MISSING PIECE IN THE PUZZLE

The health sector's role in implementing the DVA

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Successful implementation of the Domestic Violence Act is impeded by the absence of specific duties and responsibilities for health sector personnel. This article considers the role that the health sector could play. Although amending the Act would be ideal, alternatives include standardising domestic violence screening guidelines and developing an abuse management protocol for the effective implementation of the DVA. In this way, the health sector can make a significant contribution to reducing levels of domestic violence.

The passing of the Domestic Violence Act (116 of 1998) (DVA) represents a significant contribution to the fight for women's rights in South Africa. The Act aims to give victims maximum protection from domestic abuse by providing an all-encompassing legal definition of abuse, setting out the criteria for a 'domestic relationship', and outlining new legal duties and responsibilities of law enforcement to assist victims. While the Act signifies marked progress on paper, in practice the struggle to effectively implement the DVA continues.

Gaps in the DVA

As part of a project to monitor implementation, the Consortium on Violence against Women found that there was a degree of silence from the health sector that impeded successful implementation of the Act.[1] Of particular concern is that while the DVA provides new legal duties for law enforcement personnel, it does not require parallel responsibilities of health sector personnel who are presented with a domestic violence case.

The Department of Health's Strategic Plan (2000-2004) identifies gender-based violence as a 'major priority area' and outlines strategies to address the issue. These include training health personnel to provide support to victims through early diagnosis, counselling, collection of forensic evidence, and developing protocols for the management of patients with a history of abuse.[2] Despite these efforts, service provision between the justice and health sectors remains fragmented. This lack of coordination results in:

- health care workers who are not trained to confidently inquire about and document abuse and are unprepared to testify in court;
- beliefs in both sectors that domestic violence is predominantly a legal issue; and
- the revictimisation of women who struggle to receive medical, legal, and mental health assistance via a maze of disjointed service provision efforts.

Amending the DVA to include the legal obligation of health providers to assist victims of violence in a standardised manner would be ideal. Alternately, emphasis must be placed on the need for health workers to thoroughly document incidences of abuse.

This article aims to discuss the potential role played by the health sector in the implementation of the DVA. Specifically, standardised domestic violence screening guidelines and an abuse management protocol are ways in which the health sector can make a significant contribution to reducing domestic violence in this country.

Domestic violence as a public health issue

Domestic violence is the number one cause of physical trauma and injuries to women in many countries.[3] Aside from direct physical injuries resulting from abuse, women suffer from chronic conditions such as gastrointestinal problems, anxiety, stress, sleeplessness, depression, pregnancy-related problems, and alcohol or drug dependency as a result of domestic violence.

In response, professional medical associations from around the globe have increasingly recognised violence against women as a major public health concern. Prevention and intervention research, programmes, and policy addressing gender-based violence have expanded beyond the fields of criminology and law enforcement to include public health and medicine.

Research conducted by the Institute for Security Studies has shown that 53% of women who experienced physical domestic abuse sought medical assistance following the incident. Other studies have found this figure to be as high as 92% in some provinces.[4] Clearly, these statistics indicate that the health care sector is often the first point of contact for many abused women. When domestic violence is not physical in nature and women with a history of abuse present at a health care facility for reasons unrelated to domestic violence, current or past experiences of abuse may go undetected and undocumented.

Failure to inquire about domestic violence is a disservice to victims. The result of not exploring the potential cause of somatic symptoms could be misdiagnosis, over-prescribing or unnecessary medical tests. Failure to inquire about abuse and properly manage victims also presents a missed opportunity to document the identity of the abuser and history of abuse, if legal action is taken in the future.

The medical practitioner's role

By definition, domestic violence is hidden within the confines of an individual's or family's personal space – their home. While fear of the abuser and lack of hope may be important reasons for non-disclosure, the stigma that is associated with domestic violence means that victims are frequently ashamed or embarrassed by their situation, further burying the ability to disclose the abuse.

The occupational status that is associated with physicians in South Africa provides doctors with a unique opportunity to begin to reduce this stigma and address domestic violence in the public domain through regular screening practices.

When abuse is acknowledged as a risk factor for poor physical and mental health and seen as a violation of human rights *regardless* of the situation in which it occurs, domestic violence may begin to emerge from the private space to become a public issue that actively demands attention in the justice and health domains.

As health care workers and medical professionals are often the first service providers to come in contact with a victim of abuse, they have the opportunity to assist by providing resources and referrals, explaining options available within the judicial system, conducting safety assessments and safety planning, and accurately documenting the visit. The confidential and personal space created by the patient–provider relationship provides an opportunity for disclosure of abuse to take place.

In 2001 Peltzer and colleagues found that only 5% (of 402 South African doctors) felt that a major role of the health care practitioner was to examine and document the findings of a suspected battering case.[5] In this study, doctors felt that their role was to provide medical treatment, confront the patient regarding the nature of the injury if abuse was suspected, and refer the patient to other services such as psychological or social work services for help. This demonstrates the degree to which the health sector is both unaware of the role that it can play in administering legal information as well as providing legal evidence through documentation.

Hesitancy around screening

Due to the uniqueness of each case and the way in which abuse affects the victim, victims of domestic violence can be difficult to identify. In a study of 1,050 women screened for domestic violence in health centres throughout South Africa, 22% reported incidences of domestic violence. Of these women, their practitioners had suspected abuse in 17% of cases and had raised the issue with only 12%.[6]

Lack of training and knowledge about domestic violence are frequently cited as reasons why practitioners are reluctant to inquire about abuse.[7] In a recent study on the attitudes and practices of doctors toward victims of domestic violence in South Africa, Peltzer and colleagues found that only 10% of doctors had received training on domestic violence.[8]

Recent informal discussions with medical students at the University of Cape Town support findings in the literature that hesitancy around screening may stem from:

- age differences between the patient and provider that make asking about such a private issue awkward;
- cultural differences between patients and providers that make it difficult to effectively communicate about abuse due to language barriers, terminology or otherwise;
- the inability to change the victims situation or help the victim if she discloses abuse;
- fear of offending the patient;
- lack of time to address the issue; or,
- fear or lack of preparedness to assist a patient if she gets emotionally upset.

The omnipresence of domestic violence in South Africa justifies the implementation of selective (or even universal) screening practices. Patient–provider differences in age, sex, and culture and the inability to discuss private relationships may make this task difficult for inexperienced health workers, which is why education and formal protocols are required to assist practitioners.

Once screening becomes common practice, not only will women increasingly view the health sector as a place to turn for help, but they will also expect an opportunity to disclose abuse when they present at a health facility.

Screening not only allows a health care worker to identify a victim and provide health services and assistance in engaging in the judicial process, but is also an intervention itself. Inquiring about abuse has been found to be the most important service a health worker can provide to a victim.[9] A qualitative study conducted in the United States found that in several cases, asking about abuse provided the victim with a sense of hope and verification that abuse is wrong.[10] On the other side of this coin, failing to ask about abuse may further isolate the patient from assistance and resources and strip her of hope for a different future.

Standardised screening practices and management guidelines

In 2003 a strategic framework for introducing screening practices in state-run health care facilities was developed.[11] The framework was based on research conducted by the Consortium on Violence against Women and it emphasises the collaboration between health and justice sectors to secure the safety and well-being of victims of violence.

The framework provides protocol guidelines that specifically outline the responsibilities of the health sector if an integrated multisectoral service delivery system for victims of domestic violence is to be achieved. The aim is to assist health care management in the implementation of screening practices as a preventive health care measure and provide standardised management guidelines to practitioners should abuse be disclosed.

A formal standardised protocol for screening and documentation are needed to ensure that:

- health care workers are provided with the appropriate skills to conduct universal screening and effectively discuss intimate and private issues;
- health care workers inquire about abuse in a non-judgemental and compassionate manner so the patient does not experience retraumatisation;
- incidences of abuse are regularly documented for use in the justice system should a victim

want to obtain a protection order or lay criminal charges against the perpetrator, as well as for other legal matters such as child custody battles.

It has been shown that when presenting to a physician for injuries related to domestic violence, the victim frequently identifies the abuser.[12] It is expected that positive identification of the abuser will increase as screening rates increase and more women are disclosing abuse. Providing practitioners with a protocol outlining their clinical responsibilities, and training them to engage in these discussions confidently and comfortably with patients could significantly increase women's chances of attaining safety and protection against abuse.

Summary and recommendations

South Africa has frequently been described as having a 'culture of violence' where violence is used (and accepted) as a means to an end: to gain social acceptance, solve disputes, or achieve a goal. Particularly with respect to violence that occurs within the confines of a private space and between intimate partners, it is critical that the issue is addressed in a public space and it is made clear that the actions are unacceptable.

A multisectoral response between the health and justice sectors is needed to actively address the gender inequality, subordination, secrecy and shame that underlie violence against women. As many physicians are hesitant to ask about abuse because they feel it is beyond their control, it needs to be emphasised that the health practitioner's role is not to solve the problem. This shift from focusing on curative care to how to best support the victim's needs is one reason why standardised protocols around domestic violence screening and health care worker education and training around abuse is necessary.

In sum, specific recommendations for consideration are to:

- place a legal duty to assist upon health care practitioners under the DVA;
- train medical practitioners to adequately screen and document cases of abuse;
- implement the screening policy and abuse management framework, or some derivation thereof, throughout South Africa;
- assess the use of expert witnesses in domestic violence cases and ensure that medical personnel are provided with training around testifying in court; and,
- encourage (or require) medical practitioners to write accurate and thorough written reports for the courts.

Endnotes

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