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IMPACT OF VIOLENCE ON AFRICAN WOMEN'S HEALTH

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ABSTRACT

The East and Southern Africa region has high rates of sexual violence against women and girls. In seven countries, around 20 per cent of those aged 15 to 24 years reported they had experienced sexual violence from an intimate partner. Sexual violence against early adolescents aged 15 years and below is highest in the conflict and post-conflict countries of the DRC, Mozambique, Uganda and Zimbabwe.

The high rate of violence against women and girls (VAW) in the region is maintained by the persistence of harmful gender norms, alcohol use and overall increased poverty, violence in urban slum areas and conflict areas. Partner violence and the fear of abuse prevent girls from refusing sex and jeopardize their ability to negotiate condom use, studies in sub-Saharan Africa have found. Violence against women goes beyond beatings. It includes forced marriage, dowry-related violence, marital rape, sexual harassment, intimidation at work and in educational institutions, forced pregnancy, forced abortion, forced sterilization, trafficking and forced prostitution.Such practices cause trauma, injuries and death. Female genital cutting, for example, is a common cultural practice in parts of Africa. Yet it can cause "bleeding and infection, urinary incontinence, difficulties with childbirth and even death," reports the WHO. The organization estimates that 130 million girls have undergone the procedure globally and 2 million are at risk each year, despite international agreements banning the practice.

KEYWORDS:

Women, Violence, Health

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INTRODUCTION

A local organization in Zaria, Nigeria, found that 16 per cent of patients with sexually transmitted diseases (STDs) were girls under the age of five, a sign of sexual assault. In the single year 1990, the Genito-Urinary Centre in Harare, Zimbabwe, treated more than 900 girls under 12 for STDs. Such assaults, observes a WHO publication, put "African women and girls at higher risk of sexually transmitted diseases [including HIV/AIDS] than men and boys."

According to the World Health Organization (WHO), violence affects millions of women in Africa. In a 2005 study on women's health and domestic violence, the WHO found that 50 per cent of women in Tanzania and 71 per cent of women in Ethiopia's rural areas reported beatings or other forms of violence by husbands or other intimate partners.

In South Africa, reports Amnesty International, about one woman is killed by her husband or boyfriend every six hours. In Zimbabwe, six out of 10 murder cases tried in the Harare High Court in 1998 were related to domestic violence. In Kenya, the attorney general's office reported in 2003 that domestic violence accounted for 47 per cent of all homicides.

The individual or intrapersonal drivers are the biological and personal factors that influence how individuals behave and increase their likelihood of becoming a victim or perpetrator of violence. For example, demographic characteristics (age, education, and income), personality disorders, substance abuse, and a history of experiencing, witnessing, or engaging in violent behaviour. These individual experiences are also related to gender norms and values that predispose women to abuse and men to be perpetrators of abuse. For example, men who witnessed and experienced violence in childhood were more likely to be violent towards their partner. Experiences of violence in the home in childhood teach children that violence is normal in certain settings. In this way, men learn to use violence and women learn to tolerate it or at least tolerate aggressive behaviour.

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Another individual factor would be alcohol consumption; this is associated with increased risk of all forms of interpersonal violence. A study of abused women, who had consecutively received a protection order in the Vhembe district in Limpopo, showed that substance use was significantly associated with the violence perpetrated against them. Specifically, women reported greater instances of physical intimate partner violence and psychological abuse when the perpetrators grappled with a drinking problem or drug use.

Gender equitable attitudes at a personal level are also a risk factor to violence. Vetton 2013 suggests that an attitude of sexual entitlement was a common driver of rape and influenced perceptions that women or girls are responsible for their own rape. A strong relationship also exists between rape perpetration and psychopathy and lower empathy and an individual level85. In explaining the complex trends in violence in South Africa today, insufficient attention has been given to the psychological motivations of many of the perpetrators. For example, some studies posit that a primary characteristic of perpetrators of violence is that they feel powerless. For them violence is a means of reasserting control. In reasserting power through violence, a male perpetrator also reaffirms his manhood when desirable masculine behaviour is dominance and control.

Focus is on the broad societal factors that help to create a climate in which violence is encouraged or inhibited. This includes the responsiveness of the criminal justice system, social and cultural norms regarding gender roles or parent-child relationships, income inequality, the strength of the social welfare system, the social acceptability of violence, the availability of firearms, and the exposure to violence in mass media, and political instability.

For example, the preservation and perpetuation of patriarchal values and behaviours in communities is a major cause of GBV. Jewkes, et.al, (1999), reported that one in five women in Eastern Cape find violence against women to be acceptable. They believe women must be subservient to her man, must be punished by him, man have ownership of women, are entitled to sex and they interpret beating as a sign of love.

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Another study in rural Kwa-Zulu Natal exposed pervasive patriarchal behaviours. Adolescents' boys aged between 12-17 years were reportedly socialized from an early age into traditional patriarchal notions of masculinity. There was a strong belief that boys and men are unable to control their sexual urges and that responsibility of control of sexual urges lies with women and girls. Sexual violence was further understood as a strategy used by boys and men to put girls and women in their place if they became too independent and assertive. Controlling behaviour by intimate partners which in itself may be an individual as well as relationship level factor has been shown to be a driver of IPV, heightens the susceptibility of women to VAW in male-dominated family structures and social order. It is therefore not surprising that women can be accepting of such control and may even justify it.

Women's acceptance of such acts of violence is a result of the deeply rooted socio-cultural norms and practice within the society. The legacy of apartheid has also been discussed as a driver of violence in South Africa. It has been argued that the legacy of apartheid has left South Africa with a "culture of violence" that makes violence a normative rather than deviant behaviour regarded as an appropriate means of resolving social, political and even domestic conflict. The apartheid society resulted in the marginalisation of the non-white communities denying them a political voice and ensuring systematic economic disempowerment.

Violence was used to control and subjugate these communities. The resultant dehumanisation has fundamental implications for the capacity of individuals to engage in acts of violence and brutality. Violence was normalised and internalised as a tool of control and managing any form of dissent and also as a defence mechanism. The means that some of the violence that is perpetrated is rationalised as being defensive in nature, by people who experience violence themselves as disempowered and under attack or necessary to bring order in some situations.

Abusers of women tend to view violence as the only way to solve family conflicts, according to a 1999 study on violence against women by the Johns Hopkins Bloomberg School of Public

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Health near Baltimore, US. Perpetrators typically have a history of violent behaviour, grew up in violent homes and often abuse alcohol and drugs.

The story of Janet Akinyi in Kenya is a case in point. In 2006 she filed for divorce and custody of her children after her husband attempted to kill her with a knife. She had endured violent beatings throughout her 10 years of marriage. "We used to be okay until he started drinking," Ms. Akinyi told *Africa Renewal*. "Then he would get furious at anything and start beating me. He would say it is the only way to teach me to respect him."

However, violence against women, the Johns Hopkins study points out, goes beyond the brutalization of women by individuals. The prevalence of the phenomenon, "cuts across social and economic situations, and is deeply embedded in cultures around the world — so much so that millions of women consider it a way of life."

In a report by the UN Population Fund (UNFPA) in 2000, the agency noted that in interviews in Africa and Asia, "the right of a husband to beat or physically intimidate his wife" came out as "a deeply held conviction." Even societies where women appear to enjoy better status "condone or at least tolerate a certain amount of violence against women."

Such cultural norms put women in subservient positions in relation to their husbands and other males. That inferior status makes women "undervalued, disrespected and prone to violence by their male counterparts," observed a 2003 report by the UN Development Fund for Women (UNIFEM). Ms. Radhika Coomaraswamy, the former UN special rapporteur on violence against women, agreed, noting that discriminatory norms, combined with economic and social inequalities, "serve to keep women subservient and perpetuate violence by men against them."

Focusing specifically on Africa, Ms. Heidi Hudson found in a 2006 study by the South African Institute of Security Studies that "the subservient status of women, particularly rural women, in many African countries is deeply rooted in tradition."

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Violence has immediate effects on women's health, which in some cases, is fatal. Physical, mental and behavioural health consequences can also persist long after the violence has stopped. Violence against women and girls occurs in every country of Africa is rooted in social and cultural attitudes and norms that privilege men over women and boys over girls.

The abuse takes many forms, including:

- intimate partner violence (sometimes called domestic or family violence, or spousal abuse) which can be physical, sexual or emotional;
- dating violence;
- sexual violence (including rape) by strangers, acquaintances or partners;
- systematic rape during armed conflict;
- forced prostitution, trafficking or other forms of sexual exploitation;
- female genital mutilation (FGM) and other harmful traditional practices;
- dowry-related violence;
- forced marriage or cohabitation, including forced wife inheritance and 'wife kidnapping';
- femicide and the killing girls or women in the name of 'honour';
- female infanticide and deliberate neglect of girls.

While the prevalence and forms of violence against women in low- and middle income countries of Africa may differ from those in higher-income countries, the health consequences seem to be similar across all settings. However, the nature or severity of the effects of violence can be influenced by context-specific factors such as: poverty; gender inequality; cultural or religious practices; access to health, legal and other support services; conflict or natural disaster; HIV/AIDS prevalence; and legal and policy environments. The health consequences of violence can be immediate and acute, long-lasting and chronic, and/or fatal. Research consistently finds that the more severe the abuse, the greater its impact on women's physical and mental health. In addition, the negative health consequences can persist long after abuse has stopped. The

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consequences of violence tend to be more severe when women experience more than one type of violence (e.g. physical and sexual) and/or multiple incidents over time.

In most settings, women who have experienced physical or sexual violence by a partner at any time after age 15 are significantly more likely than other women to report overall poor health, chronic pain, memory loss, and problems walking and carrying out daily activities. Studies have also found that women with a history of abuse are more likely than other women to report a range of chronic health problems such as headaches, chronic pelvic pain, back pain, abdominal pain, irritable bowel syndrome, and gastrointestinal disorders.

WHO estimates that globally 100 to 140 million girls and women alive today have undergone some form of FGM.

FGM is generally performed by an individual who has no medical training and does not use anaesthetics or antiseptics. Several girls may be cut using the same instrument. This may result in physical and mental health issues, such as haemorrhage, infection, transmission of HIV and other viruses, decrease of sexual sensation, difficulties in childbirth, incontinence, scarring, reproductive health issues, psychological trauma and death. Ill health of women in turn has negative social consequences – women and girls with poor health cannot as easily contribute to the broader community, seek employment, or access education.

FGM has serious health implications and no health benefits. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. All forms of FGM can cause immediate bleeding and pain and are associated with risk of infection. The presence of FGM increases the risks of obstetric complications and perinatal death. The more severe forms of FGM cause the greatest harm. Sexual problems are also more common among women who have undergone FGM – they are 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction, and are twice as likely to report a lack of sexual desire.

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Women who experience sexual violence experience higher rates of gynaecological problems than other women, including vaginal infection, pain during intercourse, chronic pelvic pain and urinary tract infections. For example, population-based research from the USA found that women who experienced intimate partner violence had three times the risk of gynaecological problems compared to non-abused women. Even without sexual abuse, however, women who experience partner violence appear to have increased risk of gynaecological problems, though the reasons for this are not well understood. Sexual violence sometimes produces gynaecological trauma, most notably in cases of rape with objects, or when a girl is forced to have sexual intercourse and give birth before her pelvis is fully formed. Gynaecological trauma may include tearing of the vagina; fistula (a tear between the vagina and bladder or rectum, or both); haemorrhaging, infection or ulceration; and other genital injury or complications during childbirth.

Women who experience physical intimate partner violence or forced sexual intercourse by any perpetrator appear to be at greater risk of unintended or unwanted pregnancy than women with no history of abuse, both in the short term and over the course of their reproductive lives. The risk of unwanted pregnancy may occur, directly through forced sexual intercourse or difficulty in negotiating condom or contraceptive use in an abusive relationship, or indirectly via high-risk sexual behaviours linked to a history of sexual abuse in childhood or adolescence

Abortion/unsafe abortion Girls and women who become pregnant as a result of forced sexual intercourse often terminate their pregnancy, whether or not safe abortion is available. Intimate partner violence, rape by non-partners and transactional sex are all associated with higher rates of termination of pregnancy. For example, the WHO multi-country study found that, in nearly all settings, women who had experienced physical or sexual violence by an intimate partner also reported significantly higher rates of induced abortion than other women.

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For example, in southern Nigeria, where abortion is often unsafe, young women who had experienced transactional or forced sexual intercourse were significantly more likely than other women to report ever having an abortion.

Both physical and sexual violence have been linked to a greater risk of adverse mental health outcomes among women. The most prevalent include depression, suicide attempts, post-traumatic stress disorder, other stress and anxiety disorders, sleeping or eating disorders and psychosomatic disorders. Physical and sexual abuse in childhood have also been associated with a host of subsequent risk behaviours, including early sexual activity; alcohol, tobacco and drug abuse; multiple sexual partners; choosing abusive partners later in life; and lower rates of contraceptive and condom use.

CONCLUSION

Women who report a history of early sexual abuse often report feelings of worthlessness and difficulty distinguishing sexual from affectionate behaviour, maintaining appropriate personal boundaries, and refusing unwanted sexual advances. Studies have consistently linked a history of child sexual abuse with a higher risk of experiencing sexual violence later in life. Increased use and cost of health services Women who experience intimate partner violence have more health needs and seek health services more frequently than the general population, and their use of these services rises as the frequency and severity of violence increases.

A large US study found that the use of health services was highest among women in ongoing abusive relationships. By contrast, women who experience intimate partner violence are less likely to seek preventive care, such as mammograms, cholesterol and blood pressure checks and cancer screening. This has clear implications for the overall health of women who experience violence, and also for health-care costs, since prevention is usually more cost effective than treatment. In a study of more than 3000 women in the USA, annual health-care costs were 42% higher among those currently experiencing physical intimate partner violence, and 19–24% higher among those who had experienced it within the past five years.

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