A study of domestic violence among women attending a medical centre in Sudan

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دراسة العنف الأُسَري وسط النساء المتردِّدات على مركز طبي في السودان

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الخلاصة: استهدفت هذه الدراسة تقصِّي العنف الأُسَري في أوساط الأُسَر السودانية. وفي إطار هذه الدراسة تمت دراسة 394 امرأة من المتزوجات الملمَّات بالقراءة والكتابة، المتردِّدات على أحد المراكز الطبية في أم درمان، وذلك في المدة من تشرين الأول/أكتوبر 2001 إلى شباط/فبراير 2002. وقد قدَّمت هؤلاء النساء، من خلال استبيان ذاتي الاستكمال، معطيات حول الخصائص الاجتماعية الديمغرافية للأسرة وإساءة معاملة أزواجهن لهن. وبلغ عدد من أبلغن عن تعرُّضهن لإساءة المعاملة 164 امرأة (أي نسبة 41.6٪)، تعرَّضن لـ 525 حالة عنف في العام السابق، صنِّفت إلى: سلوك تأديبي (194 حالة)، وسلوك تهديدي (169 حالة)، وعنف بدني (162 حالة). وتفاوَتَ معدَّلُ تكرُّر حالات العنف من مرة واحدة (25٪) إلى أكثر من 6 مرات (20.7٪). كما أبلغت 27 امرأة (نسبة 16.5٪) عن تعرُّضهن للعنف أثناء الحمل. وشملت الأسباب المباشرة لحالات العنف: الارتياب في وجود علاقة غير شرعية، وعدم طاعة أوامر الزوج، وعدم العناية الكافية بالمنزل. وتفاوتَتْ ردود أفعال الزوجة من الصمت إلى البكاء إلى المقاومة.

ABSTRACT To investigate domestic violence in the Sudanese family, we studied 394 literate, married women attending the Arda Medical Centre, Omdurman, from October 2001 to February 2002. Through self-administered questionnaires, the women provided data on sociodemographic characteristics and abuse by the husband. Abuse was reported by 164 women (41.6%), who suffered 525 violent episodes in the previous year, classified into controlling behaviour (194), threatening behaviour (169) and physical violence (162). Frequency of violent episodes varied from 1 (25%) to > 6 (20.7%). Violence during pregnancy was reported by 27 women (16.5%). Provoking events included suspicion of illicit relations, talking back and inadequate home care. Common reactions reported by the women included staying quiet, crying and resistance.

Étude de la violence familiale chez des femmes consultant dans un centre médical au Soudan

RÉSUMÉ Afin d'étudier la violence dans la famille soudanaise, nous avons procédé à une enquête auprès de 394 femmes mariées instruites qui sont venues consulter au Centre médical Arda d'Omdurman d'octobre 2001 à février 2002. Au moyen d'auto-questionnaires, les femmes ont fourni des données sur les caractéristiques sociodémographiques et les mauvais traitements infligés par le mari. Des mauvais traitements ont été signalés par 164 femmes (41,6 %), qui ont vécu 525 épisodes de violence au cours de l'année précédente, classés comme comportements autoritaires (194), comportements menaçants (169) et violence physique (162). La fréquence des épisodes de violence variait de 1 (25 %) à plus de 6 (20,7 %). La violence pendant la grossesse a été rapportée par 27 femmes (16,5 %). Parmi les événements qui déclenchaient la violence figuraient les suivants : le soupçon de relations illicites, répondre insolemment et ne pas bien s'occuper du foyer. Les réactions courantes signalées par les femmes étaient le silence, les pleurs et la résistance.

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Introduction

Violence is defined as a behaviour toward another person which is outside the norms of conduct, and entailing a substantial risk of causing physical or emotional harm [*1*]. The main types of violence include child abuse, peer assault (including domestic violence), stranger assault, abuse of the elderly, state violence and war crimes.

Throughout history, in most societies women have held a much lower status than men [*2*]. This situation renders them profoundly disadvantaged in terms of power, wealth and personal freedom. The low value placed on women's lives in many countries can be evidenced by sombre indicators such as high maternal mortality, high level of illiteracy and unequal access to government services [*2*]. Owing to these factors, and as a result of their gender-rooted subordinate status, women are perpetual victims of family, community and government violence. Examples of violence against women include spousal abuse, rape, exploitation of labour, trafficking, forced prostitution, genital mutilation, debt bondage and infanticide [*1*].

The term "domestic violence" is usually used to define violence exerted toward the woman by a family member (most commonly the husband or the intimate male partner) [*1*]. It can be seen as a pattern of psychological, economic and sexual coercion of one partner in a relationship by the other that is punctuated by physical assault or credible threat of bodily harm [*3*].

Physical violence can be anything from pushing or punching to firearms injuries. Apart from physical assaults, domestic violence can be seen as a set of learned, controlling behaviours and attitudes of entitlement that are culturally supported and produce relationships of entrapment [*4*]. Domestic violence has a much greater prevalence than has been assumed. A prevalence of more than 40% has been reported in American and British studies [*5–7*]. Over one third of women attending general practices had experienced violence [*7*]. The healthcare costs associated with management of family violence injuries in the United States of America has been estimated at US$ 857 million annually [*8*]. In 1992, 12% of all homicides resulted from intrafamilial violence [*9*].

Violence against women is a product of the interaction of factors at individual, family, community and society levels [*1*]. At the individual level, these factors include being abused as a child, witnessing violence at home, having an absent or rejecting father and frequent use of alcohol or drugs. At the family level, marital conflicts and the dominant male control of wealth and family issues are considered strong predictors of abuse [*10*]. At the community and society levels, the factors which interplay to produce violence include poverty; unemployment; lack of support and isolation of family and women; linkage of the concept of masculinity to male honour or dominance; acceptance of violence as a way to resolve conflicts; and social tolerance of physical punishment of women [*10*]. Violence may evolve from the socially acceptable gender norms. Men are the family masters (or even women's owners!) because they provide financially. Women are expected to tend the house, mind the children and show obedience to their husbands. A breach in the woman's role or challenging the men's rights may provoke violence.

Violence against women has profoundly grave consequences. It compromises their health and erodes their self-esteem. In addition to causing injuries, violence may result in physical disability, depression, unintended pregnancy, sexually transmitted infec-

tion, adverse pregnancy outcome and suicidal thoughts [*11*]. Domestic violence can lead to marital conflict and hinder women's participation in the social and economic well-being of the society [*12*]. This is worsened by the fact that men may perceive the empowerment of their wives as a threat to their own control [*12*].

Worldwide, awareness of the extent of domestic violence has been increasing since the first report about battered women appeared in the early 1970s [*13*]. Since then, an efficient multidisciplinary system has evolved in the industrialized countries to help victims. In the developing countries, including Sudan, neither the extent of the problem nor any protective measures have been established. In Sudan, women constitute 50% of the population (15 million out of 30 million) [*2*]. They have a life expectancy of 52 years and an illiteracy rate of 60%; both figures are lower than those for their male counterparts [*2*].

This study is the first effort to study domestic violence in Sudan. Up to now the majority of health workers have been unaware of or indifferent to their role in helping victims of violence (they do not screen for or consider the role of violence in their patients' health problems). Our study aimed at investigating the problem of domestic violence among women attending a medical centre for chronic diseases in regard to extent, patterns and determinants.

Methods

This study was done among the women attending the medical clinic of the Arda Medical Centre in Omdurman, Sudan in the period 31 October 2001–28 February 2002. The centre has referral clinics in all the clinical specialties, and is run by consultant physicians and surgeons. The medical centre receives patients mainly for follow-up of chronic diseases (of which diabetes mellitus and hypertension are the commonest) first seen by junior doctors in smaller health units. The clinic receives patients from both urban and suburban areas of Omdurman (the largest city in Sudan).

We recruited 492 women as eligible for our study, 394 of them gave their consent to participate, a response rate of 86.8%. Of the respondents, 164 women (41.6%) gave a history of 1 or more forms of abusive behaviour by their husbands in the previous year. The remaining 230 women (88.4%) served as a control group for our study in regard to the sociodemographic characteristics of the abused.

The women eligible for the study were all the married and literate women seen consecutively during the study period. Women who were too ill to complete the questionnaire were excluded. The participants provided oral consent—we avoided written consent so as to preclude any chance of identifying the origin of any particular questionnaire administered. Three female research assistants, who had been trained in interview techniques, assisted in recruiting the women and answering queries raised by them in regard to completion of the questionnaire. For each eligible woman we offered a brief description of the nature of the study. We clearly explained that they would be asked sensitive questions about their relationship with their husbands. In our society, close relationships of women (including sexual life) are only allowed with the husbands following a formal marriage. Otherwise they may face death or a prison penalty according to the *sharia* (the Islamic legal code).

Each woman, after giving her consent to participate in the study, was given an anonymous, self-administered question-

naire in a private setting with strict confidentiality assured. The questionnaire was developed from those used in international studies which we modified to suit Sudanese women. It was piloted on 30 women before being used in this study.

For the purposes of our study, domestic violence was defined as an assault, threat or intimidation perpetrated by a husband [*14*]. Abusive behaviours were categorized into threats, controlling behaviours and physical assaults. The physical assaults were classified into minor (e.g. throwing objects, shoving), moderately severe (e.g. beating up, producing contusions) and severe (e.g. causing head and internal injuries). In the questionnaire we required information on sociodemographic characteristics such as age, education level, employment status (categorized as full time or intermittently employed or unemployed) and annual household income. At the time of our study, the average family in Sudan needed US$ 2500 per annum to cover the very basic requirements of living. We also asked about the age, education level and employment status of the husbands and whether they were using alcohol or illegal drugs.

Each woman was asked if her husband pushed her, hit her, kicked her or physically hurt her in some other way during the previous year. The women were also asked if they had received threats of physical injury. We enquired about the controlling behaviours adopted by their husbands (shouting or screaming at her, restricting her social life, checking her movements, etc.). Questions on violence related to sexual issues were perceived to be too embarrassing for the first fifteen women (who refused to give clear answers). These were then deleted from the survey.

Each abused woman was asked about the immediate provoking factors for violence, frequency of abuse, her reaction to the assault, whether she had sought medical or other help, whether she had been hurt by other family members (e.g. father, brother), whether she had ever been assaulted during pregnancy, whether she had even been asked by a doctor about abuse.

The analysis of the interval variables of the characteristics of both abused and non-abused women was done on frequency data using the Student *t*-test. The significance levels were determined at $P < 0.005$.

Results

Table 1 shows the sociodemographic characteristics of the abused (164 women, 49.6%) and control (230 women, 58.4%) groups and their husbands. Comparing the 2 groups, the abused women were younger, were of lower education status, had been married a shorter time, and the majority were unemployed ($P < 0.001$ for these variables). Being less educated, the abused group had a lower chance of being employed. The husbands in both groups were older than their wives, but the age gap was greater in the abused women. Compared to the husbands of the control group they were less educated, had less chance of employment, and were more likely to be alcohol or drug abusers ($P < 0.001$).

Table 2 shows the pattern of abuse among the victims of domestic violence in our study. Of the 164 abused women, 112 (68.3%) had experienced 1 or more forms of controlling behaviour by their husbands, 119 (72.6%) had been threatened with physical injury and 79 (48.2%) had experienced physical violence (of whom 26 had sustained injuries, including bruises, that needed medical attention). These women reported 162 episodes of violence, of which 107 (66.1%) were mild, 47 (29%) were moderately severe and 8 (4.9%) were

Table 1 **Sociodemographic characteristics of abused and control groups and their husbands**

Characteristic	Abused women (*n* = 164)		Control group (*n* = 230)	
	Mean	**(SD)**	**Mean**	**(SD)**
Age (years)	29	(11)	36	(10)
Duration of marriage (years)	6	(4)	9	(5)
Husband's age (years)[a]	34	(6)	38	(9)
	No.	**%**	**No.**	**%**
Education level				
6–8 years	74	45.1	39	17
9–12 years	79	48.2	160	69.6
Graduate	11	6.7	31	13.4
Annual household income				
< US$ 2500	133	81.1	122	53.1
< US$ 2500	31	18.9	108	46.9
Employment status				
Employed full time	30	18.3	134	58.3
Intermittently employed	12	7.3	35	15.2
Unemployed	122	74.4	61	26.5
Husband's education level				
6–8 years	39	23.8	17	7.4
9–12 years	98	59.7	171	74.3
Graduate	27	16.5	42	18.3
Husband's employment status				
Employed full time	70	42.7	172	74.8
Intermittently employed	31	18.9	37	16.1
Unemployed	63	38.4	21	9.1
Alcohol or drug abuse of husband	78	47.5	39	16.9

P ***< 0.001.***
[a]***Not significant.***

severe (resulting in burns and head and internal injuries). Our study group experienced a total of 525 episodes of abuse during the year prior to the visit. Forty-one women (25%) experienced 1 episode of violence, 53 (32.3%) experienced 4–5 episodes, 34 (20.7%) experienced 4–5 episodes and 34 (20.7%) experienced ≥ 6 episodes. Of the 26 women who had injuries, only half had sought medical help. They had not mentioned the real causes of injury nor had their treating doctors asked them about the possibility of domestic violence.

In accordance with our operational definition of domestic violence, we were only investigating violent behaviours by the husband. Even so, 42 of the abused group (25.6%) reported other perpetrators (father, brother or other relatives). Also, more than a third of the abused group gave a history of violent abuse before marriage. The

Table 2 **Patterns of abusive episodes among 164 women (some experienced more than one form of abuse)**

Abusive behaviour	Episodes
Controlling behaviour	194
Shouting at her	49
Criticizing her in public	42
Restriction her social life	39
Checking her movements	24
Keeping her short of money	21
Other	19
Threatening behaviour	169
Throwing things	4
Threatening with a fist	39
Threatening the children	31
Threatening with a weapon	19
Physical violence	162
Shoving	41
Punching (body)	34
Punching (face)	31
Kicking her on the floor	19
Forcing her to do something	8
Trying to choke her	6
Burning	2
Use of a weapon	2
Other	12

immediate provoking events for violence included suspicion of illicit relations, talking back, not obeying the husband, not having food prepared on time, refusing sex, failure to care for the home or children adequately, going out of the home without permission and questioning the husband about his money or illicit relations. In about 10% of the violent episodes, there were no evident reasons.

The abused women reported several reactions to the violent behaviour including staying quiet (89 women, 54.3%), crying (32 women, 19.5%), resistance (18 women, 11%), telling a relative (12 women, 7.3%), deciding to ask for divorce (10 women, 6.1%) and contacting the police (3 women, 1.8%).

Domestic violence during pregnancy was reported by 27 women (16.5%) but no one stated that it had caused miscarriage.

Discussion

Our data provides compelling evidence of the profound magnitude of domestic violence among the women who participated in the study. Our study group was highly selective and not representative of the female population of Sudan, so the results of this study (49.6% of the participants reported abuse) should not be taken as an indication of the prevalence rate of domestic violence in Sudan as a whole. Nevertheless, it is comparable with the results of international studies, where prevalence of domestic violence varied between 40% and 60%, or even higher [*14–16*].

Even if all non-respondents in our study were women who had not experienced abuse, then 1 in every 3 women attending our clinic would have experienced domestic violence. Moreover, it could be claimed that this figure is an underestimate due to sensitivity of the issue, meaning that some women may hesitate to speak openly.

The surprisingly high response rate in our study, 86.8%, indicates that many women are willing to disclose such issues when asked in a supportive fashion with strict confidentiality assured [*17*]. This may give an indication that populations at risk might cooperate in future screening and intervention programmes if done in a similarly supportive and sensitive way.

Patterns of abuse

In contradiction to some European and American studies, firearms injuries and

stabbings were rarely found among our study group [*14–16*]. The assaulters in our society seemed to prefer methods that cause no severe physical injuries. The high contribution of verbal assaults such as shouting or yelling is probably because they are culturally acceptable in our society. The typical violent episode in our study involved a combination of assault, threats and verbal abuse. The frequency of violent acts is similar to that reported internationally [*17,18*], more than 70% of the women reporting violence in all cases. Repetition of acts of assault is facilitated by the fact that victims are always readily available to the abusers, and that the assaults are carried out in private. Victims may show little or no resistance so as to minimize the renewed aggression or injuries.

Reactions to abuse

The response of an abused woman to violence is limited by the options available to her [*19*]. As elsewhere, the strongest reason that compels women to remain in an abusive relationship is probably lack of financial support [*19*]. The majority of these women are poorly educated and professionally unskilled and therefore have no access to jobs except marginal or illegal employment. Consequently, many victims capitulate to the abusers' demands and may succumb to psychological and physical problems (after an initial period of denial and self-blame) [*20*].

In our society, divorce (or even being unmarried) is socially unacceptable, especially when requested by the wife. Divorcees suffer social isolation or even further violence from other members of the family (as they are not allowed to live independently in a separate home). Moreover, the divorce is not easily obtained. According to Islamic law (*sharia*) the right to divorce is exclusively granted to the husband, and abusers tend to refuse to divorce their victims.

Nevertheless, not all abused women remain passive to violence. Some of them try to seek help (despite the fear of stigma) from relatives or doctors. In a few cases of domestic violence the police are called, especially for life-threatening injuries (when the police are required to be notified as a prerequisite to medical care). Apart from receiving physical treatment for their injuries, the victims received no other help.

Risk factors

Our study clearly indicates that risk factors for the occurrence of domestic violence include young age, poverty, unemployment, poor education, pregnancy and alcohol and drug abuse by the perpetrators. Violence occurs in a context of a relatively wide gap in age and education level between the husband and wife. These risk factors are not exclusive: any man can be a perpetrator and any woman can be a victim. In the presence of the risk factors, very minor or absurd things such as talking back or not having food ready on time are enough to trigger a violent episode.

In contrast to the European or American studies, we should emphasize the study of the cultural factors and socially acceptable norms that cause or aggravate violence. The Islamic religion, prevalent in Sudan, favours male supremacy and confers on men the right to correct their "erring" wives. Our social norms (through the perception that men have "ownership of women") predispose women to abuse by linking masculinity to male honour, and the acceptance of violence or female chastisement to resolve conflicts. These norms are not peculiar to Sudan, and may prevail in many cultures worldwide [*21,22*].

In accord with international studies, most of the abused women were young (in their late teens and twenties) [*18,23*], but the mean age for battered wives in our society was lower than in western societies, and this may be because of the younger age at marriage [*14*]. Older wives (e.g. those over 45 years) were reported as being less likely to be abused. If abuse occurred at this age, it may have even graver consequences. By this age, the woman's parents may have died and families may have broken up; they have many children and have almost no chance of earning money.

Although domestic violence can occur in all socioeconomic groups, many studies, including ours, found a higher prevalence in the poorer groups [*24,25*]. We found that 81.1% of abused women lived in families whose annual income was < US$ 2500 compared to 53.1% of the control group. Poverty, and the resultant feelings of hopelessness and crowding, increases relationship conflicts and reduces the woman's power [*26*]. It also reduces the ability of men to live in a manner that they regard as successful [*26*]. Poverty frustrates men owing to the loss of their cultural role as money providers. The situation is aggravated when husbands, as a controlling behaviour, tend to keep their wives short of money [*18*]. Poverty is the most common barrier to leaving an abusive relationship.

Unemployment (recent or long-term) and the stress of looking for work increase the risk a man will physically abuse his wife [*27,28*]. In our study, almost 40% of the husbands of abused women were unemployed compared to just under 10% of the husbands of women in the control group. Unemployment is also consistently related to alcohol and drug abuse, leading to further risk of domestic abuse [*23*]. The association of unemployment with poverty is undeniable. However, some researchers suggest that employment itself does not protect couples from violence [*29*]. Stressful work experiences have been associated with wife abuse [*28*]. It has also been suggested that the increase in female employment may generate tensions that increase the likelihood of marital conflict [*29*]. In a conservative society like ours, in a situation where the wife is working and the husband is unemployed, the latter's cultural role as family supporter is breached, and this may then generate family conflict.

Low level of education is linked to unemployment and poor income [*27*]. Poor education may be an indicator of poor communication skills, which have been linked to domestic violence (especially in the context of a large gap in education status in the couple) [*30*]. We found that 23.8% of the abused women were married to men who had ≤ 8 years of education compared to 7.4% of the women in the control group.

A strong association has been found between alcohol and drug abuse and the occurrence of domestic violence [*27*]. These factors adversely affect income and employment status and thus aggravate marital difficulties [*23*]. In the women we studied, prevalence of alcohol or drug abuse in husbands of abused women was almost 3 times that in husbands of the control group.

Pregnancy is reported to increase the risk of domestic violence and to alter the pattern of assault to be more severe [*7,31*]. Up to 41% of antenatal attendees in American studies report a history of violence at some point in their past pregnancies [*31*]. Just over 15% of the abused women we studied reported violence during pregnancy. Pregnancy, because of the hormonal and psychological changes which occur, may trigger violent assaults resulting from

minor events such as refusal to have sex or inadequate home care.

A word remains to be said about the perpetrators. Compared to husbands in non-violent relationships, perpetrators of abuse tend to be younger, unemployed and more troubled [*24*]. These factors are not the sole predictors of abuse. Any man may be an abuser and many perpetrators, apart from abusing their wives, have normal relationships in their home or work environments. Therefore, universal screening for partner abuse should be encouraged.

Limitations of the study

We are aware of the limitations of our study. Our clinic represents the maximum of diversity in terms of age, social class and education level. Nevertheless, we receive very few patients from rural areas, where women are placed at a lower social status, and some abusive behaviours are normal.

There was also a possibility of selection bias owing to the exclusion of illiterate women. The sensitivity of the issue and the need for confidentiality compelled us to use self-administered questionnaires to collect the data.

More than two thirds of our patients in the clinic suffer chronic disease (mainly hypertension and diabetes mellitus). Such women are particularly prone to abuse [*2,17*]. The husband may, for example, hide his wife's insulin or other medication, not help during hypoglycaemic episodes or refuse to arrange transport for follow-up appointments [*17*].

Conclusions

Domestic violence is a significant problem in our society. There is a need to implement a national multidisciplinary programme to deal with this problem, with the cooperation of health workers, nongovernmental organizations, government departments of health and social care, universities and other concerned bodies. This programme should aim at augmenting professional, public and government awareness of the problem and providing medical services, social support, protection and legal assistance to the victims of abuse. We should be aware that unless evidence of benefit exists, many women might hesitate to cooperate with programmes addressing domestic violence.

Relevant modifications in medical school curricula and doctors' training programmes are needed. As an interim measure, comprehensive guidelines for identification and medical management of abused women should be issued.

We suggest that future studies on domestic violence use a large sample size (preferably community-based) and apply new methods to diminish under-reporting (e.g. inclusion of rural and illiterate women). Also, future studies should cover past violent experiences and adequate periods of follow-up, and should assess the impact of personality and other psychological characteristics on violence. Perpetrators should also be studied as well as the less common possibility of abuse of husbands by their wives.

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***Preventing violence*. A guide to implementing the recommendations of the World Report on Violence and Health**

Each of the six parts of this guide corresponds to one of the six country-level recommendations of the *World report on violence and health*. Each part has provided a set of suggestions for activities in the areas of policy formulation, system development and programme implementations that, if acted upon, will assist countries in following these recommendations and thereby help to prevent interpersonal violence and improve care services for violence victims. This document, *Preventing violence*, has been prepared by WHO's Department of Injuries and Violence Prevention, in consultation with violence prevention experts from around the world, and provides conceptual, policy and practical advice on how to implement each of the six country-level activities. This document is available free on line at http://whqlibdoc.who.int/publications/2004/9241592079.pdf