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# Epidemiological and Clinical Study of Violence against Women and Girls in the Obstetrics and Gynecology Department of the Sominé Dolo Hospital in Mopti, Mali

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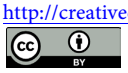
## Abstract

**Introduction:** The multidimensional crisis (security, institutional and humanitarian) that Mali experienced in 2012 caused a massive displacement of populations, particularly the most vulnerable, i.e. women and children. During the occupation, numerous cases of violence were reported by rights organizations and non-governmental organizations. **Objective:** The objective was to highlight the contribution of the obstetrics and gynecology department of the Sominé DOLO hospital in Mopti in dealing with violence against women and girls during this period. **Methods and Materials:** This was a cross-sectional study from January 1, 2016 to August 31, 2017 on victims admitted to our service for cases of gender-based violence. The sample size was 20 and was randomly selected. The inclusion criteria were all victims of violence against women and girls admitted to the service during the study period. The non-inclusion criteria concerned cases of violence against women and girls not recorded and managed in our service. **Results:** In total, we recorded 6971 outpatients in the obstetrics and gynecology department of the Sominé DOLO





hospital in Mopti during the study period, including 207 cases of violence against women and girls, i.e. a frequency of 2.96%. The types of violence were represented by early marriage (77.30% of cases, n = 160), sexual violence (11.60% of cases, n = 24), female genital mutilation and its complications (5.80% of cases, n = 12) and physical violence (5.30% of cases, n = 11). **Conclusion:** We found that violence against women is a tragedy that can have physical, psychological and obstetrical repercussions in the short, medium and long term.

## Keywords

Gender-Based Violence, Security Crisis, Mali

## 1. Introduction

Violence against women and girls has recently been recognized as a problem of violation of women's rights (Diallo, 2015). The United Nations Declaration on Violence Against Women defined gender-based violence in its Article 1 as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (Mayanja, 2010). Violence against women and girls is a problem that cannot be trivialized; it is one of the most widespread violations of women's rights. It knows no boundaries of age, race, culture, wealth, or geographic location. Violence against women is a public health problem that requires a multidisciplinary medical approach, involving specialties such as otorhinolaryngology, ophthalmology, gynecology, traumatology, psychiatry, etc. (Dembélé, 2013). Estimating the prevalence of the different forms and manifestations of violence against women is a difficult operation that immediately raises the problem of data collection and processing. Many countries continue to lack data or reliable data to measure the evolution of the problem. However, studies and surveys conducted by multiple organizations show very clearly that violence against women and girls is a widespread phenomenon with devastating effects on the health and well-being of women and their children. All surveys give similar figures: Violence against women of all kinds is a major public health problem that affects more than one-third of women worldwide, i.e. 35% (Garcia, 2013). In the United States, more than a third of women (35.6%) or approximately 42.4 million have been victims of rape, physical violence or harassment by their partner at some point in their lives (Black et al., 2011). A study conducted in Canada, in 2011, shows that 89 homicides were committed by intimate partners; among these crimes, 76 victims were women (Mazatand, 2012). In Algeria, 67.9% of Algerian women accept that their husbands beat them (Bouakba, 2009). In Tunisia, according to a national survey on violence against women in 2010, 47.6% of women aged 18 - 64 reported having experienced at least one of the multiple forms of

violence in their lifetime; 32.9% in the last twelve months (Zemni, 2014). In Ethiopia, 71% of women who had ever had a partner had experienced sexual and/or physical violence in their lifetime by an intimate partner, 35% of whom had experienced serious physical violence (WHO, 1996). In Senegal, 26% of all cases of violence recorded in 2010 involved assault and battery (Niang, 2012). The school environment is also affected in Senegal; in 2010, 24% of girls who were victims of violence were in the school environment: rape, sexual harassment, humiliation and insults (Diop, 2012). In Gabon, 52% of Gabonese women have been subjected to physical violence during their lives and 21% of women have been subjected to sexual violence during their lives (UNFPA Gabon, 2016). Indeed, a report by the United Nations Population Fund counted, in 2013, more than three thousand cases of violence against women in Mali, including 320 sexual crimes.

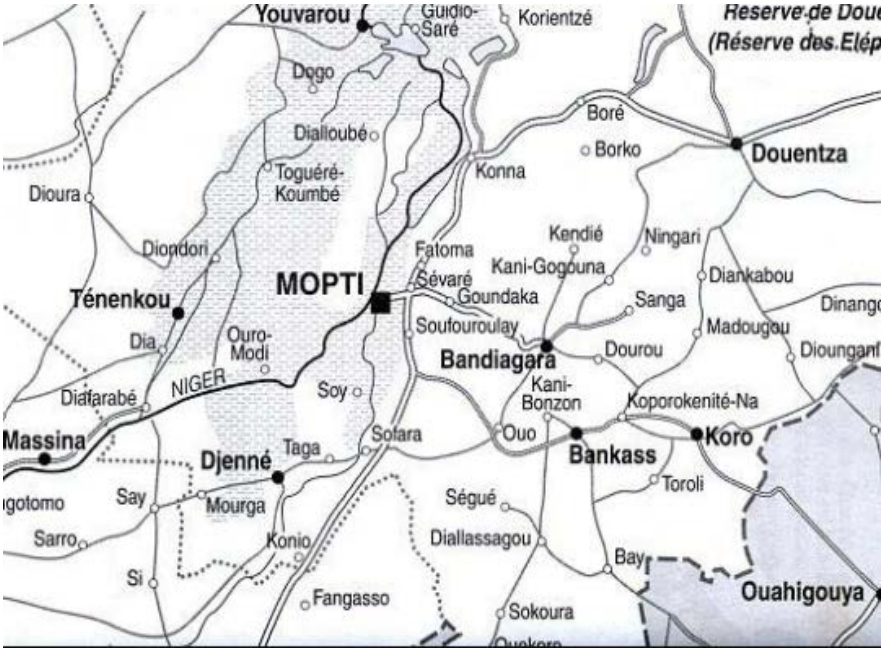
For a long time, the treatment of victims of violence was considered a social and judicial problem, with the role of doctors limited to writing medical certificates and providing emergency care.

Gradually, violence is becoming an integral part of public health, increasingly involving physicians and all health personnel. In Mali, according to the report of the Association for the Progress and Defense (APDF) of Women's Rights from the year 2004 to 2010, 730 cases of domestic violence against women were recorded of which 10.55% represented physical violence (Blondel, 2010). In 2012, Mali experienced an unprecedented humanitarian crisis due to the institutional crisis in the south and the occupation in April of the three northern regions and part of the center by several armed groups. Faced with this situation, thousands of people fled from the north to the south, the most vulnerable being women and girls. During the occupation, numerous cases of violence were reported by rights organizations and non-governmental organizations. Little is known about the numbers in Mali and Mopti. No work had been done on this subject in our department, which is why this study was initiated. The objective of our study was to highlight the contribution of the obstetrics and gynecology department of the Sominé DOLO Hospital in Mopti in the management of violence against women and girls during this period.

## 2. Methods and Materials

The setting for the study was the obstetrics and gynecology department of the Sominé Dolo hospital in Mopti, in the commune of Socoura on the road to Gao, at the gateway to the three northern regions of Mali (**Map 1**).

The 5th administrative region of Mali, Mopti is located in central Mali and covers an area of 79,017 $Km^2$ or 6.3% of national territory, its capital is the city of Mopti. The region is bordered to the north by the Timbuktu region, to the south by the Sikasso region, to the west by the Segou region and to the southeast by Burkina Faso. Its population in November 2013 was 2,356,001, which is 1,165,162 Men and 1,190,839 Women with a density of 29.81 around 30 inhabitants per




Map 1. Map of Mopti city (Source: Wikipedia image of Mali seen on 28/09/2017).

km$^2$. Located mostly in the Sahelian zone, it is divided into two major agro-ecological zones: an exodus zone in the east, comprising the circles of Bankass, Bandiagara, Koro and Douentza. This zone is divided into two parts: the mountainous and rocky part on the one hand, and the plain on the other, the flooded zone or the interior delta of the Niger, a vast marshy area during the annual flood season of the Niger River and its tributary the Bani, comprising the circles of Youwarou, Ténenkou, Mopti and Djenné. Most ethnic groups are represented there: Bambara, Peuhls, Songhai, Bozo, Dogon, Dafing, Mossi, Bobo, Samogo, Tamashek etc. In terms of communication infrastructure, the Mopti region does not have an important network: road in flooded areas and river in flooded areas during the Niger River flood. This situation makes a large part of the region inaccessible all year round. All of the cercles have at least one rural FM radio station. In terms of health care, the region does not have enough health care facilities: eight reference health centers (CS Réf), ninety-two community health centers (CS com) and two dispensaries. The human resources are not very important with only three hundred and eighty social-health agents.

The Sominé DOLO Hospital in Mopti is the only medical-surgical facility of the second level in the 5th administrative region of Mali. It is currently located in the administrative zone of Sévaré along the National Road 6 (RN6). The hospital of Mopti is today the hospital of reference for the whole region and some northern region. It has 122 beds that can be extended to 140 and employs 133 staff in all categories. Designed in a single block, the architecture offers good functionality and complementarity of services, the technical platform is equipped with the latest technology, the same platform as the hospitals of 3rd reference. October 8, 2012 was the date of transfer of the hospital to the new site in Sevaré.

It opened its doors to patients on October 8, 2012 and was inaugurated on March 18, 2014. The hospital has 4 operating rooms and the maternity ward has an operating room within it. The hospital's missions are to provide, 2nd referral curative care and emergency care; organization and training modalities (contribution to the initial training of pupils and students and continuing education of medical and paramedical staff); research in the field of health. The obstetrics and gynecology service: It provides care for all gynecological and obstetrical pathologies in the Mopti circle and in the region's reference health centers. Currently, the service is part of the "Mother and Child Pool", which is made up of the obstetrics gynecology service and pediatrics. It has two obstetrician gynecologists and one of them is the head of the department. The rest of the staff is composed of: 6 Midwives, one of whom is the midwife master, 4 students acting as interns, 6 Obstetric nurses, 3 Surface technicians. The service receives patients from the city of Mopti and the surrounding area, as well as patients referred from the Community Health Centers and the Health Centers of Reference of the circles. Other activities included prenatal consultations, family planning and birth registration. It is a place of internship that receives students and post-graduates from the Faculty of Medicine and Odontostomatology of Mali, students from the National Institute of Training in Health Sciences and from private health schools. This is a cross-sectional study that took place over a period from January 1, 2016 to August 31, 2017, i.e. duration of 20 months. The study population consisted of patients admitted to the obstetrics and gynecology department of Sominé DOLO Hospital in Mopti during the study period. Sampling was random and our sample size was 207. The inclusion criteria were all victims of violence against women and girls admitted to the service during the study period. The non-inclusion criteria concerned all victims who were not admitted to the service and for whom no treatment had been provided at our facility. For data collection, we used the files and individual collection forms for each survivor. A code was assigned to each survivor to avoid stigmatization. This code replaced the identity of the survivors on the materials (report cards, prescriptions, etc.). The difficulties and constraints related to the study were: the amicable settlement of sexual violence issues in the community; the late recourse of survivors to care structures; the absence of a psychologist in the region meant that psychological care was not properly provided. Nevertheless, the first psychological support was provided by the doctor and the social service agents, but in the end the survivors were often lost and the legal outcome was often unknown. From an ethical point of view, this was a purely scientific study and concerned the area of violence against women and girls at Sominé DOLO hospital, which remains a worrying problem. The results obtained and the recommendations were made available to all those involved in the fight against violence against women and girls for the betterment of women. Informed consent was obtained from each woman during the survey. The data collected was entered and analyzed using IBM SPSS version 22.0 software. The significance level was set at 0.05 and the confidence intervals at 95%.

## 3. Results

During our study, we recorded 6,971 patients in the obstetrics and gynecology department of the Sominé DOLO hospital in Mopti over a period of 20 months (January 2016 to August 2017). The age group of (17 - 19 years) was the most represented with 44.92% of cases (n = 93). The majority of victims resided in the commune of Mopti/Socoura with 81.15% (n = 168). The majority of the survivors were not in school (46.40%, n = 96). The ethnic group that practiced the most early marriages in our study was the Peulh with 0.63% (49).

The first service used by survivors was the health facility with 48.94%. Health admissions 24 hours after the violence were the most represented with 42.55%. The majority of the survivors were married early (77.30%). Street assaults were the most common with 36.17% of cases. The early marriage of survivors at 16 years of age was the most represented with 49.38% of cases. The stick was the most represented instrument for physical violence with 54.54% of cases. More than half of the survivors (54.17%) had an old scar on their hymen. Medical care was the most common method of treatment with 71.70% of cases.

## 4. Discussion

Our single-center, purely hospital-based study focused on several types of violence against women and girls. The frequency of violence was 2.96%. We could not make a valid judgement because many cases of violence were not reported for several reasons: prejudices of the family and social environment; profuse threats by the aggressor; attack on the honor of the family and the victim herself; insufficient awareness of the population by the public authorities, non-governmental organizations and associations for the defense of women's rights, which are themselves stigmatized; and finally, lack of knowledge by the survivors of the legal texts relating to the rights of women. In our study, the 17 - 19 age group was the most represented with 44.92%, followed by the 14 - 16 age group with 37.19% (**Table 1**). In his study, Diallo (2015) found that the 10 - 14 age group was the most represented with 37.3%. A study by the newspaper France soir found that young women aged 18-25 were the most exposed to physical violence and this rate decreased with age. The rest of the socio-demographic profile concerning our study was marked by: the Peulh ethnic group which had practiced more early marriages, i.e. 30.63% of cases, followed by the Bambara 18.25%, and the Dogon 16.87% of cases of early marriage (**Table 1**). Patients with no schooling were the most represented with 46.40% of cases. This high proportion reflects the low schooling rate of girls in Mali. The vast majority of survivors came from the urban commune of Mopti where our hospital was located, i.e. 81.15%, and the remainder from the other circles of Mopti, i.e. 18.85% (**Table 1**). More than half of the victims were housewives (68.11%) (**Figure 1**).

From a clinical point of view (**Figure 2**):

The main entry points sought by survivors of sexual and physical violence and complications of the aftermath of FGC were health (48.94%), judicial (31.92%), and nongovernmental organizations NGOs (19.14%) (**Table 2**). Since the security

Table 1. Socio-demographic characteristics of survivors.

| Age | Frequency | Percentage |
|---|---|---|
| 5 - 7 years | 10 | 4.83% |
| 8 - 10 years | 2 | 0.92% |
| 11 - 13 years | 5 | 2.41% |
| 14 - 16 years | 77 | 37.19% |
| 17 - 19 years | 93 | 44.92% |
| 20 - 22 years | 4 | 2% |
| 23 - 25 years | 7 | 3.40% |
| 26 - 28 years | 4 | 1.92% |
| >28 years | 5 | 2.41% |
| Total | 207 | 100% |
| **Provenance** | | |
| Circle/Mopti-Socoura | 168 | 81.15% |
| Other circles in the Mopti region | 39 | 18.85% |
| Total | 207 | 100% |
| **Level of education** | | |
| Not in school | 96 | 46.40% |
| Primary level | 50 | 24.15% |
| Koranic school | 35 | 16.90% |
| Secondary level | 23 | 11.10% |
| Higher education | 3 | 1.45% |
| Total | 207 | 100% |
| **Ethnicity** | | |
| Peulh | 49 | 30.63% |
| Bambara | 30 | 18.75% |
| Dogon | 27 | 16.87% |
| Malinké | 14 | 8.75% |
| Soninké | 11 | 6.87% |
| Sonrhaï | 9 | 5.63% |
| Total | 160 | 100% |

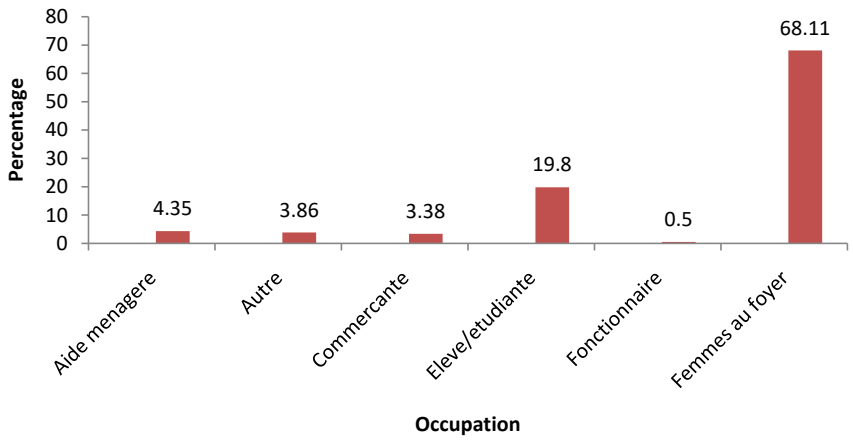



Figure 1. Distribution of victims by occupation. More than half of the victims were housewives (68.11%).

crisis that Mali experienced in 2012, some NGOs had conducted sensitization activities and training workshops to strengthen the skills of providers in the region on the management of survivors of violence against women and girls. These activities led to the establishment of a referral system for survivors and their referral to our service. The extremes of time for admission to the hospital varied between 24 hours and more than 72 hours after the assault, with 42.55% and 14.02% respectively (**Table 2**). The deformation and sensitization activities of the NGO population had a positive impact on the time of admission of survivors to our hospital. Sexual violence ranked second in our series with 11.60% of cases. Diallo (2015) found that sexual violence was higher than physical violence 59% versus 41%. In our study it was mostly punches and sticks; Diallo (2015) reported in 2015 that intentional assault and battery constituted the major part of physical violence with a rate of 95%. The UN found a rate of sexual violence of 75% in Central Africa (Mayanja, 2010). This very high rate in this part of Africa, would explain the permanent conflicts in this part of Africa. Assaults in the streets were the most common, accounting for 36.17%. These were cases of rape and other types of physical assault. Assaults in the bush were 25.53%, in the courtyards of inhabited houses 23.40% and often the victims were assaulted in places unknown to them 8.52%, closed rooms 6.38% (**Table 2**). According to the Rwandan survey, 10% of the women surveyed had experienced sexual violence in a public space (UNIFEM, 2008). These were bars, restaurants, public transport, streets and parking lots. The locations of the attacks were almost identical. It should be noted that no cases of spousal sexual violence were reported in our study, which may be related to the women's ignorance of reporting these types of violence. The majority of the girls were married before the legal age of 16 (49.70%). In Africa, this unfortunately common practice would be a way of sexually abusing a child or adolescent girl, even when this abuse takes the respectable guise of marriage. Sexual assault by penile penetration was the most common in 88% of cases (**Figure 3**). The single perpetrator was found in 88% of the cases, compared to 12% of the cases of multiple perpetrators of the survivors (**Table 2**). In 2002, Traoré (2002) found that 87.8% of victims were assaulted by a single individual, compared to 12.2% who were assaulted as a group (**Figure 3**). Among the 35 cases of sexual and physical violence recorded, we found that in 69% of the cases, the route of contact was vaginal and in 31% it was corporal (**Figure 4**). We did not find any cases of anal penetration. This would explain the higher frequency of rape in cases of sexual assault. Depending on whether it was sexual or physical violence, several types of instruments could be used. Thus, the penis was used in 88% of cases and the finger in 12% of cases of sexual violence. In our study, the stick and the fists were the most used with respectively 54.54% and 36.36% of the cases. The main complication of sexual violence was the deflation of the hymen with a rate of 33.33%. In 54.17% of cases the hymen was already scarred and in 12.5% of cases the hymen was intact (**Table 2**). Traoré (2002) reported 93%. However, the absence of a lesion did not mean that there had been

Table 2. Clinical characteristics of victims of sexual and physical violence and genital mutilation.

| First contact service | Frequency | Percentage |
|---|---|---|
| Sanitary | 23 | 48.94% |
| Judicial | 15 | 31.92% |
| ONG | 9 | 19.14% |
| **Total** | **47** | **100%** |
| **Admission deadlines** | | |
| 24 hour | 20 | 42.55% |
| 48 hour | 12 | 25.53% |
| 72 hour | 8 | 17.02% |
| >72 hour | 7 | 14.90% |
| **Total** | **47** | **100%** |
| **Type of violence** | | |
| Early marriage | 160 | 77.30% |
| Sexual violence | 24 | 11.60% |
| Female genital mutilation | 12 | 5.80% |
| Physical violence | 11 | 5.30% |
| **Total** | **207** | **100%** |
| **Place of sexual assault** | | |
| Street | 17 | 36.17% |
| Brousse | 12 | 25.53% |
| Concession inhabited | 11 | 23.40% |
| Unknown | 4 | 8.52% |
| Closed room | 3 | 6.38% |
| **Total** | **47** | **100%** |
| **Early marriage of survivors** | | |
| 14 years | 15 | 9.37% |
| 15 years | 46 | 28.75% |
| 16 years | 79 | 49.38% |
| 17 years | 20 | 12.50% |
| **Total** | **160** | **100%** |
| **Type of instrument of physical violence** | | |
| Stick | 6 | 54.54% |
| Punching | 4 | 36.36% |
| Teeth | 1 | 9.10% |
| Total | 11 | 100% |
| **Observed lesions** | | |
| Intact hymen | 3 | 12.5% |
| Recent hymenal lesion | 8 | 33.33% |

**Continued**

| | | |
|---|---|---|
| Old scarred hymen | 13 | 54.17% |
| Total | 35 | 100% |
| **Type of care** | | |
| Surgical | 15 | 28.30% |
| Medical | 38 | 71.70% |
| Total | 53 | 100% |

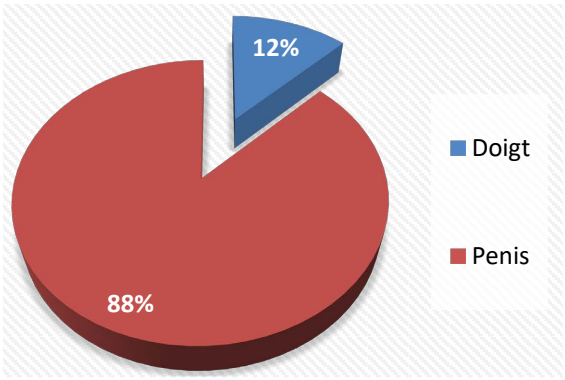



**Figure 2.** Distribution of survivors by organ used for sexual violence. Penile penetration sexual assault was most represented in 88% of cases.

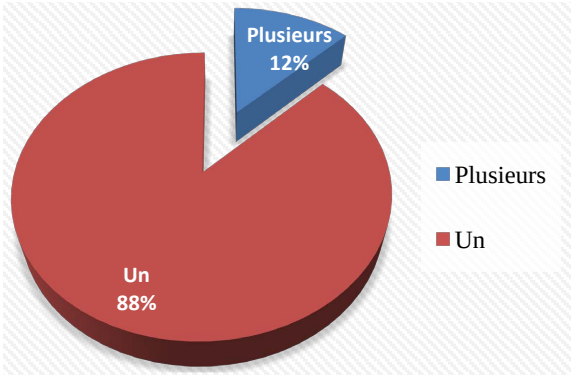



**Figure 3.** Distribution according to the number of aggressors: in 88% of the cases the aggressor was unique.

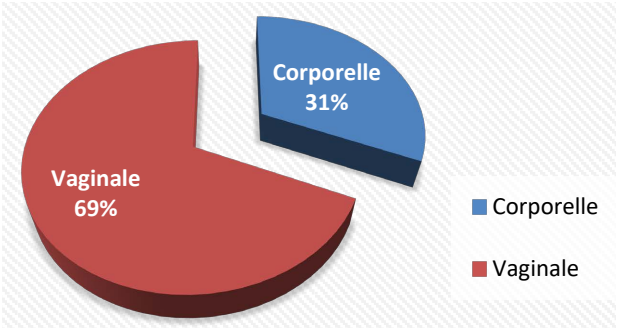



**Figure 4.** Distribution according to the way of sexual and physical contact: sexual violence by vaginal way was the most represented with 69%.

no sexual assault. Complementary examinations for sexual violence included: sperm count, HIV serology, pregnancy test, hepatitis B antigen test, vaginal smear, chlamydia test and ultrasound in some cases. We did not record any cases of positive HIV infection or positive viral hepatitis among the victims during their consultation and follow-up. Treatment was medical in 71.70% of cases. All the victims of violence had received treatment, which consisted of antibiotics, analgesics, anti-inflammatory drugs and antiseptics. The psychological care of the survivors was provided by the social service agents due to the absence of a psychologist in our institution, therefore the follow-up of these patients had not been carried out. The surgical treatment (28.30%) of the cases was based on dressing the lesions, suturing and disinfibulation (Table 2).

## 5. Conclusion

Through this study, we found that violence against women is a tragedy and can have physical, psychological and obstetrical repercussions in the short, medium and long term.

## Authors' Contribution

The study was designed by Moustapha Toure and Augustin Tiounkanou Thera. They established and validated a questionnaire beforehand. Seydou Mariko and Pierre Coulibaly were responsible for writing the manuscript. All the authors contributed substantially to the elaboration of this work. All authors read and approved the manuscript before submission of the final version.

## Acknowledgements

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## Conflicts of Interest

The authors declare no conflicts of interest.

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