cold but my body was shaky and [my] heart [was] beating fast. He looked after me that night. It was like I almost had a heart attack. But he left [in the morning]. The next day my parents took me to the doctor. The doctor said I had high blood pressure which could have led to a heart attack.
>
> *Shahana:* Did [the doctor] ask what happened?
>
> *Bongi:* Yes, I told her, I felt like killing myself. She said she can’t give me anti-depressants, she said I must go for counselling. I told her that I’ve been and I had a feeling of something eating me up, I was so hurt. Cutting yourself is a nice feeling because of how bad emotional pain is inside.

Despite Bongi’s suicidal thoughts and anxiety attack, it seems that the private doctor that she consulted did not screen for domestic violence and that important signs and symptoms for care were not recognised and responded to. The result of inaction in some cases by healthcare providers could be that women are not helped to deal with the abuse and they remain in a situation where they are exposed to greater risk (Hochfeld, 1995; Rasool, 1995). Bongi relates how the abuse escalated when she attempted suicide a second time:

Bongi: At a later stage he came back to me …. He said he'd changed, loved me and wanted to be a father. It was fine for a few weeks …Then he even set rules for me. I must follow each one or he'll throw me out. He threatened to kill me. Then he brought these girls and drug addicts there and he was lusting over girls and touching them in front of me. I felt so hurt I wanted to kill myself, I used to cut myself. I was very suicidal then. I was so hurt I can't even explain it. I started living on speed. I was out day in and day out. Drugs were the only thing that helped me cope… I ended up in hospital for attempted suicide.

Shahana: Did the doctors ask what happened?

Bongi: I went to a State hospital. You know how they are. They were saying things. Making comments like, "When I cut myself I didn't feel the pain". But when they stitched me it was sore. [They said] "Yes I want to be so stupid now I must lay still".

In the former situation at least there was an attempt by healthcare providers to supply a referral. In the latter situation, not only was Bongi not given a referral, she experienced recrimination. Women's experiences of victim blaming and a complete disregard for the circumstances in which the attempted suicide occurred, is not unusual. Davidson et al. (2001, p. 120) indicates that, "It is clear from studies reviewed that there are deficiencies in the knowledge of health service providers and attitudes that inappropriately blame the victims of the violence", as was evident in Bongi's situation. The lack of empathy displayed by medical staff creates an environment where survivors do not feel free to disclose abuse or ask for help. In fact these attitudes and views deterred women from seeking further assistance. As Warshaw (1989) points out based on her work in the United States, a woman is unlikely to indicate if she is being abused if the doctor does not appear interested in her situation. Moreover, she is unlikely to use healthcare providers as a resource and she is unlikely to refer other women to this resource if the experience is unhelpful or negative. This is regrettable, since the most common way women in this study found help was through referrals from other abused women or someone to whom they had disclosed their plight. In this regard, Sharps et al. (2001, p. 377) suggest the following, "Each contact with the healthcare system represents an opportunity for intervention by healthcare providers to increase that woman's awareness of her risk of injury or death, an opportunity to help that woman to develop a safety plan to reduce her risk of injury or death, and an opportunity to help that woman and her family receive services to address the violence. We define these opportunities as missed opportunities because 40% of the women in

[Sharp's] study had an encounter with the healthcare system that did not prevent her death".

In summary it is imperative that when women present with injuries, psychosomatic complaints, abuse during pregnancy or attempted suicide, healthcare providers use the opportunity to screen for abuse and respond in ways that are helpful to them. These interactions provide the ideal opportunity for healthcare providers to refer women to the appropriate health and social services, where effective alternatives for dealing with abuse can be explored.

The role of health services in the detection, intervention and prevention of domestic violence is critical, since abuse is a serious health issue, with abused women reporting high levels of healthcare usage (Davidson et al., 2001). Women consult health services for standard medical concerns – injury, pregnancy, psychosomatic symptoms and suicide – but they do not always reveal that they have been abused, and "doctors miss many instances of violence and abuse, with life-threatening consequences" (Mullender & Hague, 2001, p. 12). This lack of identification and recognition of abuse by healthcare professionals reinforce the view held by abused women that domestic violence is not an area for professional intervention. Healthcare professionals also ascribe to the view that they need to confine their responses to the presented symptoms, thereby ignoring the emotional and future safety needs of abused women. Peckover (2003, p. 276) confirms that in the UK, "Women have faced difficulties finding out about such specialist services, often because statutory agencies such as health, [who are] unable to offer help themselves, also fail to make available to women information and referral advice about more specialist services". It seems that the situation may be similar in the South African context, where abused women who present themselves at health settings remain undetected or unhelped on the occasions when they disclose abuse. Women seem to lack knowledge of specialist domestic violence services. However, healthcare professionals can play an important role in helping women manage abuse and by referring them to specialist services. Healthcare practitioners could also benefit from training in the effective and appropriate management of domestic violence.

References

ANC. (1994). *The reconstruction and development programme: A policy framework*. Johannesburg, RSA: African National Congress.

Artz, L. (1999). *Violence against women in rural Southern Cape: Exploring access to justice within a feminist jurisprudence framework.* Cape Town: Institute of Criminology, University of Cape Town.

Artz, L. (2004). Better safe than sorry: Magistrates' views on the Domestic Violence Act. *SA Crime Quaterly, 75*(7), 1-18.

Abrahams, N., Jewkes, R., & Laubsher, R. (1999). *"I do not believe in democracy in the home": Men's relationships with and abuse of women.* Pretoria: CERSA Women's Health/ Medical Research Council.

Bacchus, L., Mezey, G., & Bewley, S. (2002). Experiences of seeking help from health professionals in a sample of women who experienced domestic violence. *Health and Social Care in the Community, 11*(1), 10-18.

CDC. (2005). *Intimate partner violence: Fact sheet*. Retrieved from http://www.cdc.gov/ncipc/factsheets/ipvfacts.htm

Campbell, J., Webster, D., Kozoil-Mclain, J., Campbell, D., Curry, M., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: Results from a multisite case control study. *American Journal of Public Health, 93*(7), 1089-1097.

Centre for Suicide Prevention (1999). *Barriers to seeking help* (SIEC Alert No. 35). Retrieved from http://www.suicideinfo.ca/ csp/assets/alert35.pdf

Davidson, L., King, V., Garcia, V., & Marchant, S. (2001). What role can health services play? In J. Taylor-Browne (Ed.), *What works in reducing domestic violence? A comprehensive guide for professionals* (pp. 95-123). London: Whiting & Birch.

Denzin, N. (1989). *Interpretive interactionism*. London: Sage.

Dunkle, K., Jewkes, R., Brown, H., McIntyre, J., Gray, G., & Harlow, S. (2003). *Gender-based violence and HIV infection among pregnant women in Soweto.* Pretoria: Medical Research Council.

Evans, N. (2011). *Domestic violence education for Florida healthcare professionals*. Retrieved from http://www.nursingceu.com/ courses/310/index_nceu.html

Gazmararian, J. A., Petersen, R., Spitz A. M., Goodwin, M. M., Saltzman, L. E., & Marks, J. S. (2000). Violence and reproductive health: Current knowledge and future research directions. *Maternal Child Health Journal, 4*(2), 79–84.

Geertz, C. (1993). *The interpretation of cultures: Selected essays.* New York: Basic Books.

Gondolf, E. (2002). Service barriers for battered women with male partners in batterer programs. *Journal of Interpersonal Violence, 17*(2), 217-227.

Harrison, D. (2009). *An overview of health and healthcare in South Africa 1994-2010: Priorities, progress and prospects for new gains.* Muldersdrift, RSA: Henry J. Kaiser Family Foundation.

Heise, L., & Garcia-Moreno, C. (2002). Violence by intimate partners. In E. Krug, L. Dahlberg, J. Mercy, A. Zwi, & R. Lozano (Eds.), *World health report on violence and health* (pp. 87-113). Geneva: World Health Organisation.

Hochfeld, T. (1995). *Jewish family doctors as a support system for abused women: Can they be relied on?* (Unpublished honours research report). University of Witwatersrand, Johannesburg.

Hoff, L. (1989). *People in crisis: Understanding and helping* (3rd ed.). Redwood City: Addison-Wesley.

Jacobs, T., Steenkamp, M., & Marais, S. (1998). Domestic violence against women: A close look at intimate partner violence. *Trauma Review, 6*(2), 2-5.

Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schrieber, M. (1999). *"He must give me money, he mustn't beat me": Violence against women in three South African Provinces.* Pretoria: Medical Research Council.

Kurz, D., & Stark, E. (1988). Not-so-benign neglect: The medical response to battering. In K. Yillo, & M. Bograd (Eds.), *Feminist perspectives on wife abuse* (pp. 249-265). Thousand Oaks, CA: Sage.

Mandelbaum, D. (1973). The study of life history: Ghandi. *Current Anthropology, 14*(3), 177-196.

Mick, J. (2006). Identifying signs and symptoms of intimate partner violence in an oncology setting. *Clinical Journal of Oncology, 10*(4), 509-513.

Motsei, M. (1993). *Detection of battering in healthcare settings: The case of Alexandra Health Clinic* (Paper 30). Johannesburg: Department of Community Health, University of Community Health.

Mullender, A., Hague, G., Imam, U. F., Kelly, L., Malos, E., & Regan, L. (2002). *Children's perspectives on domestic violence.* London: Sage.

Patel, L. (2005). *Social welfare and social development in South Africa.* Cape Town: Oxford University Press Southern Africa.

Patel, L., & Hochfeld, T. (2008). Indicators, barriers and strategies to accelerate the pace of change to develomental welfare in South Africa. *The Social Work Practitioner-Researcher, 20*(2), 192-211.

Peckover, S. (2003). 'I could have just done with a little more help': An analysis of women's help-seeking from health visitors in the context of domestic violence. *Health and Social Care in the Community, 11*(3), 275–282.

Plichta, S. B. (2004). Intimate partner violence and physical health consequences: Policy and practice implications. *Journal of Interpersonal Violence*, *19*, 1293-1296.

Rasool, S. (2013). Re-constructing discourses of love to facilitate help-seeking after woman abuse. *AGENDA*. http://dx.doi.org/10.1080/10130950.2013.807041

Rasool, S. (2012). Do we accept the unacceptable? The privatisation of women abuse by informal networks in South Africa. *Journal of Gender and Religion in Africa.18, 2, December, 143-149.*

Rasool, S. (1995). *Women abuse: Knowledge, attitudes and practices of medical general practitioners in the Lenasia area* (Unpublished honours dissertation). University of Witwatersrand, Johannesburg.

Rasool, S., Vermaak, K., Pharoah, R., Louw, A., & Stavrou, A. (2002). *Violence against women: A national survey.* Pretoria: Institute for Security Studies.

Rubin, H., & Rubin, I. (2005). *Qualitative interviewing: The art of hearing data.* London: Sage.

Sharps, P., Koziol-McClain, J., Campbell, J., McFarlane, J., Sachs, C., & Xu, X. (2001). Healthcare providers' missed opportunities for preventing femicide. *Preventative Medicine, 33*, 373-380.

Warshaw, C. (1989). Limitations of the medical model in the care of battered women. *Gender and society, 3*(4), 506-517.

WHO. (2005). *Multi-country study on women's health and domestic violence against women*. Geneva: World Health Organization.

Williamson, E. (2000). *Domestic violence and health: The response of the medical profession.* Bristol: The Policy Press.