HOME VIOLENCE IN SOUTH AFRICA

*Surveillance during 1996 by SASPREN, a Sentinel Network of general/family practitioners**

Abstract

Objectives: To estimate and monitor the incidence of home violence in South Africa at primary care level, during 1996.

Design: Continuous surveillance and notification of new events of home violence, through a postal system.

Setting: One hundred and twenty general/family practitioners throughout South Africa, with an average of 60 responding per week. Mainly (87%) private sector, 53% city and 47% town-based.

Subjects: Mainly self-paying patients visiting these general/family practitioners at the surgery, but 28% of practitioners held public service (district surgeon) appointments.

Outcome measures: The number of new events of home violence reported per 1000 consultations, classified by gender, age group and population group.

Results: During 49 6771 consultations, 2364 new events (0,5%) of home violence were reported, yielding a national notification rate of 4,76/1000 consultations for 1996. Large variation was noted between the provinces, with the Eastern Cape (11,09/1000 cons) the highest. Women were twice as likely to be a victim as men were, with women in the age group 25-44 yielding the highest number of cases. The rate of the rural settings was twice as high as the rate in the city/large towns. The warmer months had an above average rate and the colder months a below average rate.

Conclusions: Although very likely under-reported, home violence constitutes at least 0,5% of a family practitioner's workload. The trends reported in this study warrant further research on the risk factors in order to design and implement prevention strategies. Further surveillance of home violence is warranted.

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Violence is a well-recognised problem in South Africa. Violent crime is believed to be on the rise, as reflected in the rising number of reported murders and rape[1]. During 1995, members of 188 000 households (25%) were exposed to any form of assault[2]. As a consequence, the overburdened health services have to deal with an ever increasing number of victims of violence.

Violence at home, between family/household members, was found to make up one-third of all interpersonal violence in the Cape Town metropolitan area during 1990/1. This amounted to an annual incidence of home violence of 1148 per 100 000 population[3].

Women are at particular risk for interpersonal violence at home, but there are no reliable statistics about the magnitude of the problem in South Africa. In the Cape Town metropolitan study, men were twice as likely to be injured in a violent assault outside of home, but at home the sexes were almost equally represented. The most likely place for a woman to be assaulted was at home[3]. Studies in the USA suggest that one in four women will be beaten by a man in her lifetime and 60% of teenagers who had dated would have experienced a violent episode by the 12th grade[4]. South African estimates of how many women are assaulted by their male partners vary between one in every three to one in every six women[1].

Although most serious injuries as a result of home violence are dealt with by the emergency services of the larger hospitals, the minor injuries and chronic cases very often go undetected. The family practitioner, in the public or private sector, is therefore in a unique situation to identify and deal with such cases. Sentinel networks of general/family practitioners have proven to be important sources of public health information in many Western countries[5]. In South Africa a similar network, the Southern African Sentinel Practitioner Research Network (SASPREN) was founded in 1991[6]. This network started during 1995 with a project of ongoing surveillance of 13 important health events, at primary care level.

Because of this lack of information, home violence was selected for surveillance. The occurrence of a case of home violence can rightfully be regarded as a "Sentinel health event," described by Rutstein[7] as "the occurrence of an unnecessary disease ... that justifies carefully controlled scientific search for remediable underlying causes."

This report is about the results of the 1996 surveillance of home violence by SASPREN.

Methods

The methods used by SASPREN in this project of ongoing health event surveillance were described in more detail in a previous report[8]. A network of Sentinel practitioners provides the study centre, on a weekly basis, with information about all new cases of the selected health events. The Sentinels mark all new cases of home violence by age group, gender and population group (Black/African or Other, on request by researchers from the Medical Research Council, in order to monitor the trends of certain diseases and health events in the African population), on a simple pre-printed grid on a postcard. They also provide their total number of consultations for the week. The postcards are sent by pre-paid mail to the study centre at Tygerberg, where the data are collated.

Sentinels were provided with the following case definition for home violence[3]: "Violence between members of the same family or household (however defined) in and around the home of the family."

Since the size of the population served by each Sentinel was unknown, notification rates were calculated by using the number of consultations or number of Sentinels as denominator. Rates were determined weekly, monthly and quarterly on a provincial and national basis.

Results

A total number of 186 Sentinels joined the network until the end of 1996. One hundred and twenty of them (64,5%) participated in surveillance at any stage during the report-year, on average 69 Sentinels per month. Almost half of them (53%) practised in cities, the rest in towns (43%) or in small settlements (4%). Most practised in the private sector (87%), of which 28% also held state appointments (mostly district surgeons).

A total of 49 6771 consultations were covered during 1996, during which 47 375 events were notified. The provincial notification rates for home violence are tabulated in Table I. A total of 2364 cases of home violence was reported, on average 4,76 per 1000 consultations, or 34,24 cases per Sentinel per year. The Eastern Cape was the province with by far the highest notification

**Family practitioner (alt. general practitioner) is the preferred term for the medical professional that provides comprehensive and continuing medical care to individual patients within the context of their families and communities, as an essential part of primary health care. The scope of family practice can differ from an urban, mainly consulting practice, to a rural practice which also requires additional surgical and emergency care skills. Family practice can be in the private sector (e.g. a private practice or HMO) or the public sector (e.g. in a clinic/community health centre/day hospital or general district hospital).*

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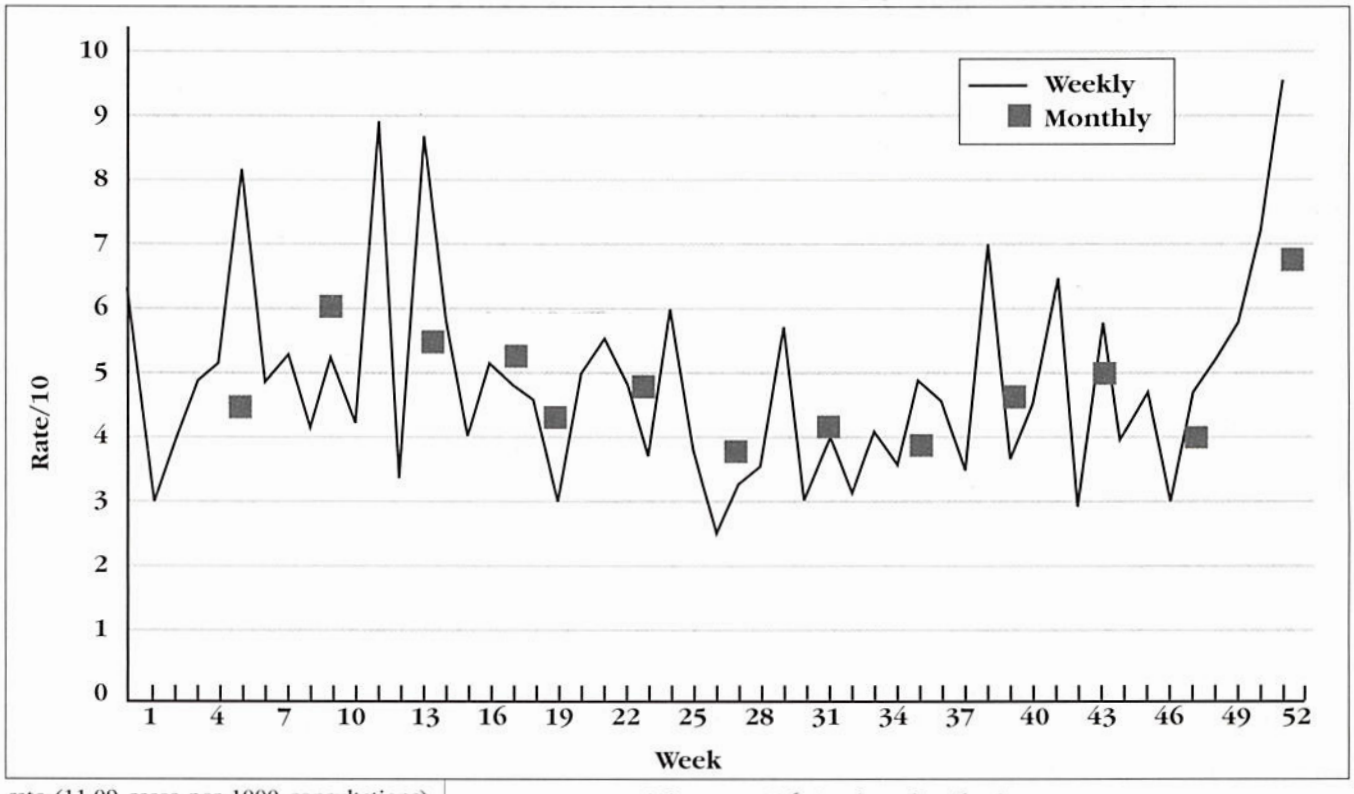
Figure 1: Home violence – 1996: National trend in notifications



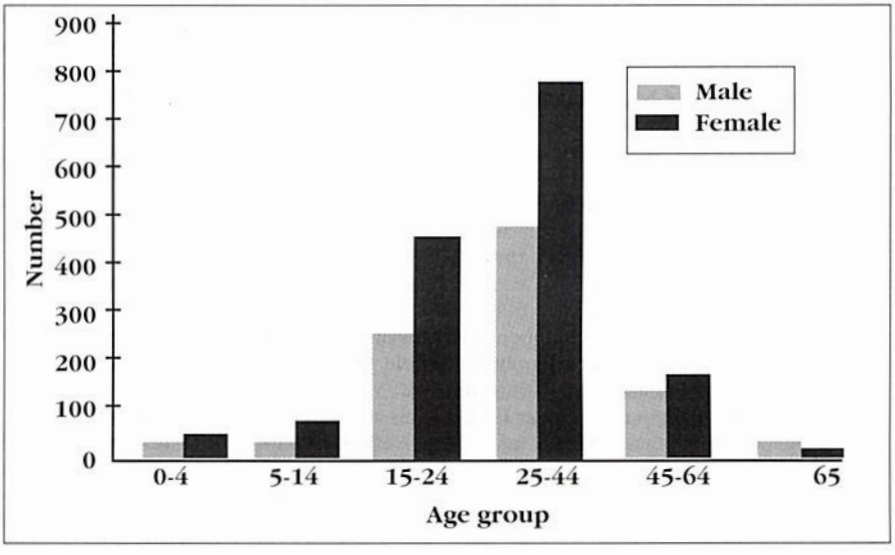
rate (11,09 cases per 1000 consultations) and KwaZulu-Natal the lowest (1,67 per 1000 consultations). Almost 50% of the notifications (1186) were from the African population group.

The small towns and settlements (less than 10 000 people) had a notification rate of 8,05/1000 consultations, more than double the rate of the cities and larger town (3,7/1000). In fact, 44% of all notifications came from the small towns and settlements, although only 23% of Sentinels practised there.

The trend in the notification rate over time is depicted in Figure 1. The months of February, March and April had higher than average (4,76 per 1000 cons) notification rates, with the peak rate in December (6,58 per 1000 cons).

The age-sex distribution of the notified cases (Figure 2) demonstrates that females (62,3%) were more likely to be victims of home violence than men (28,7%). This is the case in all age groups except in the older than 65 years group. Females between the ages of 25 and 44 years were the most likely victims. This trend was especially evident in the non-African population, in which 67% of the victims were female.

Figure 2: Home violence – 1996: Age/sex distribution



Discussion

Home violence was responsible for almost 0,5% of cases seen by the SASPREN Sentinel general/family practitioners during 1996 (Table I). It therefore represented only a small proportion of the workload of these practitioners. These reported cases are, however, probably a gross underestimation of the true incidence. It is estimated, for instance, that only 2,8% of rape cases are reported in South Africa[1]. The sequelae of home violence have, however, a far greater impact than is generally realised. These victims most often do not report the abuse and may suffer from psychological consequences like depression, post-traumatic stress disorder and somatisation. Such patients are very often perceived by the family practitioner as "difficult" patients[9]. As a result, a lot of unnecessary special investigations and consultations with specialists are performed on these patients, leading to unnecessary medical expenses. Apart from unusual or subtle presentation, other barriers to the detection of such cases have been well documented[10].

Our study found that women were almost twice as likely as men to be victims of home violence. This is in contrast to the finding of the Cape Metropolitan study[3], that found that the sexes were equally involved in home violence. The latter study, however, included hospital-based data, which would have been the more serious injuries. Females between the ages of 25 and 44 were the most likely victims in the present study, followed by the 15 to 24 age group. Each Sentinel practitioner during 1996 encountered, on average, 21 women who reported battering. This figure can be regarded as the tip of the iceberg because of the well-known phenomenon of under-reporting of this particular problem. Females in the non-African population groups were more at risk than the African group in the present study.

There was large variation between the notification rates of the provinces.

Province	Average No of Sentinels	Number of Notifications	Notifications per 1000 consultations	Number of Notifications per Sentinel	Total number of Consultations
KwaZulu-Natal	5.80	80	1.67	13.79	47 845
North West	3.75	109	3.18	29.06	34 288
Western Cape	18.35	465	3.51	25.34	132 522
Gauteng	12.21	267	4.15	21.87	64 262
Northern Cape	3.98	208	4.54	52.26	45 795
Mpumalanga	7.00	242	4.72	34.57	51 304
Free State	6.60	250	4.93	37.88	50 682
Northern Prov	1.31	63	7.26	48.09	8 676
Eastern Cape	10.08	680	11.09	67.46	61 297
All provinces	69.04	2364	4.76	34.24	49 6771

Table I: Home Violence 1996: Notifications by Province

KwaZulu-Natal had a notably low rate, while the Eastern Cape had a six times higher rate (Table I). It is currently unclear whether these differences are real or a mere result of the distribution of the Sentinel practitioners in the social strata of the provinces. More socio-demographic information is needed about these notified cases.

The higher reported rates in the rural settings (small towns and settlements) were a surprising finding. The rural rate was more than double the urban rate, maybe as a result of the social standing of women in the rural settings. Conversely it may be argued that urbanisation has led to greater empowerment of women which lowered their risk of being abused by men.

An interesting phenomenon found by this study is the fact that the warmer months have higher than average notification rates while the colder months have lower than average rates. The very high peak rate during December may be partly explained by the fact that husbands and intimate partners are spending more time at home and the higher usage of alcohol during this period.

All these findings have to be interpreted with caution, in the light of the well-known biases of volunteer Sentinel networks[11]. The SASPREN Sentinels are not yet representing typical family practice in South Africa and the geographical distribution of the Sentinels does not mirror the distribution of the population. It may, however, be the best available data at the present time, and can be collected relatively quickly and at a reasonable cost. In addition to this, in particular when the woman is the victim, home violence is prone to under-reporting, and the family practitioner may remain the best available source of such information.

The study did, however, highlight home violence as a significant health problem encountered by general/family practitioners in South Africa and highlighted some disturbing trends. The ongoing surveillance of home violence is, therefore, warranted and can be used to monitor the impact of future socio-economic and educational interventions to address the problem.

The need for more information about the following aspects of home violence became evident: the causes or risk factors, the factors that influence help-seeking behaviour of victims, the psychological consequences on perpetrators and victims and the responses of health workers to the problem. Some of these aspects will be covered in a forthcoming study by SASPREN on home violence, focusing on women as victims.

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The following general/family practitioners contributed more than 26 weeks of surveillance data during 1996 (in ascending order according to the number of weeks contributed):
LA Gallon (Florida); C Delport (Port Nolloth); MJ Heystek (Waverley); A Vermeulen (Carnavon); HA Brathwaite (East London); JG Viljoen (Kimberley); JA Sherwood (Winkelspruit); W Darlow (Southernwood); PA Matthews (Southernwood); JJ Rust (Honeydew); BM Richards (Tygerpark); I Motala (Klerksdorp); S Imamdin (Gatesville); KE Coetzee (Moreleta Park); C Schoeman (Prieska); AE van Greunen (Joubertina); S Ragavan (Pietersburg); K Manda (Elim Hospital); S Abed (Pietersburg); J van der Poel (Ermelo); DVF Brown (Kokstad); HK Reinecke (White River); M Ragavan (Pietersburg); LG Meyer (White River); WF Seidel (Welkom); DC Brink (Gatesville); EA Ralston (Strand); C Clark (Butterworth); ED Agenbach (Durbanville); JA Zeilinga (Bon Accord); L Engelbrecht (Witbank); EJ Evans (Wynberg); GK Brink (Glenashley); BA, Michaelides (Newton Park); Morris Cohen (Claremont); Z Rosochacki (Somerset West); J Reynders (Olifantsfontein); EN Pemba (Amalinda); FFJ Frantz (Rocklands); S J Roux (Thaba Nchu); JJ Engelbrecht (Groblershoop); D Peiser (Howick); V Herbst (Thaba Nchu); JK Nzembela (Pietersburg); JA Balt (Pietermaritzburg); M Freese (Klerksdorp); C Schmaman (Auckland Park); BE Strauss (Kalk Bay); AS Liddle (Sarepta); H Conradie (Dordrecht); SIE Moosa (Gatesville); RM Becker (Harrismith); GK Geingca (Flagstaff); F Haffejee (Overport); CW van der Merwe (Bethlehem); Bewsey (Lyndhurst); KL Eksteen (Groot Drakenstein); DG van Hardenbroek (Donny Brook); T Eugene (St Lucy's Hospital); WH Smith (Brandhof); FE de Villiers (Uitenhage); JJ van Staden (Rustenburg); W Lotter (Fearie Glen); IS van der Westhuizen (Waterval Boven); GS Wolfaardt (Welgemoed); AA Dasoo (Meyerton); DA Hellenberg (Bonteheuwel); CWM de Muelenaere (Pretoria); S Furman (Milnerton); S Mazaza (Mowbray). ●

References

1. Nowrojee B, Manby B. *Violence Against Women in South Africa.* 1995; New York: Human Rights Watch. 1 p. State Response to Domestic Violence and Rape.
2. Hirschowitz R, Orkin M. *Living in South Africa: selected findings of the 1995 October household survey.* Pretoria: Central Statistical Service, 1996.
3. Van de Spuy J. *Home Violence - Some Data from the National Trauma Research Programme (NTRP).* Trauma Review 3rd ed. 1994; (2) pp1-8. Cape Town: The National Trauma Research Programme of the Medical Research Council of South Africa.
4. Easly M. *Domestic Violence.* Ann Emerg Med 1996;27:762-3.
5. Teutsch SM, Churchill RE. *Principles and practice of public health surveillance.* New York: Oxford University Press, 1994.
6. Volmink J, Furman S. *The South African Sentinel Practitioner Research Network: Organisation, Objectives, Policies and Methods.* S Afr Fam Prac 1991;12:467-71.
7. Rutstein DD et al. *Measuring the quality of medical care: a clinical method.* N Engl J Med 1976;294:582-8.
8. De Villiers PJT, Geffen LN. *The development of passive health surveillance by a sentinel network of family practitioners in South Africa.* S Afr Med J 1998;88:256-9.
9. McCoy M. *Domestic Violence: Clues to Victimisation.* Ann Emerg Med 1996;27:764-5.
10. Neufeld B. *SAFE Questions: Overcoming Barriers to the Detection of Domestic Violence.* Am Fam Phys 1996;53:2527-80.
11. Bartelds AIM. Validation of Sentinel data. Gesundh-Wes 1993;55:3-7.