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Domestic Violence Against Women (Case Study: Health Centers in Khartoum)

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ABSTRACT

Violence against women is a global issue that persist in all countries of the world, and the perpetrators of the that the violence are often well known to their victims, up till date government and policy makers see violence against women; or as less priority problem of individual rather than a national problem, this is a case study. This study employed a qualitative approach to data collection. The population of this study consist basically of two folds, purposive selected married women from Khartoum state irrespective of their age, race, ethnicity, race tribe and religion basically to ensure there is no bias in selecting the women who faced violence and to gain access to most of the married women, and randomly selected health centers. Objectives of the study investigated the domestic violence against women, investigate to impact of Domestic violence on women, investigate the skills and knowledge of the health workers in identifying physically violated women, and to identify the factor contributing to violence against women and to evaluate the response of Women to violence against them. The questionnaire was developed by adapting the questionnaire used in the WHO Multi-Country Study on Women's Health and Domestic Violence against woman. The findings from the study underscored the immerse difficulties that women suffering domestic violence face in seeking and obtaining help. The study found that a substantial proportion of in violent relationships do not tell other about the violence they are facing or seek help. Indeed, for many women interviewed, the study was the first instance in which they had told anyone about their partner's violence towards them. The findings and conclusion from this study showed that, women still lack considered as personal issues and never intend to seek help from appropriate channels.

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Introduction

The term violence against women has been used to describe a wide range of acts, including murder, rape, and sexual assault, physical assault, emotional abuse, battering, stalking, prostitution, genital mutilation, sexual harassment, and pornography.

Whooping 30 percent of women globally were found to be victims of domestic violence. 'This finding send a meaningful message that violence against women is a global health problem of epidemic proportions' said Dr. Margaret Chain director-general of WHO, in a

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statement. 'we also see that world health systems can and must do more for women who experience violence; (Mosbergen, 2013).

Violence against women is a global issue that persist in all countries of the world. The perpetrators of the violence are often well known to their victims. Yet date government and policy makers see violence against women as a relatively minor social problem of individual rather than a national problem. The general view was that cases of violence could be appropriately addressed through the social welfare or handled within the family or justice system. During the past decades all combined efforts from grass to root aimed to combat the violence against women by organizations, institutes to end violence have not gain a profound transformation in the public awareness regarding this issue. (Heise L 1998). Violence against women, also known as gender base violence, it is now known an issue known globally as a serious human right abuse, and increasing as a public health problem that concern all sector of society (Mayhew S 2002). Awareness of violence as a health issue and rise was strengthened at the declaration at the international conference on human right (Vienna 1993).

Materials and Methods

Study Area

This study was conducted in Khartoum State, Sudan. The population of this study consist basically of two folds, purposive selected married women for Khartoum State irrespective of their age, race, ethnicity, race tribe and religion. Basically to ensure there is no bias in selecting the women who faced violence and to gain access to most of the married women, and conveniently selected health centers.

Study design

The candidate collected data for this study from both primary and secondary sources. The questionnaire was developed by adapting the questionnaire used in WHO Multi-Country Study on Women's Health and Domestic Violence against women.

The adaptation made included rephrasing on knowledge, prevalence, and health consequences of domestic violence. Also question about the awareness of the availability of centers that handle violence incidents.

The questionnaire was pilot-tested on 10 randomly selected women.

The final instrument consisted of a self-administered questionnaire, which comprised of 17 questions, and was presented to 15 women.

The questionnaire was essentially self-administered by the respondents because of the sensitive nature of the questions. However, data collection was done in the presence of trained research assistants in order to ensure a higher response rate as well as assists respondents with necessary clarification.

Sample Size

Candidate had two sample size; first sample population were married woman selected as purposive selection in nature, while the second study population were conveniently selected health centers, the candidate visited at least six health centers within the locality of North Khartoum. The number of this sample was limited to 15 due to the nature, guided by the information provided by Snowball Selection Respondents Driven Sampling (RDS). The participants for the study comprised of 15 women to 20 to 50 and above years who were living in Al-Khartoum North. This study was pertinent and significant especially in the wake of increases in domestic violence against women in Sudan.

The candidate adopted the purposive method because this best suit the kind of the nature of this study since it was very sensitive topic which was very difficult to acquired its information.

Sampling techniques

The respondents were selected purposively using snowball sample selection, their characteristic re related to the causes of and types of violence against women.

Procedure for data collection

Prior to the commencement of the interview, permission was sought from the directors of the trauma health centers who assisted the candidate o identify victims of violence, rape/violence among the women just to take part. They were equally assured of anonymity and confidentiality. The questionnaire consisted of a combination of close and open-ended questions. Discussions produce descriptive data about people own written or spoken and observable behavior.

According to Gibbs (1997), focus group is useful for revealing through interaction, the beliefs, attitudes, experiences and feelings of participants in ways which would not be feasible using other qualitative method. Litosseliti (2003) points out that compared with other qualitative methods where meaning emerges from the paticipants, focus group have an element of flexibility and adaptability. Their open-ended nature allows the opportunity of gaining insight into the world of participants in their own language and promotes self-disclosure in a friendly environment.

Data Analysis

Candidate analyzed the data manually and grouped the answers of each question together and supported these answers with quotations from the respondents. Considering the demographic factors and other factors contributing to violence against women also discussing women response about violence against

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them, researcher also gave explanation about health center roles and knowledge about violence against women.

Ethical Consideration

Ethical approval for the study was obtained from the Ahfad University for Women Research Ethical Review Committee. The participants gave verbal informed consent before data collection and were free to decline of withdraw at any point during the study. In order to assure anonymity and confidentiality, information on names and other forms of identification were not included in the questionnaire. The research assistants were trained on the confidentiality of all responses given, and on referral of women who needed care and counseling.

Table 1: Showing Results and Frequency of Respondents' Characteristics

Items		Frequency	Percent
Age	20-30	5	33.3
	31-40	9	60
	41-50	0	0
	50 Above	1	6.6
Total		15	100.0

Table 2: Showing the Result and Frequently of Socio-economic Factors

Educatioal Qualification	Khalwa	1	6.6
	Primary	4	26.6
	Intermediate	5	3.3
	High education	1	6.6
	University	4	26.6
Total		15	100.0
Job	Employed	4	26.6
	Un Employed	11	73.3
Total		15	100.0

Table 3: Showing the Causes of Violence Against Women

Causes of violence	Frequency	Percent
Money	6	40
Children	0	0
Social activities	5	33.3
Other (Controlling attitude)	4	26.6
Total	15	100.0

Table 4: Showing Types of Violence Faced

Type Of Violence Experience	Physical	7	46.6
	Psychological	0	0
	Emotional	8	53.3
Total		15	100.0

Table 5: Responses of Women in Seeking for Help

Seeking for help from health centers	Yes	0	0
	No	15	100
Total		15	15

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Table 6: Women Awareness about Traumatic Centers for Violated Women

	Awareness about centers	Frequency	Present
	Yes	2	13.3
	No	13	86.6
Total		15	100.0

Table 7: Respondents Who Reported Violence in Health Centers

	Numbers of women who report violence to Health Centers	Frequency	Present
	Yes	0	0
	No	15	100
Total		15	100.0

Table 8: Factors Contributing to Violence Against Women

	Factors contributing to violent again women	Frequency	Percent
	Controlling attitude, feeling of superiority	4	26.6
	Money	6	40.0
	Social activities	5	33.3
Total		15	100.0

Questionnaires Rate of Return

Table 1 presents a summary of the response rate. A total of 15 questionnaires were distributed to the respondents. Therefore, the sample size population was adopted to distribute and fill the questionnaires and fortunately all the questionnaires were return to researcher. The overall response rate was 100%, and this high response rate was due to the fact that the researcher personally administered the questionnaire one to one, face to face and collection was instantly.

Result: Table 1 showed that all questionnaire administered to respondent were all answered with overall response rate 100%.

Social Characteristics of the Respondents:

The candidate asked the respondents about their social characteristics (see table 1)

The respondents were selected purposively using snowball sample selection, their characteristic re related to the causes of and types of violence against women.

Demographic factors

Respondent Characteristics

Text:

The age of the selected respondents ranges between 20 –above 50. (9) of the respondents age range between 31-40 years, (5) between 20-30 years and (1) is above 50 years. Thus it seems both young and middle age women were unable to protect themselves from domestic violence.

Age

Younger age is associated with greater domestic violence perpetration and victimization in most representative community surveys as shown in table 2. There is little research that elucidates this relationship. Although youth is generally associated with more frequent criminality according to (Hotaling and Sugarman 1986, Saunders 1993, Riggs *et al*., 2000 Walby and Myhill 2001b, Schumacher et al 2001). Frequency of physical assaults tends to decrease with age as the result of this, this study showed the frequency of women above 50 years as (1) 6.6%. However, many surveys do not ask about psychological abuse emotional violence. Less frequent assaults may be counterbalanced by more psychological abuse as the perpetrator gets older (Piispa 2002). Clear associations between domestic violence perpetration and younger age are less apparent in studies using target samples of perpetrators seeking help or involved in the criminal justice system of the United Kingdom (Hotaling and Sugarman 1986). Ages ranges from 19-60 and averaged 35 in an analysis of over 300 United Kingdom perpetrators referred to domestic violence programmes (Gilchrist et al 2003). Younger men were found more likely to breach restraining orders and assault their partners/ex-partners in a US study (Klein 1996). Age disparity of ten years or more between the couple has been found to be significantly associated with partner homicide; generally, men are more likely to kill their partners if

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they are substantially younger than them (Aldridge and Browne 2003).

Responses obtained from respondents when asked about their socio economic factors were as follows: (Table 2)

Education level

Most of the respondents are educated, and their education level range between Khalwa levels to university level.

Socio-economic factor

Whilst domestic violence occurs across all social and economic groupings, internationally, most studies show a significant association between low income, unemployment, low educational attainment, and risk of violence to a partner, although the correlation is a weak one in some studies (Hotaling and Sugarman 1986, Schumacher 1993, Holtzworth- Munroe et al1997b, Heise 1998, Riggs *et al*., 2000, Walby and Myhill 2001b, Schumacher *et al*., 2001). 60% perpetrators 2003). There is also some evidence that men of lower socio-economic status tend to perpetrate more severe violence than their higher status counterparts. One hypothesized explanation is that some men, who feel frustrated and inadequate at being unable to fulfill cultural expectations of being a breadwinner.

The result obtained from respondent when asked about causes of violence against them (Table 3)

The findings from the study underscored the immerse difficulties that women suffering domestic violence face in seeking and obtaining help. The study found that a substantial proportion of in violent relationship do not tell other about the violence they are facing or seeking help. Indeed, for many women interviewed, the study was the first instance in which they had told anyone about their partner's violence towards them.

Some studies which were reviewed indicated that, women living in violent relationship often experience feeling of extreme isolation; hopelessness and powerlessness that make it particularly difficult for them to seek help.

As shown in chapter two in conceptual framework of the study violent partners often keep women isolated from potential source of help, and women may fear that, disclosure of their situation will lead to relation against themselves or their children. Feelings of shame and self-blame, and stigmatizing altitude on the part of services providers, families and community.

Types of violence faced (table 4)

The majority of the respondents faced emotional violence compare to those who faced physical violence by their husband, respondents reported having been violated emotionally by their husband, some reported that they were physically abused.

Although this study found out that, respondents mentioned that they suffered physical violence such as slapping kicking etc. in the hands of their spouse, but some of them still believe he has the right as the husband to do so.

However, exactly how attitudes towards wife-beating may influence women's experience of violence at individual level is not clear. It may be that experience of violence 'teaches' women that violence is acceptable. Alternately, women who believed that, women deserve abuse in certain circumstances may be less likely to challenge male authority and therefore be protected from abuse.

Although none of the respondent mentioned been sexually violated but studies reviewed points out that, sexually violated women in the sense of violence condoned or prepared by the state, through is agents or its public policy, can perpetrate kinds of physical, sexual and psychological violence against women.

Help Seeking (Table 5)

result from the above table shown, that, none of the respondent seek for help despite the level of their education as shown previously, many of the factors bearing on women's decision to remain in or leave violent relationships are also salient influences on their decision about help seeking, and reflect their transition through various stage and processes of coping with domestic violence, as well as the trajectory of abuse, this is similar to most of the US study of the women who has sought help, most used private strategies extensively, and kept the abuse to themselves before extending their responses to include more public help-seeking as violence increased.

Women prefer the use of personal coping strategies, such as placating and resistance, were most common, but retrospectively rated as least helpful, as they did not significantly change or challenge their partner's control, or the balance of power in the relationship (Goodman *et al*., 2003). A view of domestic violence as a personal problem, often reinforced by community and perpetrator denial, as well as fear of retaliation and socially ostracizing, deter many women from confiding in other aand seeking help (Dominy and Radford 1996, WHO 2002)

Barriers to disclosure and help-seeking UK surveys indicate that majority of victims keep abuse to themselves. Over half of all those who disclose domestic violence victimization in the 1996 BCS had not told anyone about the last attack, and 1 in 3 women disclosing last year were over three times more likely than other BSC domestic violence victims to report the police had been alerted at some point, 64% these victims were unknown to police. Police were not

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informed of more than 3 in 4 assaults where the victims were injured (Mirrles-Black, 1998). The 2001 BSC focused on the reporting of worst incidents and found police were made aware of only 23% of worst last year domestic assaults and threats, and in 1 in 4 of these incidents they were informed by someone other than the victim. Whilst police were twice as likely to come to know about worst incidents when the woman received serious injuries (i.e internal injuries and broken bones), they were still not informed in the majority of such cases. Younger women (under 25), and those in household with above average income were less likely to involve the police (Walby and Allen, 2004).

Victims' views and decisions about the pros and cons of help seeking can be understood in subjective cost/benefits terms. Using US crimes victimization survey data, Felson *et al*. (2002) analyzed the reasons given by victims of violence for calling/not calling the police. Women who had experienced domestic violence were more likely to call the police for reasons of self-protection (i.e. to stop the incident or to get protection from future attack) than were other violent crime victims. However, concerns about privacy, fear of reprisal, and concern about the consequences of arrest for perpetrators, inhibited victims of domestic violence from calling the police more than victims of other violent crimes, identified cost factors constrained more domestic violence victims from calling the police, than the benefits motivated others to do so. Whilst overriding consideration of safety and self-preservation often prompt women to involve the police, they also deter a substantial proportion of women who fear reprisals (Patterson 2003). A UK study of victim intimidation reported in the BCS (Tarling *et al*., 2000) validates domestic violence victims' concerns about further abuse, and retaliation if they involve criminal justice agencies 38% of abused women reported further violence or intimidation in the aftermath of a domestic violence incident, and rates of intimation were over twice as high when the offence had been reported to the police.

Help seeking in response to escalating violence

Education of violence is associated with women's increased use of all types of coping strategies, including placating, resistance, safety planning, use of informal networks, use of helping agencies such as social and medial service and shelters, and use of legal serves e.g. lawyer and police (Lewis *et al*., 2003, Humphreys & Thiara 2002 & 2003). Most women who had sought assistance from their informal networks (e.g. talking to or staying with family and friends making sure someone was with them at risky times), considered them particularly helpful in reducing the incidence and impact of abuse, particularly in the short-term (Goodman *et al*., 2003). Women participating in the 2001 BCS were more likely to tell the police if they had told others, especially if they also sought legal advice (Walby and Allen, 2004). Whilst many women do not disclose abuse to public agencies, in spite of experiencing frequent and serious violence, UK studies indicate that many of those who do turned to more formal sources of help when support from social networks did not extend to confrontation of men's abusive behavior, and when attempts at using in formal controls failed to stop the violence (Lewis *et al*., 2000). In a survey of users of UK domestic violence outreach services, women who experienced reperated violene repeated violence reported high levels help-seeking: 80% had called the police, 68% had contact with their local authority housing department (20% of whom were refused housing), and 44% and contact with social services for their children (Humphreys & Thiara 2002).

The 2001 BCS found women were much more likely to report domestic violence to police when it caused injury, was more severe and accorded more frequently (Walby & Allen 2004). Other studies have consistently demonstrated that key predictors of victim's decision to involve the police are a previous history of abuse, violence severity and frequency level of injury, use of weapons, children witnessing assaults, and alchol consumption by the perpetrators at the time of the incident (Rodgers 1994), (Dutton *et al*., 1999), (Mirrlees – Black 1999), (Dauvergne & Johnson 2001), (Hirschel & Hutchinson 2003). Experience of high levels of dominance/isolation has also been found to predict more frequent calls to police. (Dutton *et al*., 1999).

The following results were obtained when respondents were asked about their awareness of health centers dealing with violence against women (table 6)

Awareness of Traumatic Centers for violated women

Few of the respondents confirmed their awareness of the traumatic centers for violated women which they knew through the university they attended, but the majority of the respondents claimed they never heard about any traumatic centers that can raise any help or supporting aids for them.

Reporting Violence in health centers (Table 7)

Responses obtained from the respondents during the questionnaire showed that, none of the respondents ever report to the health when they are violated due to reasons that varies from one woman to another (such

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as traditional, cultural, economic, stigmatization reasons).

Thus, this show weakness and gap in the awareness of the respondents in reporting violence to the health center.

The researcher visited about 6 health centers in different localities such as Ombada and Riyadh just to take comparison and to justify if the status of the women in these localities will differ based on their education level, access to health centers, their economic status, when it comes to reporting violence,, but this study found out that, none of the violated women is willing to report the incident due to reasons such as stigmatization, and being too sad or willing to see anybody at that moment, the health centers visited also made it clear that, handling violence and against is a big issue not included in their routine performed daily as there were centers specialized for such, such as trauma centers, social centers for women and child or police station.

Factors Contributing to Violence Against Women (Table 8)

The Reponses pointed out some factors related to social activities; all the women considered that, the violence is multi-dimensional, the following factors related to the general socio economic environment.

The factors related to controlling attitude are:

Some respondents complained of feeling of superiority of husband and tendency to show controlling attitude if the woman tries argue.

Factors related to money:

Also some respondents considered money to be the leading factors leading to being violated, while some argued that social activities are the cause, some noted that husband consume alcohol and demand for sex at inconvenience time, while some that men lost confident in women specifically for those who stayed long hours in the work place and signs of jealousy due to their high income.

Women Reponses to violence

Women respond to the violence in a variety of ways:

They do not trust anyone.

Many tolerate the violence due to fear of economic burden.

Fear of their family nit accepting divorce from their partner.

Women don't have the right to challenge their husband's domination.

They fear the disadvantage and consequences of a broke home on the children.

Perception of Women on Reporting Violence

All respondents elaborate the points that domestic violence affects them, their children, health, family and the society they lived in. they cited the following as the impacts of violence on them:

Emotional problems such as loss of self-esteem, confidence among their fellow women.

Physical problems such body pains, difficulties while doing house chores.

Tension on the children, children hear the fighting and also witness the injuries, thus they become isolated and withdrawn; and most of the kids living such environments tend to look for ways of escaping from such environments and become homeless, drug users and alcohol consumers.

Also some of the respondents emphasized that; victim help-seeking is often an indicator of a serious situation. If not there is no need for such action, more so it doesn't warrant creating bad record about their children's future.

The 2001 BCS found that police were much more likely to be informed if violence was frequent, severe and caused injury (Walby, 2004). A US hospital study (Block 2003), found women who were seriously injured or murdered by their partners were more likely to have sought help in past than were other victims of domestic violence. Analysis of London homicide reviews also found that women killed by their partners had often been in contact with keys agencies immediately proper to their death (Richards, 2003). In an US study, which randomized police responses following a domestic violence call-out (Hirschel & Hutchinson, 2003), victims who wanted their partner arrested were consistently more likely to suffer subsequently abuse, based on victims and police reports. As victim preferences did not influence police decision, due to the experimental nature of the study, the association was not had often attributable to the nature of police action, but rather indicated that a correctly perceived, significant risk of re-victimization may be characteristic of cases where the victim requests police involvement and want an arrest.

Health Centers Knowledge about Identifying Violated

Most of the health centers visited and interviewed clarify that, they were not trained to identify violated women for two reasons. Firstly, the violated women will not come to go out after being violated due to the traumatic feelings she might be going through, talk less of coming to the health center, then secondly 'this is not part of our job' since they are specialized centers for such issues, although we do recommend support to some women that showed sign of weight reduction during pregnancy. Some of them mentioned awareness about gender based violence programmes being launched by some institute such as Ahfad Univesity for women, UNFPA, CAFA and so on but it is still obvious that the objectives of this programmes are not

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tackling the problems of domestic violence at individual level, but rather seen as community problem.

Conclusion

It is obvious that, women who faced domestic violence are not empowered enough economically or even still accept that violence is not the right of a man. They see it as personal issue rather than seeing it as health-related issue which they can endure with coping strategy instead of seeking help from appropriate channel like police station, health care center, through it is difficult for the women victims to avoid risks, but the positive side of the conflicts is that, it provides good chances for women to challenge their subordinated status and to empower themselves to prevent violence.

According to the interview the candidate found that, many women intend to learn more strategies and some intended to learn copping mechanics to gain confidence and respect, since leaving an abusive relation has many consequences which many women are afraid of facing the challenges all alone. More so the health centers too are not helping the situation; they are not encouraging in seeking help from them, because they didn't show enough skills and knowledge on how to identify violated women talk less of full preparedness in helping the violence victims.

The finding from this study identify many health related problems faced by women that may arise from the consequences of domestic violence against women such as emotional, physical mental and psychological problems like loss of self-esteem, confidence among their follow women, body pains, difficulties while doing house chores, gynecological problems like abortion, low birth weight, sexually transmitted diseases. Findings also showed that, that, domestic violence arise due to socioeconomic factors like money issues, unemployment, and living with dominant partners with controlling attitude.

Conflict of Interest

Non

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