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VIOLENCE AGAINST PREGNANT WOMEN – THE PATIENT'S PERSPECTIVE

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ABSTRACT

Objective: To determine pregnant women's perspective of violence against them and to establish the main perpetrators in the society.

Design: Descriptive cross-sectional study

Setting: Department of Obstetrics and Gynaecology, University of Ghana Medical School, Accra. The Department is a tertiary referral centre serving mainly the southern sector of Ghana but also provides services to other regions in Ghana.

Sample: Two hundred and thirty three pregnant women.

Methods: A nurse mid-wife interviewed all patients attending the Antenatal clinic in our unit. The recommended questionnaire by the American College of Obstetricians and Gynaecologist (ACOG) in Domestic violence: the role of the Physician in Identification, Intervention and Prevention (1995) was used. Specific questions were asked about physical and sexual violence against them within the past one year and during the current pregnancy. Results were analysed using Epi Info Version 6.

Results: Ninety five percent of the women were married and most of them were Para 0 carrying their first pregnancy or Para 1 having delivered once. The prevalence of physical violence among pregnant women was 17/233 = 7.3% and the prevalence of sexual violence was 4/233 = 1.7%. Out of the patients interviewed, 78% did not want to talk about it and 67% did not want to report to any body. The main offenders were the husbands forming about 40%.

Conclusions: The husbands mainly cause violence among pregnant women. Others may be co-tenants, brothers, landlords, previous boy friends, foster mother and sometimes strangers or anonymous assailants. Abuse of pregnant women occurs irrespective of the educational status of the woman in the society and could be in the form of physical assault or being forced to have sex when they did not want to.

INTRODUCTION

Women of every age face the threat of violence irrespective of their social, political or marital status. At every age in the life span, females are more likely to be sexually or physically assaulted than males, probably because of their gender. This occurs all over the world[1-6]. The United Nations Commission on the Status of Women drafted a declaration against violence against women. This was adopted by the General Assembly in 1993. According to Article 1 of the declaration, violence against women includes: "any act of gender based violence that results in, or likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, or whether occurring in public or private life"[7].

When a woman comes into our consulting rooms having been beaten by her partner, spouse or husband it is mainly the patching of her physical wounds that we are often seen to be attending to. The emotional trauma is difficult to thoroughly assess and deal with completely in the short consulting time.

Moreover, many medical schools do not include violence against women in their syllabuses for them to realise the importance of violence of any form against a woman. Perhaps, many doctors might get involved to understand women if the medical schools' curriculum are reviewed to sensitise future doctors as well as post-graduates on Violence against Women.

The medical doctor's response to domestic violence can contribute to a woman's understanding of the seriousness of abuse and her determination to end the violence. Sharing concern about abuse validates the woman's sense that violence threatens her physical and mental well being. Listening to her concerns encourages the exploration of options that contribute to her safety.

Failure to identify abuse when injury is relatively minor may result in the withholding of important resources at exactly the point when a woman is most able to initiate change in her life. Intervention at this point may prevent a more serious injury later.

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Successful identification and intervention in domestic violence begins with creating a safe and confidential health care setting. Attitudes and knowledge of staff members contribute to a physically and emotionally safe space.

The aim of this article is to determine the patients' perspective of violence against pregnant women in Korle Bu Teaching Hospital, the main perpetrators and then give suggestions to minimise such acts in our society. It is hoped that the results of this research will be used by various health organisations to help reduce violence against women especially pregnant women.

PATIENTS AND METHOD

This study was conducted in the Department of Obstetrics and Gynaecology, of the University of Ghana Medical School, Accra, in March 1999. The Department is a tertiary referral centre serving mainly the southern sector of Ghana but also provides services to other regions in Ghana. The hospital also manages non-referral patients and uncomplicated obstetric cases especially in the Capital City, Accra. Hospital attendance at the Antenatal Clinic is about 43,200 per year. A total of 10,000 to 12,000 deliveries are done annually.

A nurse mid-wife interviewed all patients attending the Antenatal clinic during the first week of March 1999 in our Unit. The recommended questionnaire by the American College of Obstetricians and Gynaecologist (ACOG) on Domestic violence: the role of the physician in Identification, Intervention and Prevention (1995) was used[9]. This is a pretested questionnaire "assessing for abuse in pregnancy and follow-up of yes answer". Physical violence considered was such behaviours towards the patients such as beating, slapping, kicking, punching, or using objects with the intend to hurt, or induce pain or instil fear. Sexual violence was regarded as behaviours such as unwanted touching or fondling with the intent to have sexual intercourse not desired by the victim or forced sex. Privacy was maintained by interviewing each patient alone in a room. Specific questions were asked about physical and sexual violence against them within the past one year and during the current pregnancy. Results were analysed using Epi Info Version 6.

RESULTS

Tables 1 to 3 show the outcome of the study. The median age of the patients interviewed was 27. Ninety five percent of the women were married; were Para 0, carrying their first pregnancy or para 1, having delivered once. The prevalence of physical violence among pregnant women was 17/233 = 7.3% and the prevalence of sexual violence was 4/233 = 1.7%. Out of the patients interviewed, 78% did not want to talk about it and 67% did not want to report to any body. The offenders are listed in fig. 1 with the husbands being the greatest offenders, forming about 40%. Sixteen percent of the patients did not attend any formal school and majority, 54% had primary school education. Twenty-five and six percent of the patients attended secondary schools and tertiary institutions respectively.

Table 1:

Age Group	%
10 – 14	0.4
15 – 19	6.4
20 – 24	21.0
25 – 29	33.9
30 – 34	22.3
35 – 39	14.2
40 – 44	1.3
45 – 49	0.4
Total	**100**

Table 2

Parity	Frequency	%
0	67	28.8
1	74	31.8
2	37	15.9
3	23	9.9
4	14	6.0
5	9	3.9
6	5	2.1
7	3	1.3
10	1	0.4
Total	**233**	**100.00**

Table 3: **Other Characteristics of Patients**

Marital Status	Married		94.8%
	Unmarried		3.4%
	No Response		1.8%
Violence in Pregnancy	Violence both previous year & present pregnant	(6)	
	Violence present pregnancy alone	(7)	
	Forced sex in present pregnancy	(4)	
	Total	**17**	**7.3%**
Patients who want to talk about violence against them	Yes		22.2%
	No		77.8%
Patients who reported violence against them	Yes		33.3%
	No		66.7%
Education	No School	37	16%
	Primary School	125	54%
	Secondary School	58	25%
	Tertiary School	13	6%
	Total	**233**	**100**

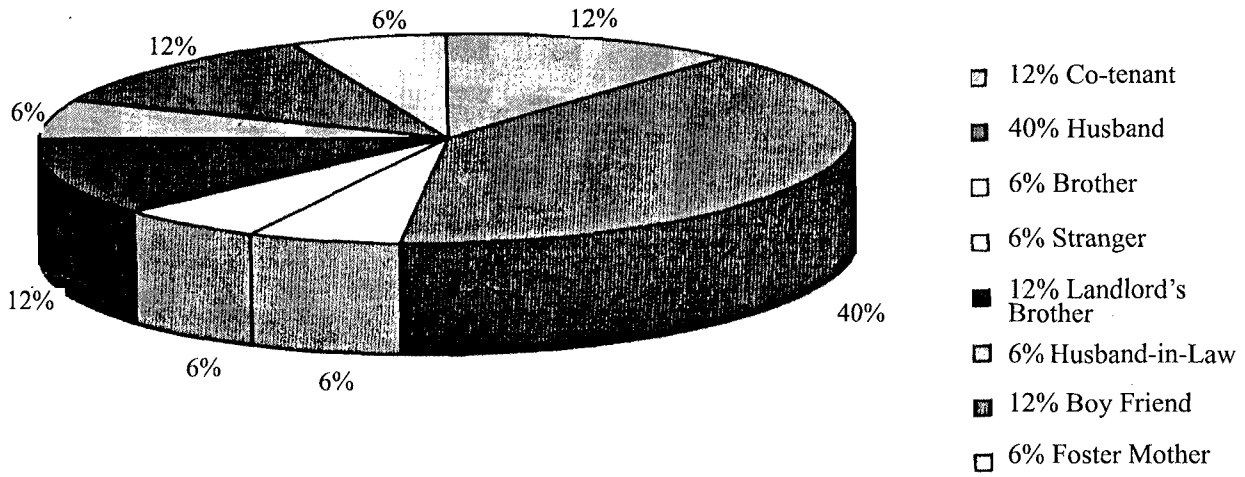

Fig. 1. **Perpetrators of Physical Violence against Pregnant Women.**

DISCUSSION

Violence against women has been discussed all over the world but is generally under reported in Africa[7-9]. The vulnerable age group in this study was between 20 to 34 years. This age is the most fertile period for women and therefore they are probably more exposed to violence during pregnancy. Similarly, those women who had delivered one child (Para 1) or are in their first pregnancy (Para 0) were most assaulted. The perpetrators were mainly the husbands who formed 40%. This figure is not different from a similar study from Kumasi, Ghana, recording the husbands forming 43% as offenders[9].

Fig. 1 shows that apart from husbands assaulting pregnant women, co-tenants, brothers, landlords, previous boy friends, foster mothers and sometimes strangers or anonymous assailants are also involved. Table 3 also revealed that abuse of pregnant women occurs irrespective of educational status of the woman in the society and other researchers have shown that violence may start or intensify during pregnancy[8].

In the general population in Ghana, 54% of the women studied had suffered violence in the form of physical assault within the past year and 44.9% were forced to have sex when they did not want to[10]. Our study recorded 7.3% of the pregnant women interviewed had suffered violence in various ways including having forced sex.

In a personal communication with the Chief Psychiatrist of the Ministry of Health, he revealed that in 1996 "out of a sample of 100 women admitted to the Accra Psychiatric Hospital for treatment, 70% had problems concerning relationships with men". Among the distressing factors mentioned were unpreparedness to be part of a polygamous relationship and withdrawal of sex and material support". In some remote villages in Ghana women are regarded as properties owned by men and therefore they can be disciplined.

The threat of violence may limit a woman's ability to keep hospital appointment, utilise family planning or safe sex, obtain and take prescribed medicine, or enroll early for antenatal care. Consequently, victims of violence may appear unreliable, non-compliant or ignorant of appropriate health behaviours.

Sexual violence is associated with teenage pregnancy, multiple sex partners and prostitution[1]. It has also been shown that when wife abuse is present, at least 50% of their children are abused[8].

In the general population in Ghana 35% of those who were beaten went to the hospital as a result[10]. In this present study, only a fifth of the women interviewed wanted to talk about it and only a third of the victims confided in another person let alone a policewoman or policeman. It could be concluded that victims tend to protect their partner's image and find it difficult to readily agree to having been assaulted by them.

The time spent with the patient in the consulting room might provide clues about violence in her home but time constraints prevent most doctors from adequately resolving personal and sexual violence. As health workers our role in providing care to any woman who is abused or sexually assaulted begins with establishing a physically and emotionally safe encounter with the patients. The victim can then rely on non-judgmental and supportive interpersonal communications to enable her participate in the complex medical and legal evaluations at hand without further victimization. In so doing, they themselves might develop a safety plan to address future threats of violence.

In conclusion, it is suggested that there must be training of all health personnel in the health care system, continuing education programmes and participation of health professionals in public education campaigns. Violence against women should be included in our medical and nursing training schools. There should be an integrated approach by all health workers, police officers, social welfare officers, legal practitioners, clergy and counsellors to effectively manage violence against women especially the pregnant patients.

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