

Programmes for change

Addressing sexual and intimate partner violence in South Africa

Nwabisa Jama Shai and Yandisa Sikweyiya*

nwabisa.shai@mrc.ac.za

yandisa.sikweyiya@mrc.ac.za

<http://dx.doi.org/10.4314/sacq.v51i1.4>

South Africa has a number of locally evaluated interventions that have been designed to prevent sexual and intimate partner violence before it occurs. This article describes such programmes that have been evaluated and found to be promising or effective. Seven locally evaluated primary prevention interventions are described, along with the evidence regarding their level of effectiveness. These interventions include mother-child, parent-teen, individual and group-based interventions. All of these interventions are developed based on evidence and primary prevention principles: a sound theory of change, cultural relevance, participatory methods and evaluation through randomised controlled trials.

Sexual and intimate partner violence in South Africa

According to the World Health Organization (WHO), intimate partner violence (IPV) is the most common form of gender-based violence (GBV).¹ It includes physical, sexual and emotional abuse and controlling behaviour by a current or former intimate partner or spouse, and can occur in heterosexual or same sex couples.² Sometimes referred to as partner or domestic violence, IPV is a violation of human rights and a public health concern of which 'the overwhelming global burden is borne by women'.³ The WHO estimates that 30%, or one in three women will experience sexual or physical IPV in their lifetime.⁴

Consistent with this estimate, studies report that girls have a two- to threefold risk of sexual abuse compared to boys.⁵ While there is some evidence to show that men can and do suffer violence in intimate heterosexual relationships, 'the prevalence and frequency of IPV against men is highly disputed, with different studies coming to varying conclusions, and many countries having no data at all'.⁶ On the other hand, evidence indicates that violence against women and girls is mostly perpetrated by male intimate partners or ex-partners.⁷

Sexual violence is one of the common forms of violence women experience in heterosexual intimate relationships, and has also been reported in women's same-sex relationships, though to a lesser extent.⁸ Sexual violence is defined as 'a completed or attempted sex act against the victim's will, involving a victim who is unable to consent or to refuse, abusive sexual contact, and non-contact sexual abuse, including sexual harassment', and may be

* Nwabisa Shai is a senior scientist at the Gender and Health Research Unit, Medical Research Council, and a honorary lecturer at the School of Public Health, University of the Witwatersrand. Yandisa Sikweyiya is a specialist scientist at the Gender and Health Research Unit, Medical Research Council, and a honorary senior lecturer, School of Public Health, University of the Witwatersrand.

perpetrated by a current or previous partner or non-partner.⁹

Global statistics indicate that at least 20% (one in five) women have been sexually or physically assaulted by a man or men, not necessarily partners, in their lifetime.¹⁰ In Ethiopia and Zimbabwe, 26% to 59% of women have been forced to have sex by intimate partners.¹¹ In South Africa, 24.6% to 37.7% of adult women have experienced sexual and/or physical IPV in their lifetime,¹² and 31% in their most recent marriage or cohabiting relationships.¹³

Sexual and intimate partner violence (SIPV) is known to have injurious effects on the physical, mental and sexual health of victims.¹⁴ Victimization by an intimate partner increases women's health risk behaviours, including alcohol abuse, smoking and non-medical use of sedatives or analgesics.¹⁵ A recent systematic review found that 'women who experienced IPV were less likely to report that their male partners used condoms than women who did not'.¹⁶ The degree of harm to the victim may range from mild to severe, including death.¹⁷ Other adverse health effects on victims include physical injuries, gynaecological disorders, negative pregnancy outcomes, sexually transmitted infections and mental health problems,¹⁸ including post-traumatic stress disorder, severe emotional distress and suicidal thoughts.¹⁹ These health impacts have been reported in several studies.²⁰

South Africa has one of the highest rates of SIPV globally.²¹ This violence has a profound impact on survivors, their families and their communities. There is an urgent need for South Africa to identify and implement effective programmes for the primary prevention of SIPV.

The purpose of this article is to identify and describe programmes that have been evaluated and found to be promising or effective in reducing SIPV in South Africa.

Social determinants of SIPV

Research has identified the factors associated with IPV through the ecological model.²² The ecological model conceptualises that all forms of IPV, including SIPV, result from a confluence of individual, relationship, societal and political factors, driven by

pervasive patriarchal norms that promote the use of violence as an acceptable practice in intimate relationships.²³ Literature from South Africa similarly describes social factors associated with different forms of GBV,²⁴ pointing to multiple social norms. These include the notion that SIPV is a private matter between the couple in the relationship;²⁵ social norms that promote male control of women and male sexual entitlement; as well as men's inequitable gender attitudes, risk-taking and antisocial behaviour.²⁶ Ideals of femininity that promote women's subordination to men²⁷ and expectations on women to acquiesce to male partners' sexual desire and needs²⁸ play an important role in SIPV. Having less power in relationships also increases women's vulnerability to forced sex with intimate partners.²⁹ In turn, these factors have been attributed as reasons for low levels of reporting of SIPV.³⁰

Childhood adversity and child sexual abuse is associated with adulthood perpetration of violence or victimisation.³¹ Attachment – the bond between the primary caregiver (e.g. mother) and child – is integral to how children form later relationships with peers, partners and their own children.³² When attachment is poor due to a negligent or violent relationship with the primary caregiver, the ability to have healthy relationships is disrupted, sometimes for generations, and the risk of perpetrating violence is increased.³³ Studies on why some men perpetrate severe forms of violence such as child sexual abuse and intimate femicide suggest that the nature of the relationship men had with their primary caregiver(s) influenced perpetration in adulthood.³⁴ Therefore, challenging these social constructions of gender, gender inequities and parenting practices is central to preventing SIPV before it happens.

Public health approaches to primary prevention of SIPV

Many approaches have been employed in response to SIPV in South Africa, most particularly progressive legislative, judicial and health policies that promote basic human rights and equality. Currently, services provided by government and non-governmental sectors are mainly reactionary in nature as they focus on enforcing the law and ensuring that justice is done, or on restorative justice and providing care

and support to victims. These efforts are considered to be secondary prevention because they come into effect after violence has already occurred. Primary prevention involves efforts to address the underlying causes of SIPV in order to prevent such violence from occurring in the first place.³⁵

A review of the literature and work currently underway in South Africa identified the following seven South African interventions that have been evaluated and found effective, or are currently undergoing evaluation and look promising. The interventions are briefly described below.

Programmes were identified using the following criteria, based on those developed by Whitaker and colleagues:³⁶

- The programme targets sexual and/or intimate partner violence perpetration or victimisation.
- The programme is being evaluated or was evaluated using a study design that included a comparison or control group in an experimental or quasi-experimental design.
- The programme evaluation measured at least one SIPV-related outcome.
- The programme was found promising or effective in reducing SIPV.

Thula Sana

Thula Sana is a home-visiting intervention aimed at promoting mothers' engagement in sensitive, responsive interactions with their infants. It targets pregnant women and mothers of infants aged 0–2 years from low-resource environments. Implementation takes place through home visits twice during pregnancy, then weekly for eight weeks postpartum, thereafter fortnightly for the next two months, and then monthly for two months, resulting in a total of 16 visits over a six-month period. The first evaluation of this programme consisted of a randomised controlled trial (RCT) (1999–2003) to test the efficacy of the intervention. The results at follow-up indicated that mothers in the intervention group were significantly more sensitive and less intrusive in their interactions with their infants. The intervention was also associated with a higher rate of secure infant attachments at 18 months, compared

to the control groups. Where social adversity was not extreme, there was also a significant benefit of the intervention in terms of child cognitive outcomes.³⁷ These findings are promising due to the association between poor attachment and later perpetration of violence.³⁸

A follow-up study of the cohort of the same mothers and children, now aged 12–13 years, is currently underway to assess the long-term outcomes on adolescent aggressive behaviour and child growth and cognitive functioning, school attainment and the home environment.³⁹ While the initial findings of the efficacy of this intervention were positive, the only limitation is the lack of measurement of sexual violence in the current RCT. Measuring violent sexual behaviour and experiences would provide invaluable evidence of the links between improvements in attachment and parenting skills and later behaviour.

The Sinovuyo Caring Families Programmes

Sinovuyo focuses on reducing the risk of child maltreatment for children from high-risk families among children aged 2–9, and pre-teens and teenagers aged 10–17 years. This is a group-based programme that aims to improve caregiver–child relationships through active social learning (role play, home exercises, modelling, experiential activities, group discussion and problem solving), and caregiver mental health through mindfulness-based stress reduction techniques and social support. The child programme addresses emotion regulation and positive behaviour management approaches over 12 weeks. A parent–teen programme, based on similar principles, is implemented in separate groups of parent and adolescents, with some joint sessions.

A pilot evaluation of the programme for parents of 2–9 year-olds found improvements in positive parenting behaviour (parenting knowledge, skill and competence, discipline and supervision of children, and caregiver mental health and social support) in the intervention group, compared with the control group.⁴⁰ The programme is being tested in a bigger RCT; post-test data collection is still in progress and so no outcome data is yet available.⁴¹ While data analysis is ongoing, preliminary results of the

teenage programme piloted in the rural Eastern Cape showed reductions in parents' use of violent and abusive discipline and in adolescent rule-breaking and aggressive behaviour.⁴² Similar to the Thula Sana programme, should these participants be followed over the long term, the new studies would do well to include sexual violence measures to establish the impact on SIPV.

PREPARE

PREPARE is an HIV-prevention programme aimed at reducing sexual risk behaviour and IPV among adolescents. This school-based intervention comprises 21 lessons focused on developing individuals' motivation and skills, with a focus on gender and power, relationships, assertiveness and communication, decision-making, risk-taking, violence, self-protection and support. Another component of the programme aims to create a supportive school environment by working with students, teachers, parents and the police to conduct a participatory school safety audit, develop a safety plan, create a climate of zero tolerance towards violence, and strengthen links with local support services.⁴³ This intervention was initially intended to be implemented during the life orientation class in schools, but in the end it was implemented as an after-school programme. An RCT was conducted in the Western Cape to test its effectiveness and found significant reductions in IPV among young teenagers.⁴⁴

Skhokho Supporting Success

Skhokho Supporting Success is a multi-faceted programme that aims to prevent IPV among young teenagers. The components of the programme engage high school learners directly in classroom sessions and after school workshops; high school educators and school staff through skills building workshops; and parents or caregivers of young teenagers through weekend workshops. These components seek to engage the various participant groups in gender transformative interventions that strengthen relationship-building skills (e.g., communication and conflict resolution, supportive styles of interaction, positive discipline strategies and risk-minimisation strategies), encourage adaptive

stress management and mental health promotion, and foster values-based decision-making. While the classroom sessions are facilitated by educators teaching Grade 8 life orientation classes, the other workshops have external facilitators.⁴⁵

The programme is currently being evaluated in Gauteng in a cluster RCT with 18-month follow-up. The results of the programme impact will be available in early 2016. While this evaluation is still underway, anecdotal evidence from pilot testing of the intervention in Gauteng and the Western Cape suggest high levels of acceptance of the programme and high rates of attendance and participation in both the parent and educator workshops. Parents reported that the new techniques of positive discipline helped reduce their stress levels and that they experienced improved communication with their teenage children and teenage behaviour post intervention. Teenagers appreciated open discussions with parents and reported less harsh discipline by parents.⁴⁶

Stepping Stones

Stepping Stones, a participatory community-based intervention for preventing HIV and strengthening relationship skills, has been rigorously evaluated in an RCT in the Eastern Cape. Stepping Stones is a workshop series designed to promote sexual health, improve psychological well-being and prevent HIV. Workshops are held with two or more peer groups drawn from a single community. The workshop series consists of 10 sessions held with separate peer groups. Stepping Stones was found effective in reducing HIV risk factors such as genital herpes and perpetration of IPV.⁴⁷ At 24 months' follow-up, men from the intervention arm reported a 38% reduction in perpetration of SIPV. This same effect was not found among women.⁴⁸ The qualitative findings of this study suggested that the lack of significant impact on women's self-reported experiences of IPV (compared to men) may have been influenced by their limited power in relationships, as well as by external sources such as economic independence.⁴⁹

Stepping Stones and Creating Futures

A third adaptation of Stepping Stones⁵⁰ was combined with a locally developed livelihoods strengthening intervention called Creating Futures.⁵¹ This intervention is a peer-facilitated group intervention comprising 11 three-hour sessions in single-sex groups of about 20 people, and draws from sustainable livelihoods theory and practice.⁵² A quasi-experimental study tested the combined effectiveness of livelihood strengthening and reducing HIV risk behaviour and different forms of IPV among young people residing in informal settlements. The combined intervention was tested in a shortened interrupted time series design with one year follow-up.⁵³ This evaluation found that there was a significant reduction in women's experience of SIPV in the three months prior, but this effect was not observed among men. Gender attitudes and controlling behaviour were measured, using scales that have been tested in other studies in South Africa.⁵⁴ Findings show that both men and women significantly improved their gender attitudes, and men significantly reduced their controlling practices in their relationships. This change in social norms is important when considering their association with SIPV. Further evaluation of the

impact of this combined intervention on reducing SIPV is planned to start in 2015.

IMAGE

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) was the first to combine a training programme on poverty, gender inequalities, IPV and HIV/AIDS with group-based microfinance. The programme was tested in an RCT and was delivered to adult women during fortnightly loan repayment meetings.⁵⁵ A participatory learning approach was used, with two phases. The first phase comprised 10 one-hour training sessions on gender roles, cultural beliefs, relationships, communication, domestic violence and HIV. The second phase was a wider community mobilisation approach to engage both youth and men in the intervention. After two years there was a significant reduction in past year SIPV experienced by women in the intervention arm. There were improvements in women's economic wellbeing and their empowerment indicators (self-confidence, financial confidence, challenging gender norms, autonomy in decision-making, perceived contributions to the household, communication within the household, relationship with partner, social group membership and participation in collective action).⁵⁶

Table 1: Promising and effective primary prevention interventions

Intervention name	Intervention aim	Target	Implementation method	Evaluation design	Outcomes
Thula Sana	Promote mothers' engagement in sensitive, responsive interactions with their infants	Pregnant women and mothers of infants aged 0–2 years from low-resource settings	Home visits take place twice during pregnancy, and then occur weekly for 8 weeks postpartum, fortnightly for the next 2 months, and then monthly for 2 months, with 16 visits in total	An RCT to assess the efficacy of an intervention designed to improve the mother–infant relationship and security of infant attachment in a South African peri-urban settlement with marked adverse socioeconomic circumstances Measurement periods: 6, 12, 18 months postpartum	Significant benefit to the mother–infant relationship Mothers in the intervention group were significantly: <ul style="list-style-type: none"> • More sensitive (6 months: mean difference=0.77 (SD 0.37), t=2.10, P<0.05, d=0.24; 12 months: mean difference=0.42 (0.18), t=-2.04, P<0.05, d=0.26) • Less intrusive (6 months: mean difference=0.68 (0.36), t=2.28, P<0.05, d=0.26; 12 months: mean difference=-1.76 (0.86), t=2.28, P<0.05, d=0.24) The intervention was also associated with a higher rate of secure infant attachments at 18 months (116/156 (74%) v 102/162 (63%); Wald=4.74, odds ratio=1.70, P<0.05)

Intervention name	Intervention aim	Target	Implementation method	Evaluation design	Outcomes
Thula Sana <i>(continued)</i>				A current study aims to follow up with the mothers and children enrolled in the previous RCT in 2012–2014 – 12–13 year-old children	To assess: <ul style="list-style-type: none"> • Aggressive behaviour at this stage of their development • Child cognitive functioning and school attainment • Child emotional/behavioural functioning • The home environment, child health and growth, family functioning • Neural functions implicated in self-regulation and the stress response
The Sinovuyo Caring Families Programme	Improve the parent–child relationship, emotional regulation, and positive behaviour management approaches	Young children, covers the 2–9 years age group	Social learning and parent management training	A quasi-experimental study to test the effectiveness of the intervention	<ul style="list-style-type: none"> • Improvements in positive parenting behaviour in the group that received the programme, as compared with a group of parents who did not receive the programme • High attendance rates (75%) • High participant satisfaction • Culturally acceptable and faithfully implemented by the paraprofessional community facilitators
		Teens aged 10–17 years	Social learning and parent management training principles, with group-based parent, adolescent, and joint parent-adolescent sessions. Utilises a collaborative learning approach, with activity-based learning, role-play and home practice	A quasi-experimental study, the findings of which have been taken into a bigger RCT	Reductions in parents' use of violent and abusive discipline, and in adolescent rule-breaking and aggressive behaviour
PREPARE	Reduce sexual risk behaviour and intimate partner violence, which contribute to the spread of sexually transmitted diseases (STIs)	Young adolescents (12–14 years)	Draws on psychological and behaviour change theory to identify the individual and social determinants that underpin sexuality, intimate partner violence and sexual violence	An RCT to evaluate the effects of the intervention on sexual risk behaviour and intimate partner violence, and to assess the extent to which norms, attitudes and experiences of IPV influence sexual risk behaviour	Significant reductions in IPV among young teenagers
Skhokho Supporting Success	Prevent IPV among young teenagers	High school learners aged 13–14 years	Classroom sessions facilitated by educators teaching Grade 8 life orientation classes; high school educators and school staff through skill-	Qualitative pilot evaluation of the effectiveness of the intervention in strengthening parent–child relationships and prevent IPV among teens	Parents reported: <ul style="list-style-type: none"> • The new techniques of positive discipline helped reduce their stress levels

Intervention name	Intervention aim	Target	Implementation method	Evaluation design	Outcomes
Skhokho Supporting Success <i>(continued)</i>			building workshops; and parent–child weekend workshops facilitated by external facilitators, with teens and their parents or caregivers attending separate sessions and engaging in dialogues at the end of each day's workshop	Currently underway is a cluster RCT with 18-month follow-up among learners in 2014–2015	Teenagers reported: <ul style="list-style-type: none"> • Appreciation of open discussions with parents • Less harsh discipline by parents
Stepping Stones	Promote sexual health, improve psychological well-being and prevent HIV	Community-based programme, peers of teens and young adults	Stepping Stones draws from the social learning theory; employs participatory approaches e.g. drama role-playing, group work and discussions, and critical reflection; and engages separate gender groups, but combine these for peer group sessions at intervals during programme implementation	Community cluster RCT to test the effectiveness of the programme in reducing HIV, HSV2 incidence, and improved gender relations and sexual behaviour, over two years	Reduction of about 33% in the incidence of HSV-2 (0.67, 0.46 to 0.97; P=0.036); that is, Stepping Stones reduced the number of new HSV-2 infections over a two-year period by 34.9 (1.6 to 68.2) per 1 000 people exposed Significantly improved the number of reported risk behaviours in men: lower proportion of men reporting perpetration of IPV across two years of follow-up Less transactional sex and problem drinking at 12 months
Stepping Stones/ Creating Futures	Reduce HIV risk behaviour and victimisation and perpetration of different forms of IPV and strengthen livelihoods	Young people (18 years and older) residing in informal settlements	Stepping Stones and Creating Futures draw from the social learning theory; employ participatory approaches e.g. drama role-playing, group work and discussions, and critical reflection; and engage separate gender groups, but combine these for peer group sessions at intervals during programme implementation. Creating Futures mainly draws from sustainable livelihoods theory and practice	A proof of concept study using a shortened interrupted time-series design with two data collection points at baseline that were two weeks apart, follow-up interviews 28 weeks and 58 weeks post-baseline	Significant reduction in women's experience of SIPV in the prior three months – 30.3% to 18.9% (p = 0.037) Significant improvement in gender attitudes among both men (50.8 vs. 52.89, p= 0.007) and women (53.7 vs 55.29, p=0.01) Significant reduction in controlling practices in their relationships among men – more equitable relationships at 12 months follow-up (19.4 vs 21.74, p<0.001)

Intervention name	Intervention aim	Target	Implementation method	Evaluation design	Outcomes
IMAGE (Intervention with Microfinance for AIDS and Gender Equity)	Improve household economic wellbeing, social capital and empowerment and thus reduce vulnerability to IPV and HIV infection	Poorest women in the communities 14–35-year-old household and village residents	Participatory learning and action principles; group-based learning; community mobilisation; leadership training run in parallel with the microfinance intervention	Community RCT to determine improvement in household economic wellbeing, social capital and empowerment, and reduction in women's vulnerability to IPV and HIV infection	Significant reduction in women's experience of IPV by 55% (adjusted risk ratio [aRR] 0.45, 95% CI 0.23–0.91; adjusted risk difference -7.3%, -16.2 to 1.5)

Discussion and conclusion

The primary prevention interventions described above were developed based on evidence-informed theoretical frameworks and cultural relevance, and are notable for their efforts to prevent SIPV before it occurs. They address a spectrum of the ecological model, from parenting programmes that strengthen relationships between mothers and infants (Thula Sana), parents and teenagers (Sinovuyo and Skhokho Supporting Success) and educators and learners, to individual or peer group-based programmes that engage men and women on gender norms and positive relationships (Skhokho Supporting Success, Prepare, and Stepping Stones) and livelihood strengthening skills (IMAGE and Stepping Stones/Creating Futures).

All of these programmes address the social determinants of violence. Some programmes also promote communication, problem-solving, conflict resolution and parenting skills, as well as other elements that may be protective against violence. Facilitators are usually adults with a high school qualification and community work experience, who are provided with training (and on-going support and supervision) on the programme content, facilitation skills, non-judgmental interactions and community relations. It is essential that facilitators buy into and support the ideology of the primary prevention interventions and are supported through a transformative process promoted by the intervention before they begin facilitating it. Furthermore, ongoing support for facilitators is important to prevent

vicarious trauma, burnout and compassion fatigue, and ensure sustained high-quality implementation.

All interventions described in this article use a manualised intervention and importantly, participatory workshop methods rather than didactic approaches. User-friendly, structured yet flexible manuals ensure high rates of fidelity to the programme and limit deviations that may compromise the intended outcomes of it. A participatory approach allows participants to engage in critical reflection and dialogue about their own experiences, ideas and beliefs, as well as those of others in their communities. This approach facilitates personal transformation and integration of new knowledge and skills into their daily lives and their identities.

Intervention evaluations provide indications of acceptability to participants, efficacy of implementation, and effectiveness in changing desired outcomes (e.g., behaviour, attitudes and quality of relationships). An in-depth discussion of intervention evaluation is presented in the Tomlinson et al. article in this issue.

Primary prevention – stopping the violence before it starts – remains the most effective strategy available to us in addressing the epidemic of SIPV in South Africa. The interventions identified in this article have been shown to be effective or promising in reducing SIPV perpetration and/or victimisation. They provide an incredible platform of evidence for developing a SIPV primary prevention policy and comprehensive programme for South Africa.



To comment on this article visit

<http://www.issafrica.org/sacq.php>

Notes

- 1 L Maxwell et al, Estimating the effect of intimate partner violence on women's use of contraception: a systematic review and meta-analysis, *PLoS ONE*, 10:2, 2014, e0118234–e0118234.
- 2 World Health Organization (WHO), *Understanding and addressing violence against women: intimate partner violence*, Geneva: WHO, 2012.
- 3 Ibid.
- 4 EG Krug et al, The world report on violence and health, *The Lancet*, 360:9339, 2002, 1083–1088; C Garcia-Moreno et al, Prevalence of intimate partner violence: findings from the WHO Multi-country Study on Women's Health and Domestic Violence, *The Lancet*, 368:9543, 2006, 1260–1269; K Devries et al, The global prevalence of intimate partner violence against women, *Science*, 340:6140, 2013, 1527–1528.
- 5 FW Putman, Ten-year research update review: child sexual abuse, *Journal of American Academia Child Adolescence and Psychiatry*, 2003.
- 6 Wikipedia, Domestic violence against men, 2015.
- 7 L Heise, M Ellsberg and M Gottemoeller, *Ending violence against women*, Baltimore: Johns Hopkins University School of Public Health, Center for Communications Programs, 1999; E Fulu et al, 'Why do some men use violence against women and how can we prevent it?' *Quantitative findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific*, Bangkok: UN Partners for Prevention, 2013.
- 8 C Chan, Domestic violence in gay and lesbian relationships, Australian Domestic and Family Violence Clearinghouse, Topic Paper, 2005.
- 9 Centers for Disease Control and Prevention (CDC), *Preventing intimate partner and sexual violence: program activities guide*, 2011, http://www.cdc.gov/violenceprevention/pdf/IPV-SV_Program_Activities_Guide-a.pdf.
- 10 WHO, Violence against women, Fact Sheet 239, Geneva: WHO, 2001.
- 11 C Watts and S Mayhew, Reproductive health services and intimate partner violence: shaping a pragmatic response in sub-Saharan Africa, *International Family Planning Perspectives*, 2004, 207–213.
- 12 R Jewkes, J Levin and L Penn-Kekana, Risk factors for domestic violence: findings from a South African cross-sectional study, *Social Science & Medicine*, 55:9, 2002, 1603–1617; M Machisa et al, *The war at home*, Johannesburg: GenderLinks, 2011.
- 13 JD Gass et al, Intimate partner violence, health behaviours, and chronic physical illness among South African women, *South African Medical Journal*, 100, 2010, 582–585.
- 14 C Garcia-Moreno et al, *WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses*, Geneva: WHO, 2005.
- 15 JD Gass et al, Intimate partner violence, health behaviours, and chronic physical illness among South African women, *South African Medical Journal*, 100, 2010, 582–585.
- 16 L Maxwell et al, Estimating the effect of intimate partner violence on women's use of contraception: a systematic review and meta-analysis, *PLoS ONE*, 10:2, 2014, e0118234–e0118234.
- 17 N Abrahams et al., Intimate partner femicide in South Africa in 1999 and 2009, *PLoS Medicine*, 10:4, 2013, e1001412; N Abrahams et al, Mortality of women from intimate partner violence in South Africa: a national epidemiological study, *Violence and Victims*, 24:4, 2009, 546–556; C Watts and C Zimmerman, Violence against women: global scope and magnitude, *The Lancet*, 359:9313, 2002, 1232–1237.
- 18 M Ellsberg et al, Intimate partner violence and women's physical and mental health in the WHO Multi-country Study on Women's Health and Domestic Violence: an observational study, *The Lancet*, 371:9619, 2008, 1165–1172.
- 19 K Devries et al, Violence against women is strongly associated with suicide attempts: evidence from the WHO Multi-country Study on Women's Health and Domestic Violence against Women, *Social Science & Medicine*, 73:1, 2011, 79–86.
- 20 CE Jordan, R Campbell and D Follingstad, Violence and women's mental health: the impact of physical, sexual, and psychological aggression, *Annual Review of Clinical Psychology*, 6, 2010, 607–628; M Machisa et al, *The war at home*, Johannesburg: GenderLinks, 2011; C Garcia-Moreno et al, *WHO Multi-country Study on Women's Health and Domestic Violence against Women: initial results on prevalence, health outcomes and women's responses*, Geneva: WHO, 2005.
- 21 Social Development Department, *Fact sheet: gender equality and equity in South Africa – 1996–2008*, Pretoria: Social Development Department: Population and Development, 2011.
- 22 LL Heise, Violence against women: an integrated, ecological framework, *Violence Against Women*, 4:3, 1998, 262–290.
- 23 K Devries et al, Violence against women is strongly associated with suicide attempts: evidence from the WHO Multi-country Study on Women's Health and Domestic Violence against Women, *Social Science & Medicine*, 73:1, 2011, 79–86.
- 24 A Gevers, N Jama-Shai and Y Sikweyiya, Gender-based violence and the need for evidence-based primary prevention in South Africa: perspectives, *African Safety Promotion*, 11:2, 2013, 14–20.
- 25 WHO/London School of Hygiene and Tropical Medicine (LSHTM), *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, Geneva: WHO, 2010.
- 26 KM Wood, H Lambert and R Jewkes, 'Showing roughness in a beautiful way': talk about love, coercion, and rape in South African youth sexual culture, *Medical Anthropology Quarterly*, 21:3, 2007, 277–300; Y Sikweyiya and R Jewkes, Force and temptation: contrasting South African men's accounts of coercion into sex by men and women, *Culture, Health & Sexuality*, 11:5, 2009, 529–41; R Jewkes and R Morrell, Gender and sexuality: emerging perspectives from the heterosexual epidemic in South Africa and implications for HIV risk and prevention, *Journal of the International AIDS*

- Society*, 13:6: 2010, 1–11; R Jewkes et al, Why, when, and how men rape: understanding rape perpetration in South Africa, *SA Crime Quarterly*, 34, 2010, 23–31; R Jewkes, M Flood and J Lang, From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls, *The Lancet*, Violence against women and girls 3, 2012; M Seedat et al, Violence and injuries in South Africa: prioritising an agenda for prevention, *The Lancet*, 374:9694, 2009, 1011–1022.
- 27 T Shefer et al, Gender, power and resistance to change among two communities in the Western Cape, South Africa, *Feminism & Psychology*, 18:2, 2008, 157–182; A Strelbel et al, Social constructions of gender roles, gender-based violence and HIV/AIDS in two communities of the Western Cape, South Africa: original article, *SAHARA: Journal of Social Aspects of HIV/AIDS Research Alliance*, 3:3, 2006, 516–528; M Hunter, Cultural politics and masculinities: multiple-partners in historical perspective in KwaZulu-Natal, *Culture, Health & Sexuality*, 7:4, 2005, 389–403; M Hunter, The materiality of everyday sex: thinking beyond ‘prostitution’, *African Studies*, 61:1, 2002, 99–120.
- 28 KM Wood, H Lambert and R Jewkes, ‘Showing roughness in a beautiful way’: talk about love, coercion, and rape in South African youth sexual culture, *Medical Anthropology Quarterly*, 21:3, 2007, 277–300; K Wood, F Maforah and R Jewkes, ‘He forced me to love him’: putting violence on adolescent sexual health agendas, *Social Science & Medicine*, 47:2, 1998, 233–242.
- 29 E Fulu et al, ‘Why do some men use violence against women and how can we prevent it?’ Quantitative Findings from the United Nations Multi-country Study on Men and Violence in Asia and the Pacific, Bangkok: UN Partners for Prevention, 2013; AE Pettifor et al, Sexual power and HIV risk, South Africa, *Emerging Infectious Diseases*, 10:11, 2004, 1996–2004; KL Dunkle et al, Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa, *The Lancet*, 363:9419, 2004, 1415–1421.
- 30 L Artz, *An examination of the attrition of domestic violence cases within the criminal justice system in post-apartheid South Africa*, Belfast: Queen’s University, 2008; R Jewkes et al, *He must give me money, he mustn’t beat me: violence against women in three South African provinces*, CERSA (Women’s Health), Medical Research Council, 1999; RK Jewkes, JB Levin and LA Penn-Kekana, Gender inequalities, intimate partner violence and HIV preventive practices: findings of a South African cross-sectional study, *Social Science & Medicine*, 56, 2003, 125–134; M Machisa et al, *The war at home*, Johannesburg: GenderLinks, 2011.
- 31 RK Jewkes et al, Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth, *Child Abuse & Neglect*, 34:11, 2010, 833–841.
- 32 J Belsky, Ethology of child maltreatment: a developmental-ecological analysis, *Psychological Bulletin*, 114, 1993, 413–34; WE Norton et al, A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health, *Implementation Science*, 7, 2010, 118–23.
- 33 J Belsky, Ethology of child maltreatment: a developmental-ecological analysis, *Psychological Bulletin*, 114, 1993, 413–34; WE Norton et al, A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health, *Implementation Science*, 7, 2012, 118–23; CL Ward et al, Parenting for lifelong health: from South Africa to other low- and middle-income countries, Cape Town: Department of Psychology and Safety and Violence Initiative, University of Cape Town, 2014; F Meinck et al, Risk and protective factors for physical and emotional abuse victimisation amongst vulnerable children in South Africa, *Child Abuse Review*, 2013.
- 34 AA Kleijn, The demographic profile and psychosocial history of a group of convicted perpetrators of the rape of children under the age of three years, (Vol. 1), thesis, University of the Witwatersrand, Johannesburg, 2010; S Mathews, R Jewkes and N Abrahams, ‘I had a hard life’: exploring childhood adversity in the shaping of masculinities among men who killed an intimate partner in South Africa, *British Journal of Criminology*, 2011.
- 35 A Gevers et al, Gender-based violence and the need for evidence-based primary prevention in South Africa: perspectives, *African Safety Promotion*, 11:2, 2013, 14–20.
- 36 DJ Whitaker et al, Effectiveness of primary prevention efforts for intimate partner violence, *Partner Abuse*, 4:2, 2013, 175–195.
- 37 PJ Cooper et al, Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial, *British Medical Journal*, 338, 2009, b974.
- 38 J Belsky, Ethology of child maltreatment: a developmental-ecological analysis, *Psychological Bulletin*, 114, 1993, 413–34; WE Norton et al, A stakeholder-driven agenda for advancing the science and practice of scale-up and spread in health, *Implementation Science*, 7, 2012, 118–23; RK Jewkes et al, Associations between childhood adversity and depression, substance abuse and HIV and HSV2 incident infections in rural South African youth, *Child Abuse & Neglect*, 34:11, 2010, 833–841.
- 39 Prevention Research for Community Family and Child Health (PRCFCH), The long term impact on cognitive and socio-emotional functioning of an intervention to enhance the mother-infant relationship, Saving Brains Thula Sana, Project summary, 2014, <http://www.preventionresearch.org.za/thula-sana/>.
- 40 CL Ward et al, Parenting for lifelong health: from South Africa to other low- and middle-income countries, Cape Town: Department of Psychology and Safety and Violence Initiative, University of Cape Town, 2014.
- 41 CL Ward, Status of the Sinovuyo programme evaluation (RCT), Department of Psychology and Safety and Violence Initiative, University of Cape Town, (Email communication with Nwabisa Jama Shai and Y Sikweyiya 19 February 2015).
- 42 CL Ward et al, Parenting for lifelong health: from South Africa to other low- and middle-income countries, Cape Town: Department of Psychology and Safety and Violence Initiative, University of Cape Town, 2014.
- 43 P Mahlangu, A Gevers and A De Lannoy, Adolescents: preventing interpersonal and gender-based violence, *Child Gauge*, 2014, 73.
- 44 C Mathews, Impact evaluation of Prepare among school going adolescents in the Western Cape, Cape Town: Gender and Health Research Unit, Medical Research Council, 2015. (Email communication, 6 March 2015).

- 45 P Mahlangu, A Gevers and A De Lannoy, Adolescents: preventing interpersonal and gender-based violence, *Child Gauge*, 2014, 73.
- 46 A Gevers et al, Primary prevention of gender based violence: the acceptability of a workshop for parents of teens in South Africa, in *SVRI Forum 2013: evidence into action 2013*, Bangkok: Sexual Violence Research Initiative, 2013.
- 47 R Jewkes et al, Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial, *British Medical Journal*, 2008, 337.
- 48 Ibid.
- 49 R Jewkes and R Morrell, Sexuality and the limits of agency among South African teenage women: theorising femininities and their connections to HIV risk practices, *Soc Sci Med*, 74:11, 2012, 1729–37.
- 50 R Jewkes, M Nduna and N Jama, *Stepping stones*, South African adaptation 2010, Pretoria: Medical Research Council, 2010.
- 51 A Misselhorn et al, *Creating futures 2012*, Durban: HEARD/ Medical Research Council, 2012.
- 52 R Chambers and G Conway, Sustainable rural livelihoods: practical concepts for the 21st century, Institute of Development Studies (UK), 1992.
- 53 A Gibbs et al, Combined structural interventions for gender equality and livelihood security: a critical review of the evidence from southern and eastern Africa and the implications for young people, *Journal of the International AIDS Society*, 15:3 supp 1, 2012; R Jewkes et al, Stepping stones and creating futures intervention: shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa, *BMC Public Health*, 14:1, 2014, 1325.
- 54 KL Dunkle et al, Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa, *The Lancet*, 363:9419, 2004, 1415–1421; R Jewkes et al, Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study, *The Lancet*, 376 2010, 41–48.
- 55 JC Kim et al, Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa, *Journal Information*, 97:10, 2007; PM Pronyk et al, Effect of a structural intervention for the prevention of intimate partner violence and HIV in rural South Africa: a cluster randomized trial, *The Lancet*, 368:1973–83, 2006.
- 56 JC Kim et al, Understanding the impact of a microfinance-based intervention on women's empowerment and the reduction of intimate partner violence in South Africa, *Journal Information*, 97:10, 2007.
- 57 A Gevers et al, Gender-based violence and the need for evidence-based primary prevention in South Africa: perspectives, *African Safety Promotion*, 11:2, 2013, 14–20.
- 58 SL Dworkin, S Treves-Kagan and SA Lippman, Gender-transformative interventions to reduce HIV risks and violence with heterosexually-active men: a review of the global evidence, *AIDS and Behavior*, 17:9, 2013, 2845–2863.