

TOWARDS A MORE COMPREHENSIVE
UNDERSTANDING OF THE DIRECT
AND INDIRECT DETERMINANTS OF
**VIOLENCE AGAINST
WOMEN AND CHILDREN
IN SOUTH AFRICA**
WITH A VIEW TO ENHANCING
VIOLENCE PREVENTION

FINAL REPORT
DECEMBER 2016



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CONTENTS

Figures and Tables	8
List of Acronyms	9
Foreword	10
Executive Summary	13
1. Project Information and Methodology	19
1.1 Background to this Report	20
1.2 Project Objectives	20
1.3 Analytical Framework	20
1.3.1 Research Questions	22
1.3.2 Methodology	22
1.3.2.1 Critical Reviews and Conceptual Models	23
1.3.2.2 Data Scoping and Analytical Framework	23
1.3.2.3 Predictive Modelling	23
1.3.2.4 Illustrative Case Studies	24
1.3.2.5 Best Practices for Violence Reduction and Prevention	24
2. Violence against Children: Research Findings	27
2.1 Definitions	28
2.2 Background	28
2.2.1 Physical Violence and Homicide	28
2.2.2 Corporal Punishment	28
2.2.3 Sexual Violence	28
2.2.4 Emotional Abuse	28
2.2.5 Neglect	30
2.2.6 Intimate Partner Violence	30
2.2.7 Bullying	31
2.2.8 Gang Violence	31
2.2.9 Consequences of Violence against Children	31
2.3 Legislative Framework	31
2.3.1 Preventing Violence in the Home	32
2.3.1.1 Children's Act	32
2.3.1.2 Social Assistance Act	32
2.3.1.3 Family Policy	33
2.3.2 Preventing Violence in Schools	33
2.3.3 Combating Substance Abuse	33
2.3.4 Supporting Children who have Experienced Violence	34
2.3.5 Interpretation of the Law	34
2.3.6 Implementation Challenges	35
2.3.7 Criminal Law	35
2.4 Constructing a Conceptual Framework for VAC: Review of Existing Research	36
2.4.1 Overview of the Evidence Base in South Africa	36
2.4.2 Individual Level Risk Factors	38

2.4.2.1 Gender	38
2.4.2.2 Age	39
2.4.2.3 Substance Use	39
2.4.2.4 Vulnerable Groups	39
• Children with Disabilities	39
• Children Living on the Streets	40
2.4.2.5 Other Characteristics	41
2.4.2.6 Risk Factors for Corporal Punishment	41
2.4.3 Relationship Level Risk Factors	41
2.4.3.1 Family and Peer Substance Use	41
2.4.3.2 Family Structure and Functioning	41
2.4.3.3 Orphans and Child-Headed Households	42
2.4.3.4 Households with Chronic Illnesses	42
2.4.3.5 Family History of Criminality	43
2.4.3.6 Discipline Practices	43
2.4.3.7 Family Conflict and Domestic Violence	43
2.4.3.8 Other Caregiver-Related Factors	44
2.4.3.9 Bullying	44
2.4.3.10 Delinquent Peers	44
2.4.4 Community and Societal Level Risk Factors	45
2.4.4.1 Violence and the Availability of Weapons and Substances in the Community	45
2.4.4.2 Gangs	46
2.4.4.3 Harmful Cultural and Traditional Practices	46
• Harmful Traditional Practices Affecting Girls	46
• Male Circumcision	47
2.4.4.4 Violence in the Media	47
2.4.4.5 Social Norms and Values	47
2.4.4.6 Social Myths	48
2.4.4.7 Poverty, Inequality and Unemployment	48
2.4.5 Protective Factors	48
2.4.5.1 Parent and Family Characteristics	48
2.4.5.2 Social Support and Support for Caregivers	49
2.4.5.3 Economic Opportunities and Social Assistance Grants	49
2.4.5.4 Other Protective Factors	50
2.4.5.5 Factors Protective against Youth Offending	51
2.4.6 Summary and Conclusion	51
2.5 Structural Equations Modelling: VAC	52
2.5.1 Cape Area Panel Study (CAPS)	52
2.5.1.1 Overview and Motivation	52
2.5.1.2 Key Variables (CAPS)	53
2.5.1.3 CAPS SEM Key Findings	56
• Risk/Protective Factors: Base/Background Variables	56
• Risk/Protective Factors: Intermediate Variables	56
• Risk/Protective Factors: Victimization and Perpetration	56
2.5.2 The National Youth Lifestyle Survey (NYLS)	56
2.5.2.1 Overview and Motivation	56
2.5.2.2 Key Variables (NYLS)	57
2.5.2.3 NYLS SEM Key Findings	59
• Risk/Protective Factors: Base/Background Variables	59

• Risk/Protective Factors: Intermediate Variables	59
• Risk/Protective Factors: Victimisation and Perpetration	60

3. Violence against Women: Research Findings	63
3.1 Definitions	64
3.2 Background	64
3.2.1 Intimate Partner Violence	64
3.2.2 Emotional Violence	64
3.2.3 Sexual Violence	64
3.2.4 Physical Violence and Homicide	66
3.2.5 Economic Violence	66
3.2.6 Consequences of VAW	67
3.3 Legislative Framework	67
3.3.1 Firearms Control Act	67
3.3.2 Domestic Violence Act	68
3.3.3 Sexual Offences and Related Matters Amendment Act	68
3.3.4 Implementation Challenges	68
3.4 Constructing a Conceptual Framework for VAW	69
3.4.1 Overview of the Evidence Base in South Africa	69
3.4.2 Individual Level Risk Factors: Victimisation	70
3.4.2.1 Previous Victimisation	70
3.4.2.2 Substance Use	71
3.4.2.3 Age	71
3.4.2.4 Education and Socio-Economic Status	72
3.4.2.5 Gender Attitudes	73
3.4.2.6 Part of a Vulnerable Group	74
• Lesbian and Bisexual Women	74
• Elderly Women	74
• Women with Disabilities	75
• Sex Workers	76
• Migrant and Refugee Women	77
3.4.3 Individual Level Risk Factors: Violence Perpetration	78
3.4.3.1 Childhood Adversity and Abuse	78
3.4.3.2 Substance Use	79
3.4.3.3 Age	80
3.4.3.4 Education and Socio-Economic Status	80
3.4.3.5 Psychological State	81
3.4.3.6 Engagement in Other Violent or Criminal Behaviour	82
3.4.3.7 Gender Attitudes	83
3.4.4 Relationship Level Risk Factors: Violence Victimisation and Perpetration	83
3.4.4.1 Male Controlling Behaviour and Gender Inequity in Relationships	83
3.4.4.2 Sexual Risk-Taking Behaviour	84
• Male Sexual Risk Behaviour	84
• Female Sexual Risk Behaviour	84
• HIV and HIV-Risk Behaviour	85
• Poor Communication and Relationship Conflict	86
3.4.4.3 Relationship Characteristics	87
• Economic Dependence	87

• Age and Educational Disparities	87
• Cohabitation versus Marriage	88
3.4.5 Community Level Risk and Protective Factors	88
3.4.5.1 <i>Locations within Communities and Violence in Institutions</i>	88
3.4.5.2 <i>Community Silence versus Community Sanctions against VAW</i>	89
3.4.5.3 <i>Promotion of Gender Equitable Attitudes</i>	89
3.4.6 Societal Level Risk and Protective Factors	90
3.4.6.1 <i>Cultural Norms and Values</i>	90
3.4.6.2 <i>Patriarchal Norms</i>	91
3.4.6.3 <i>Hegemonic and Violent Masculinities</i>	91
3.4.6.4 <i>Male Sexual Entitlement and the Male Sex Drive Discourse</i>	92
3.4.7 Summary and Conclusion	92
3.5 Structural Equations Modelling: VAW	94
3.5.1 The Gender Links Surveys	94
3.5.1.1 <i>GBVS Sampling Issues</i>	95
3.5.1.2 <i>GBVS Design Issues</i>	95
3.5.1.3 <i>GBVS Measurement/Field Issues</i>	95
3.5.2 Key Variables: Violence Victimisation	95
3.5.2.1 <i>Background/Base Variables: Violence Victimisation</i>	96
3.5.2.2 <i>Individual Variables: Violence Victimisation</i>	96
3.5.2.3 <i>Relationship Variables: Violence Victimisation</i>	97
3.5.2.4 <i>Outcome Variables: Violence Victimisation</i>	97
3.5.3 SEM Models: Violence Victimisation	97
3.5.3.1 <i>Physical Intimate Partner Violence</i>	97
3.5.3.2 <i>Emotional Intimate Partner Violence</i>	98
3.5.3.3 <i>Economic Intimate Partner Violence</i>	98
3.5.3.4 <i>Sexual Intimate Partner Violence</i>	99
3.5.3.5 <i>Sexual Violence (Non-Intimate Partner)</i>	99
3.5.3.6 <i>Key SEM Findings: Violence Victimisation</i>	100
• Risk/Protective Factors: Base Variables	100
• Risk/Protective Factors: Intermediate Variables	100
3.5.4 Key Variables: Violence Perpetration (Men's Survey)	100
3.5.4.1 <i>Background/Base Variables: Violence Perpetration</i>	101
3.5.4.2 <i>Individual Variables: Violence Perpetration</i>	101
3.5.4.3 <i>Relationship Variables: Violence Perpetration</i>	102
3.5.4.4 <i>Outcome Variables: Violence Perpetration</i>	102
3.5.5 SEM Models: Violence Perpetration	102
3.5.5.1 <i>Physical Intimate Partner Violence</i>	102
3.5.5.2 <i>Emotional Intimate Partner Violence</i>	103
3.5.5.3 <i>Economic Intimate Partner Violence</i>	103
3.5.5.4 <i>Sexual Intimate Partner Violence</i>	104
3.5.5.5 <i>Sexual Violence (Non-Intimate Partner)</i>	104
3.5.5.6 <i>Key SEM Findings: Violence Perpetration</i>	105
• Risk/Protective Factors: Base/Background Variables	105
• Risk/Protective Factors: Intermediate Variables	105
3.5.6 Summary of Key Findings: Victimisation and Perpetration	105
3.5.6.1 <i>Childhood/Background Factors</i>	105
3.5.6.2 <i>Relationship Characteristics and Dynamics</i>	105
3.5.6.3 <i>Personal Characteristics and Behaviours</i>	106

4. Best Practices for the Prevention of Violence against Women and Children	109
4.1 About this Section	110
4.2 Violence against Children	110
4.2.1 Introduction	110
4.2.2 Preventing Violence in the Home	110
4.2.3 Violence Prevention in Communities	111
4.2.4 Violence Prevention in Schools	111
4.3 Violence against Women	112
4.3.1 Introduction	112
4.3.2 General Characteristics of Good VAW Prevention Strategies	114
4.3.2.1 <i>Multi-level Strategies and Services</i>	114
4.3.2.2 <i>Integration vs. Specialisation</i>	114
4.3.3 Primary Prevention Practices	114
4.3.3.1 <i>Comprehensive Youth Sex and Relationship Education</i>	115
4.3.3.2 <i>Economic Interventions for Women</i>	116
4.3.3.3 <i>Working with Men and Boys</i>	117
4.3.4 Secondary Prevention	117
4.3.4.1 <i>Domestic Violence Screening in Health Care Settings</i>	118
4.3.4.2 <i>Bystander Interventions</i>	118
4.3.4.3 <i>Specialised Services for Victims of VAW</i>	119
4.3.4.4 <i>The Role of SAPS</i>	120
4.3.4.5 <i>Access to Services for Vulnerable Groups</i>	120
4.3.5 Tertiary Prevention	121
4.3.5.1 <i>Strengthening the Legal and Policy Framework</i>	121
4.3.5.2 <i>Long-term Victim Services</i>	123
4.3.5.3 <i>Coordinated Service Provision and Information Management</i>	123
5. Key Recommendation: Working Towards the Eradication of VAC and VAW: A Population-based Public Health Approach	125
5.1 Motivation	126
5.2 A Proposed Population-Based Early Intervention Public Health Approach to Eradicating VAC	126
5.2.1 Screening of Parents during Pregnancy	126
5.2.2 VAC Screening (Routine and Targeted)	127
5.2.3 Universal VAC Screening Directive	127
5.2.4 Training of Child Care Workers	128
5.2.5 VAC Surveillance System	128
5.2.6 Home-based Interventions and Referrals	128
5.2.7 Limitations/Challenges	128
References	131

FIGURES AND TABLES

Figures

Figure 1: Conceptual Illustration of the Socio-Ecological Model.	21
Figure 2. Construction of Predictive Models: Research Methods Process.	22
Figure 3. Primary Model Indices.	24
Figure 4. Key Variables (CAPS).	53
Figure 5. VAC: Victimisation of All Listed Violence (CAPS).	55
Figure 6. VAC: Perpetration of All Listed Violence (CAPS).	55
Figure 7. NYLS Key Variables.	57
Figure 8. Determinants of Sexual Violence (NYLS).	58
Figure 9. Victimisation and Perpetration of Violence (including Bullying) (NYLS).	58
Figure 10. Victimisation and Perpetration of All Violence: Community Influences (NYLS).	59
Figure 11. The Association between Male Sexual Risk Behaviour and VAW Perpetration in South African Literature.	85
Figure 12. Ecological Model of the Key Risk and Protective Factors for VAW Victimisation and Perpetration Identified in the South African Literature.	93
Figure 13: GBVS Key Variables (Violence Victimisation).	96
Figure 14. Physical Intimate Partner Violence (Victimisation).	97
Figure 15. Emotional Intimate Partner Violence (Victimisation).	98
Figure 16. Economic Intimate Partner Violence (Victimisation).	98
Figure 17. Sexual Intimate Partner Violence (Victimisation).	99
Figure 18. Sexual Violence: Non-Intimate Partner (Victimisation).	99
Figure 19. Key Variables: Violence Perpetration (Men's Survey).	101
Figure 20. Physical Intimate Partner Violence (Perpetration).	102
Figure 21. Emotional Intimate Partner Violence (Perpetration).	103
Figure 22. Economic Intimate Partner Violence (Perpetration).	103
Figure 23. Sexual Intimate Partner Violence (Perpetration).	104
Figure 24. Sexual Violence: Non-Intimate Partner (Perpetration).	104
Figure 25. Population-Based Early Intervention Public Health Approach to Eradicating VAC.	129

Tables

Table 1. Factors Operating at Each Level of the Socio-Ecological Model, with some Examples.	21
Table 2. Key VAC Definitions.	29
Table 3. Rates of IPV Victimisation and Perpetration Among Grade 8 Learners.	30
Table 4. Prevalence of Bullying in Urban and Rural Locations.	30
Table 5. Prevalence of Physical and Sexual Abuse by Gender.	38
Table 6. Self-Reported Ease of Access to Alcohol, Drugs and Weapons in Learner's Neighbourhood.	45
Table 7. Definitions of the Types of Violence against Women in South Africa.	65
Table 8. IPV Victimisation of Women in Seven Provinces.	66
Table 9. Perpetration of IPV by Men in Four Provinces.	66
Table 10. Prevalence of Acts of Economic IPV.	67
Table 11. Findings regarding the Age Range of Rape Perpetrators in South Africa.	80
Table 12. Significant Differences in Previous or Current Criminal or Violent Behaviour between Men who have and Men who have not Perpetrated Rape.	82
Table 13. Associations between Gender Attitudes and Beliefs and Different Types of VAW Perpetration in South African Literature.	83
Table 14. Descriptions and Outcomes of Five Integrated Interventions and Campaigns Targeting GBV and HIV.	90
Table 15. Possible Practices to Reduce the Risk of Violence in Schools.	113

LIST OF ACRONYMS

AHP	Allied Health Professional	LBT	Lesbian, Bisexual and Transgender
AIDS	Acquired Immune Deficiency Syndrome	MCCW	Maternal and Child Community Worker
BAC	Blood Alcohol Concentration	MRC	Medical Research Council
BT20	Birth to Twenty	MSF	Médecins Sans Frontières
CAPS	Cape Area Panel Study	NACCW	National Association of Child Care Workers
CCTV	Closed Circuit Television	NCIPC	National Centre for Injury Prevention and Control
CDC	Centre for Disease Control and Prevention	NEDLAC	National Economic and Development Labour Council
CDG	Care Dependency Grant	NGO	Non-Governmental Organisation
CHW	Community Health Worker	NIMSS	National Injury Mortality Surveillance System
CJCP	Centre for Justice and Crime Prevention	Non-IP	Non-Intimate Partner
CM	Child Maltreatment	NPA	National Prosecuting Authority
COAV	Children in Organised Armed Violence	NPF	National Policy Framework
CPF	Community Police Forum	NPO	Non-Profit Organisation
CSG	Child Support Grant	NSVS	National School Violence Studies
CSIR	Council for Scientific and Industrial Research	NYLS	National Youth Lifestyle Study
CW	Child Worker	NYVS	National Youth Victimisation Study
CYCW	Community-Based Child and Youth Care Worker	OMC	'One Man Can'
DALYs	Disability Adjusted Life Years	OPA	Older Persons Act (No. 13 of 2006)
DBE	Department of Basic Education	OVC	Orphans and Vulnerable Children
DHA	Department of Home Affairs	PEP	Post-Exposure Prophylaxis
DHIS	District Health Information System	PHA	Protection from Harassment Act (No. 17 of 2011)
DOH	Department of Health	PPS	Probability-Proportionate-to-Size
DoJ&CD	Department of Justice and Constitutional Development	PSU	Primary Sampling Unit
DOP	Department of Police	PTSD	Post Traumatic Stress Disorder
DSD	Department of Social Development	PWD	Persons with Disabilities
DV	Domestic Violence	RAPCAN	Resources Aimed at the Prevention of Child Abuse & Neglect
DVA	Domestic Violence Act (No. 116 of 1998)	RCT	Randomised Control Trial
ECD	Early Childhood Development	RDP	Reconstruction and Development Programme
ECDG	Early Childhood Development Centre	REC	Reach Every Community
ECLC	Early Childhood Learning Centre	RtHC	Road to Health Chart
ECP	Early Childhood Practitioner	SADC	Southern African Development Community
ELC	Early Learning Centre	SAPS	South African Police Service
EPI	Expanded Program on Immunisation and Vaccine Preventable Disease Surveillance	SASA!	'Start, Awareness, Support, Action'
FCA	Firearms Control Act (No. 60 of 2000)	SASAS	South African Social Attitudes Survey
GBH	Grievous Bodily Harm	SASH study	South African Stress and Health study
GBV	Gender-Based Violence	SASSA	South African Social Security Agency
GBVS	Gender Based Violence Prevalence and Attitudes Household Survey	SaVI	Safety and Violence Initiative
GHS	General Household Survey	SEM	Structural Equations Modelling
HCW	Health Care Worker	SES	Socio-Economic Status
HIV	Human Immunodeficiency Virus	SO	Sexual Offences
HSRC	Human Sciences Research Council	SOA	Sexual Offences and Related Matters Amendment Act (No. 32 of 2007)
ICD	Independent Complaints Directorate	STI	Sexually Transmitted Infection
IMAGE	Intervention with Microfinance for AIDS & Gender Equity	TCC	Thuthuzela Care Centre
IMC	Inter-Ministerial Committee	UCT	University of Cape Town
IP	Intimate Partner	UN	United Nations
IPF	Intimate Partner Femicide	UNDAW	United Nations Division for the Advancement of Women
IPID	Independent Police Investigative Directorate	UNICEF	United Nations Children's Fund
IPR	Intimate Partner Relationship	USA	United States of America
IPV	Intimate Partner Violence	VAC	Violence Against Children
IR	Intimate Relationship	VAW	Violence Against Women
KZN	KwaZulu-Natal		
LB	Lesbian and Bisexual		



Ms Bo Dlamini, MP | Minister of Social Development

FOREWORD FROM THE MINISTER OF SOCIAL DEVELOPMENT

It is a great honour to write the foreword to this report which seek to improve our understanding and strengthen our legislative framework and our national efforts in tackling the scourge of violence against women and children that remains so pervasive in our country. It is a valuable contribution to our ongoing joint national effort of protecting the most vulnerable members of our society because the prevalence of violence remains unacceptably high with devastating lifetime impact.

From the outset I would like to thank UNICEF and the University of Cape Town research team who have made this report and its publications possible due to their continued support of making South Africa safe and a better place to live for women and children and to enable them to fulfil their individual and collective potentials. The Constitution of the Republic of South Africa is built on a culture of reverence for human rights and guarantees all citizens the right to live free from any form of emotional, physical or sexual violence. Recognising that violence against women and children is a gross violation of human rights, preventing and ending it remains a key focus of our Government.

To support Government's commitment to tackling violence against women and children, Cabinet established the Inter-Ministerial Committee (IMC) to investigate the root causes of violence and to develop a comprehensive framework and strategy to address violence against women and children.

The findings and recommendations of this report are therefore important as few studies have explored what drives and

determines violence as current efforts have focussed on addressing normative behaviours of violence against children through a combination of behavioural and biomedical interventions (such as parenting practices in the home, disciplinary measures in schools and post-rape care response in health centres).

Many of these interventions focus on individual-level interventions without identifying the structural forces that are fuelling interpersonal violence. Structural interventions—or drivers, as we explored in this study include social, cultural, economic, legal, organisational, or policy responses to mitigate violence. Without a clear understanding of the central role that these structures play in creating vulnerability to violence, and in constraining both individual and collective agency to prevent violence, investments in primary, secondary and tertiary prevention are unlikely to succeed.

It is by knowing what drives the scourge of violence against women and children that we will be able to prevent it from occurring at the first place.

Understanding these drivers therefore provides a gateway into building effective child protection systems based on violence prevention. Understanding the true extent of violence against children has also been challenging due to the lack of reliable national prevalence estimates as well as the magnitude of under-reporting of some types of violence. Nevertheless, understanding the risk and protective factors of violence against women and children enables the identification of several key factors and relationships that will enhance our prevention interventions.

The complexity of the scourge and its far-reaching effects demand a broader response where we work together to create a safe, secure and peaceful country, in which women and children are free from violence and abuse. For this reason, I want to take opportunity to thank many individuals, community groups and organisations who continue to work tirelessly to prevent, protect and support victims of violence throughout the country.

Finally, I want to extend a huge thank you to all those who gave of their time to participate in this study as it will go a long way to strengthen our work and improve our prevention, early identification and ensure timely intervention.

Indeed, ending violence against women and children is everybody's business.

A handwritten signature in black ink, appearing to read 'Bo Dlamini', with a stylized flourish at the end.

MS BO DLAMINI, MP
MINISTER OF SOCIAL DEVELOPMENT
REPUBLIC OF SOUTH AFRICA



EXECUTIVE SUMMARY

The Executive Summary provides a brief overview of the background to the report and the research methodology used. It further outlines the key structural equations modelling findings on violence against women and children in South Africa and identifies key policy recommendations.

BACKGROUND AND METHODOLOGY

The main objective of this report is to provide the Inter-Ministerial Committee (IMC) to Investigate the Root Causes of Violence Against Women and Children with a critical analysis of the risk and protective factors, or determinants, associated with violence (physical, sexual and emotional) against women and children in South Africa, as well as an in-depth understanding of the relationship between the relevant variables, and to recommend practical violence reduction and prevention interventions.

The victimisation from, and perpetration of, interpersonal violence are complex and dynamic phenomena that are the result of a combination, sequencing and intensity of a variety of variables experienced over the course of individuals' lives. This complexity and dynamism is amplified where large population groups are considered as not all individuals with similar experiences will become victims of, and/or perpetrate, violence. Consequently, root cause analysis is generally not viewed in the violence prevention scholarship as an appropriate theoretical and methodological approach. The reason for this is that root cause analysis is typically used to investigate the principal causes of single, less complex events, such as a plane crashes. It is also highly reliant on the availability of timely and accurate data, which is not the case with data on violence.

Consequently, this research project made use of the public health socio-ecological analytical framework. This framework is comprised of four levels, namely the individual, relationship, community, and societal levels. Its core purpose is that of risk reduction, and posits that there will be a reduction in the risk of violence against women and children if there is a decrease in the risk factors and/or an enhancement of the protective (or resilience) factors that are associated with violence against women and children.

This research project employed both qualitative and quantitative research methods in order to address the research questions and construct predictive models on the determinants of violence against women and children in South Africa. The models are the outcome of a coherent and interconnected process of: a review of existing research in relation to South Africa; the formulation of conceptual frameworks derived from the literature reviews; and the vetting of relevant data sets on the basis of this conceptual framework. Thereafter predictive modelling was pursued.

In general terms predictive modelling is the process by which a statistical model is created or selected in order to predict the probability of an outcome. For this project the type of predictive modelling that was pursued was structural equations modelling (SEM). SEM permits the simultaneous analysis and explanation

of a number of outcome or dependent variables by a number of predictor or independent variables.

Twenty data sets were identified as potential sources for SEM in relation to this project. After an extensive vetting process the accessible data sources that were deemed to be appropriate for the purposes of predictive modelling for this project were the Cape Area Panel Study, as well as the data sets held by the Centre for Justice and Crime Prevention and Gender Links. The results of the SEM on these data sets are summarised below.

The Cape Area Panel Study (CAPS) was initiated in 2002, and is a longitudinal (panel design) study (comprised of five waves) of young people in Cape Town, and it is one of a very small number of studies of its kind in South Africa. The intention of this survey was to investigate the multidimensional nature of the lives of the young men and women especially in relation to educational, psychological, familial, sociological, economic and community considerations as these young people transition from childhood through adolescence and into adulthood. The panel nature of the survey offers considerable benefits as compared to cross-sectional studies. Namely, it allows us to investigate how early childhood conditions relate to later adolescent and adult behaviours; and enables a better test of how violence victimisation early in life leads to violence perpetration and further victimisation in later years.

The National Youth Lifestyle Study (NYLS) undertaken by the Centre for Justice and Crime Prevention is a cross-sectional study that was designed to provide a national probability sample of all youth in the country aged between 12 and 22 years of age in 2008. The sampling frame for the study was based on the 2001 national census data and was obtained from Statistics South Africa. Following the completion of the fieldwork, the obtained sample was reweighted using the census 2001 data to ensure sufficient sample-population congruence with the cohort of youth aged 12 to 22 years.

The Gender Based Violence Prevalence and Attitudes Household Survey (GBVS) undertaken by Gender Links is also a cross-sectional study. The objective was to develop a core set of prevalence indicators that will provide for baseline data at inception, and subsequently; robust data for monitoring on-going trends and patterns. Two surveys were conducted: one for adult women and one for adult men. The women's survey examined violence victimisation and various determinants and risk factors. The men's survey examined violence perpetration and various determinants and risk factors. Both surveys employed a probability-proportionate-to-size stratified design to survey a representative number of respondents in four provinces: Gauteng, Limpopo, KwaZulu-Natal and Western Cape.

Review of Existing Research

Available research indicates that many South African children are exposed to high rates of violence in their homes, schools and communities. Reported rates are suspected to be much lower than actual incidence rates, owing to high levels of under-reporting. The most prevalent forms of violence include physical violence and homicide, corporal punishment, sexual abuse and rape, emotional abuse, neglect, intimate partner violence (IPV), bullying and gang violence.

At the individual level, risk factors for victimisation include age, gender and substance use. Being a member of a vulnerable group, such as being a street child or having a disability, also increases the risk of victimisation. Relationship level risk factors include: substance use by a child's family and peers; poor family structuring and functioning; family conflict; harsh or inconsistent discipline; having a family member who has been incarcerated; having parents with untreated mental health problems; and having peers involved in delinquent behaviour. At the community level, risk factors for illegal victimisation and perpetration include: the availability of weapons and substances; and social norms, which accept patriarchy and violent expressions of masculinity.

South Africa has one of the highest reported rates of gender-based violence in the world. However, the lack of reliable national prevalence estimates for IPV and non-intimate partner (non-IP) sexual violence, and the under-reporting of these types of violence make it difficult to determine the true extent of violence against women. At the individual level, age, substance use, and previous experiences of and/or exposure to violence all contribute to women's victimisation and men's perpetration of violence. There is a significant relationship between childhood experiences and witnessing of violence and later female victimisation or male perpetration of violence. Women may be at greater risk for victimisation if they are members of certain marginalised social groups (e.g. elderly women, women with disabilities and refugees).

Men who perpetrate IPV and sexual violence are often involved in other anti-social behaviour, particularly violent behaviour, in a variety of settings. Existing research suggests an association between psychopathic traits and the perpetration against women. Male dominance and control in relationships speaks to both individual attitudes and beliefs regarding gender roles and broader societal level values and norms that support gender inequity. These gender inequitable attitudes and practices increase the risk for violence.

SUMMARY OF KEY FINDINGS OF PREDICTIVE MODELLING

Violence against Children (Victimisation and Perpetration)

- Children living in households where neither parent is present are at the highest risk for violence, while those with one parent present are at moderate risk, and those with both parents present at lowest risk. Clearly, having both parents at home to look out for children is a strong defence against their becoming victims of violence, as well as against their perpetrating violence.
- Children from households with scarce financial resources are significantly more likely to experience violence in some form, as well as eventually to perpetrate it.
- Males are significantly more likely than females to be victims of physical violence, while females are significantly more likely to suffer emotional and sexual violence. Males are at greater risk for perpetrating all forms of violence.
- Children living in households where they are exposed to drugs/alcohol and crime are at greater risk for violence.
- Children living in households where, as a result of heightened temper and conflict, members resort to violence are at greater risk for suffering violence, as well as perpetrating it. Family temper and conflict is an indication of the pervasive impact of poverty on family life and dynamics.
- Greater exposure to community members who are involved in drugs/alcohol and/or crime places children at greater risk for violence, both as victims and perpetrators. Boys are significantly more likely than girls to associate with such persons in the community and thus more vulnerable to suffering violence, and are at greater risk for perpetrating it.
- Children who use and abuse alcohol are at higher risk in terms of perpetration of violence. Alcohol use/abuse is most affected by exposure to these substances in the household and exposure to it in the community. In this regard, boys are at much higher risk than girls.
- Children who use drugs are at higher risk in terms of perpetration of violence, with boys are at much higher risk than girls.

- Children from households with higher levels of conflict are more likely to escape such conflict by engaging with community structures, but those who have suffered physical violence as a result of this family conflict are significantly less likely to do so. Greater participation in such structures could serve as a protective factor by removing the child from a high-conflict family situation, even if temporarily.
- Girls are significantly more likely to perceive and report emotional violence than are boys.
- Girls are at significantly greater risk for sexual violence than are boys.
- Both boys and girls appear to be at equal risk for suffering physical violence at home.
- Children who have suffered some form of violence at home are at a greater risk for experiencing violence outside the home.
- Children who have suffered some form of violence are significantly more likely to perpetrate violence against others, be it in the home, the community or at school.
- Perpetration of violence appears to begin in the home and extends outside the home into the community.
- Boys are significantly more likely than are girls to perpetrate all forms of violence, even when all other determinants are held constant.

Violence against Women

Victimisation (Women)

- Women from poorer backgrounds are at much greater risk for all types of violence, with higher levels of poverty amongst women being significant determinants of greater economic dependency.
- The educational levels of women are significantly indirectly related to their risk of violence victimisation, with lower levels of education being associated with increased risk of violence victimisation. Education is a significant direct determinant of greater economic dependency on male partners, and a diminished control in the relationship. It is also a significant determinant of increased alcohol abuse.
- Emotional, physical and sexual abuse suffered by women as children was a significant base determinant of violence victimisation. In many instances of victimisation, childhood abuse was the most significant risk factor.
- Economic dependency by women on their partners left them vulnerable to all forms of intimate partner violence.
- Women who abuse alcohol are at greater risk for all forms of violence victimisation.
- The abuse of alcohol by the partner of women is a significant determinant of violence victimisation. The

effect is indirect through the perceived infidelity of the partner. The partner's alcohol abuse is significantly directly determined by their control in the relationship and the extent to which the women are economically dependent on them.

- Perceived infidelity by their male partners is a significant determinant of increased risk for violence victimisation. Such infidelity is predicted by the control the male has in the relationship, as well as the abuse of alcohol by the woman. Women who abuse alcohol are more likely to be in relationships with partners who are more likely to be unfaithful.

Perpetration (Men)

- Individual and household poverty feature significantly as a base indirect determinant for perpetration. Men from poorer backgrounds are more likely to perpetrate all forms of intimate partner violence. They are also more likely to have been exposed to trauma or suffered abuse during childhood.
- Educational levels are significantly indirectly related to the risk of violence perpetration, with lower levels of education being associated with increased risk of perpetration of all forms of violence. Lower education is a significant direct determinant of greater male control in the relationship and inequitable personal gender norms.
- Emotional, physical and sexual abuse suffered by men as children was a significant base determinant of violence perpetration. In many instances, childhood abuse was the most significant risk factor for violence perpetration.
- The experience of trauma was a significant indirect determinant of violence perpetration. Higher levels of trauma were significantly directly associated with: increased alcohol abuse; greater control in the relationship; and perpetration of emotional intimate partner violence.
- The extent of control of the relationship by the male partner was both a significant indirect and direct determinant of violence perpetration.
- Personal norms about inequitable gender relationships were a significant direct and indirect predictor of increased violence perpetration.
- Personal rape views were a significant indirect determinant of increased perpetration of sexual violence, through the direct effect on more multiple sexual partners.
- Alcohol abuse is a significant direct determinant of almost all forms of violence perpetration, with increased abuse predicting increased propensity for such perpetration.
- The increased number of concurrent sexual partners by males has a direct impact on the increased probability of violence perpetration.

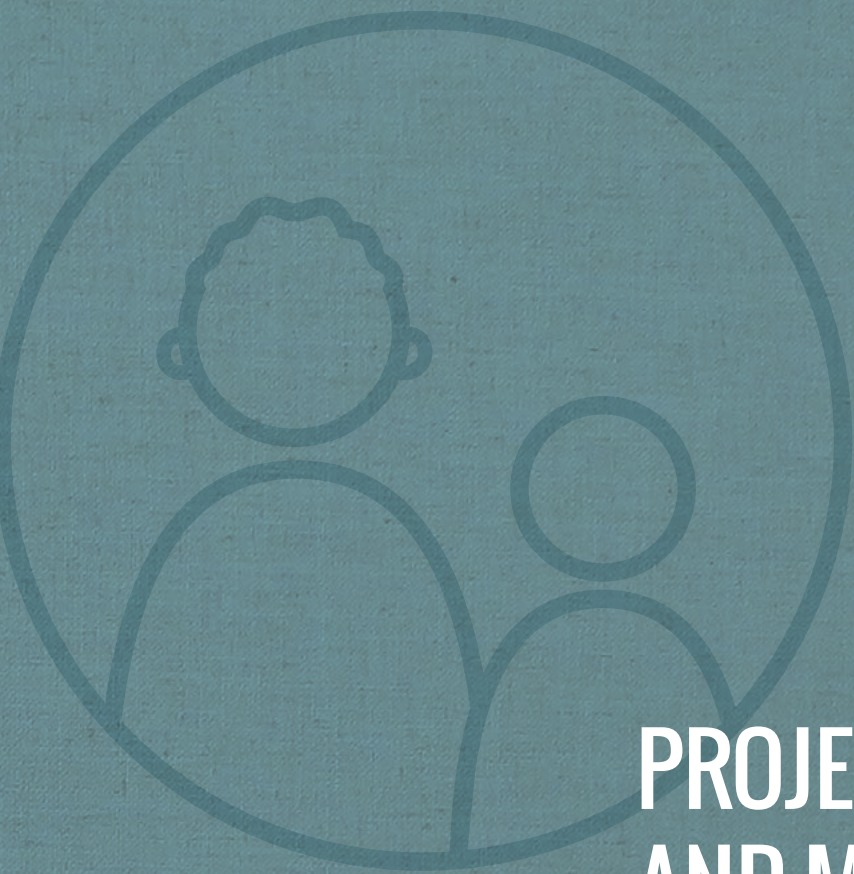
Key Policy Recommendations

The research presented in this report underlines the high prevalence of violence against children throughout South Africa. Not only is this a critical issue for children and their families, but violence against children has also been found to be a principal risk factor with respect to violence against women. Hence, a strong focus on preventing violence against children, particularly through early intervention, may be the most appropriate course of action for the South African government to have a significant impact on reducing and preventing many forms of violence in the long term.

A population-based early intervention public health approach to **eradicating** violence against children is therefore proposed. Such an approach should ideally make use of a four-pronged strategy:

1. Early intervention and prevention;
2. More detailed research on the prevalence of violence, through analysis of data generated through universal screening for violence against children;
3. Intervention programmes at scale; and
4. Improved information and surveillance systems.

In essence the proposed approach would aim to address violence against children through early screening of parents and children. Parents identified as being at risk of perpetrating violence and children displaying signs of maltreatment should then be identified and referred for appropriate interventions and support. In addition, high-risk children and parents should be carefully monitored.



01

PROJECT INFORMATION AND METHODOLOGY

The Project Information and Methodology section provides an overview of the project objectives and an introduction to the socio-ecological model – the analytical framework for this project. It then highlights how data sets were identified and vetted and discusses structural equations modelling, which was used to analyse the chosen data sets.

1.1 BACKGROUND TO THIS REPORT

This report presents the findings of a research project facilitated by the Safety and Violence Initiative (SaVI) at the University of Cape Town (UCT) entitled: 'Towards a more comprehensive understanding of the direct and indirect determinants of violence against women and children in South Africa with a view to enhancing violence prevention'. This research project was formally initiated in December 2013 at the request of the Cabinet-level Inter-Ministerial Committee (IMC) to 'Investigate the Root Causes of Violence Against Women and Children' following close to six months of consultations on the scope, range and methodology of this project. Funding and technical support was provided the United Nations Children's Fund (UNICEF) in Pretoria.

This research project was implemented in partnership with the Children's Institute (UCT), and drew on expertise from a number of other UCT entities, such as the Centre for Social Science Research, the Department of Psychology, the Gender Health and Justice Research Unit, and the Division of Nursing and Midwifery. The members of the research team were as follows:

- A/Prof Shanaaz Mathews (Children's Institute)
- Prof Rajen Govender (Centre for Social Science Research)
- Guy Lamb (SaVI)
- A/Prof Floretta Boonzaier (Department of Psychology)
- A/Prof Sinegugu Duma (Division of Nursing and Midwifery)
- A/Prof Andrew Dawes (Department of Psychology)
- A/Prof Catherine Ward (Department of Psychology)
- A/Prof Lillian Artz (Gender, Health and Justice Research Unit)
- Lauren Baerecke (SaVI)
- Giselle Warton (SaVI)
- Talia Meer (Gender, Health and Justice Research Unit)
- Rebecca Smith (Gender, Health and Justice Research Unit)
- Lucy Jamieson (Children's Institute)
- Stefanie Röhrs (Children's Institute)

Additional research support was provided by:

- Claire McDonald (SaVI)
- Shayni Geffen (SaVI)

Guy Lamb, the Director of SaVI, was responsible for the overall management of the project and the finalisation of this report, with administrative support being provided by Lameez Mota (SaVI).

Throughout the duration of the project regular progress reports, including the presentation of the preliminary and final research findings were provided to the IMC Technical Task Team for their feedback. Where possible, this feedback was incorporated into this report.

1.2 PROJECT OBJECTIVES

The main project objective was to provide the IMC with a critical analysis of the risk and protective factors (determinants) associated with violence (physical, sexual and emotional) against women and children in South Africa, as well as an in-depth understanding of the relationship between the relevant variables, and to recommend practical violence reduction and prevention interventions. More specifically this project sought to:

- Develop conceptual models based on a critical review of available research on the risk and protective factors in relation to violence against women and children in South Africa;
- Access and assess the available and relevant data sets and establish eligibility for predictive modelling, namely structural equations modelling (SEM);
- Subject to data availability and integrity, construct hypotheses and estimate predictive models to establish the key factors in explaining violence against women and children and the critical causal relations amongst these;
- Using existing information from publicly available research, provide appropriate illustrative case studies of women's and children's experiences of violence in South Africa;
- Undertake research and compile illustrative case studies on children's experiences of protection and support services in South Africa in relation to child maltreatment;
- Review relevant South African and international best practice for interventions to prevent and reduce violence against women and children; and
- Provide recommendations on the prevention of violence against women and children in South Africa.

1.3 ANALYTICAL FRAMEWORK

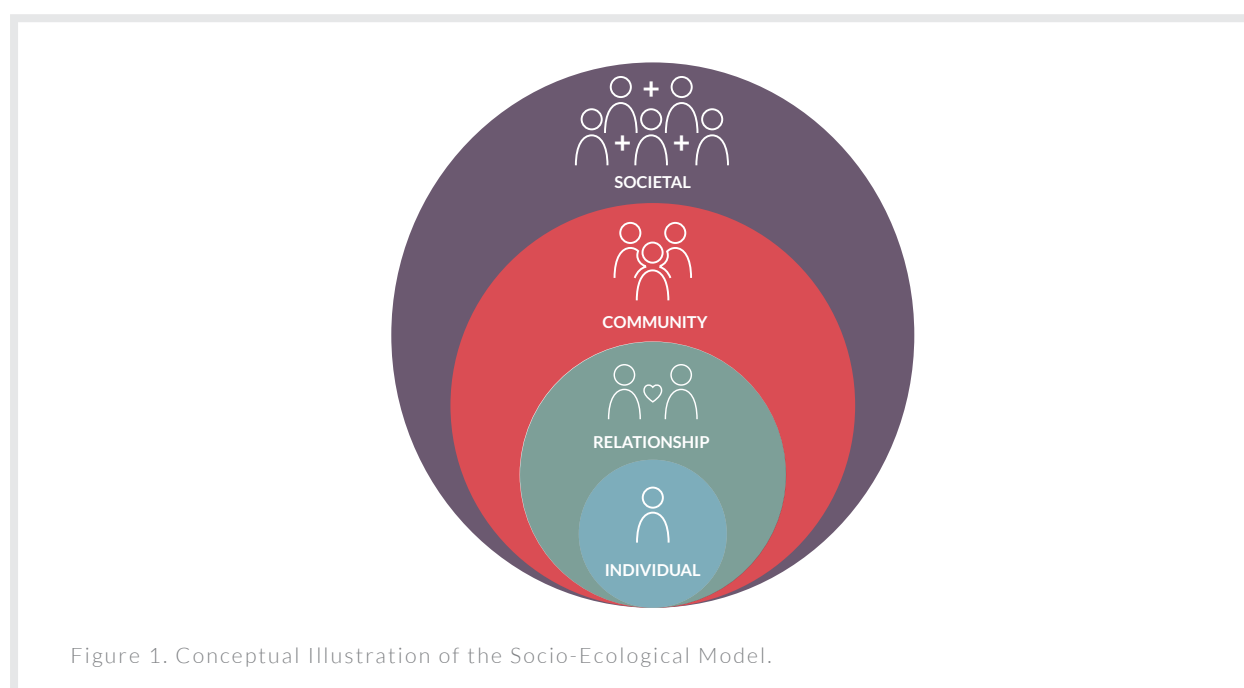
There is growing consensus within the international literature on violence prevention that victimisation from, and perpetration of, interpersonal violence are complex and dynamic phenomena that are the result of a combination, sequencing and intensity of a variety of variables experienced over the course of individuals' lives. This complexity and

dynamism is amplified where large population groups are considered, as not all individuals with similar experiences will become victims of, and/or perpetrate, violence. Consequently, root cause analysis is generally not viewed in this scholarship as an appropriate theoretical and methodological approach. The reason for this is that root cause analysis is typically used to investigate the principal causes of single, less complex events, such as a plane crashes and the collapse of buildings. It is also highly reliant on the availability of timely and accurate data on all aspects of the event to needs to be studied, which is not the case with data on violence (particularly in South Africa).

Consequently, this research project made use of the public health socio-ecological analytical framework. The core purpose of this framework is that of risk reduction, and posits that there will be a reduction in the risk of violence against women and children if there is a decrease in the risk factors and/or an enhancement of the protective (or resilience) factors that are associated with violence against women and children [1].

This analytical framework is the most widely used model to explain the occurrence of violence and conceptualise violence prevention. It is also the model that has been used by the Centre for Disease Control and Prevention (CDC)'s National Centre for Injury Prevention and Control (NCIPC), as well as by the World Health Organisation (WHO) World Report on Violence and Health. The model acknowledges that there are a wide range of factors operating at multiple, inter-connected levels that may increase the risk of, or protect against, interpersonal violence.

This framework is comprised of four levels, namely: individual; relationship; community; and societal (see Figure 1 below for a conceptual illustration of this model). Factors in all four levels act in combination to increase or decrease the likelihood that a person will experience interpersonal violence. Table 1 provides description of the types of factors operating at each level of the socio-ecological model.



LEVEL	FACTORS	EXAMPLES
INDIVIDUAL	Biological, psychological or behavioural characteristics of an individual	Age and gender; alcohol or drug use; witnessing violence; beliefs that condone interpersonal violence
RELATIONSHIP	Family or caregiver influences (family environment and parental behaviour); relationships with peers and/or intimate partners	Patriarchal or physically violent family environment; parental substance use; delinquent peers
COMMUNITY	Relationships with schools and neighbourhood; social integration and capital	Poor policing; access to firearms, drugs and alcohol; poverty; lack of consequences for perpetrators; tolerance of interpersonal violence
SOCIETAL	Demographic and social changes; income inequality; political structures; cultural influences and norms; economic and social policies	Inadequate laws governing firearms; policies that maintain inequality or discrimination based on race or gender; culture of male sexual entitlement; pro-violence norms

Table 1. Factors Operating at Each Level of the Socio-Ecological Model, with some Examples [2], [3].

A critical analysis of risk and protective factors is essential to determining effective and relevant violence prevention interventions. However, due to considerable data limitations (lack of appropriate data sets for predictive modelling) with respect to societal level and structural violence in South Africa, only three levels of the socio-ecological framework were considered for this study, namely the individual, relationship and community level.

1.3.1 Research Questions

The key research questions of this project were as follows:

- What are the most relevant risk and protective factors that relate to violence against women and children in South Africa in terms of: violence at the individual level; in the family/home; and in communities (including schools)?
- To what extent are these risk and protective factors supported by sufficient evidence?
- With respect to explaining violence against women and children, how do these risk and protective factors behave:
 - *As direct and indirect determinants regardless of the presence/absence of other variables?*
 - *By interacting with each other in that the presence of more than one variable to have a multiplicative impact on increasing/decreasing probability of such violence?*
 - *By moderating the effect of one or other variables in specific ways to either increase or decrease such violence?*

- Which factors or variables are most critical in determining violence towards women and children when all other factors are controlled for, as a means towards identifying specific areas for prevention and intervention strategies?
- What are the most practical and achievable prevention strategies and interventions that can be pursued that will result in the significant reduction in the violence against women and children?

1.3.2 Methodology

This research project employed both qualitative and quantitative research methods in order to address the research questions and construct predictive models on the determinants of violence against women and children in South Africa. The models are the outcome of a coherent and interconnected process of: a review of existing research in relation to South Africa; the formulation of conceptual frameworks derived from the literature reviews; and the vetting and testing relevant data sets on the basis of this conceptual framework. Only data sets that: contained the key variables; were obtainable; and passed the vetting processes were used for the purposes of predictive modelling.

The methodological process is outlined in more detail in Figure 2 and the subsections below.

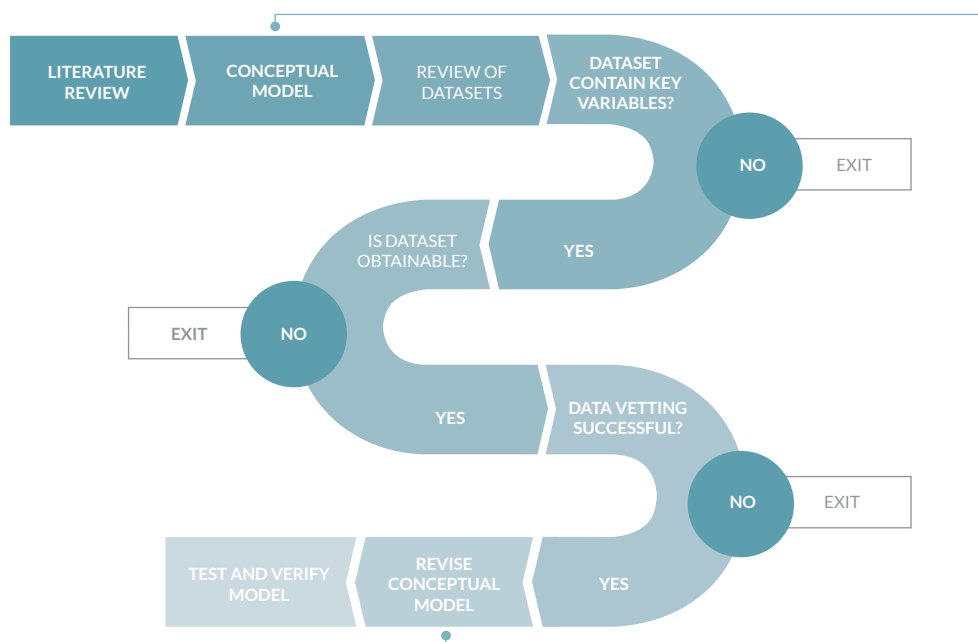


Figure 2. Construction of Predictive Models: Research Methods Process.

1.3.2.1 Critical Reviews and Conceptual Models

Critical reviews of the risk and protective factors (in terms of physical, sexual and psychological/emotional violence) were undertaken on the basis of exiting published research on violence against women (VAW) and violence against children (VAC) in South Africa. The critical reviews assessed the scope, methodology and quality of research on VAC and VAW in South Africa. This process clarified existing knowledge on the risk and protective factors for VAC and VAW in South Africa, and contributed to the development of conceptual frameworks for predictive modelling. In addition, reviews of the relevant South African legislation in relation to VAC and VAW were undertaken.

1.3.2.2 Data Scoping and Analytical Framework

The critical reviews, combined with consultations with other researchers in the field of violence against women and children, were the basis on which a list of relevant data sets was compiled and the analytical framework constructed. The research team then endeavoured to gain access to these data sets, as well as the associated survey instruments and sampling methodology (in the case of survey data). Data sets were then evaluated in terms of their relevance (in relation to the key violence variables), credibility, representivity, robustness and availability. The most appropriate and available data sets were thereafter selected for predictive modelling.

Twenty data sets were identified as potential sources for structural equations modelling, which included amongst others: the National Income Dynamics Study; Afrobarometer data; National Injury Mortality Surveillance System data; Cape Area Panel Study; South African Police Service crime data; Statistics South Africa's victims of crime survey data; data held by the Medical Research Council on violence against women; data held by Lucie Cluver at the University of Oxford, and various data sets that had been produced by the Centre for Justice and Crime Prevention and Gender Links. After an extensive vetting process, the accessible data sources that were deemed to be appropriate for the purposes of predictive modelling for this project were the Cape Area Panel Study, as well as the data sets held by the Centre for Justice and Crime Prevention and Gender Links.

1.3.2.3 Predictive Modelling

Predictive modelling is the process by which a statistical model is created or selected in order to predict the probability of an outcome. The research team was of the view that structural equations modelling (SEM) was the most appropriate form of predictive modelling for this project. SEM is a general class of statistical techniques that permits the simultaneous analysis and explanation of a number of outcome or dependent variables by a number of predictor or independent variables.

The technique offers the following analytical benefits, *inter alia*:

1. The paths between the independent and dependent variables are specified based on theory and indicate the causal flow in the theoretical model. Accordingly, these paths test precise relationships and hypotheses and provide confirmation of *specific theoretical explanations*.
2. The impact of each independent variable on the outcome variable is assessed within the context of all other variables in the model, which allows for a closer *approximation to social reality* where multiple determinants of human behaviour exist simultaneously.
3. The individual predictor variables and their impact on the outcome variables are assessed relative to other predictor variables, which allows identification of the predictor variables with the *strongest causal relationships* with the outcome variables.
4. The relationships amongst predictor variables and the outcome variables can be *properly sequenced*. Hence it is possible to examine the role of demographic variables as these determine psychological/cultural/community variables and the consequent role of these latter variables in determining propensity for violence or actual perpetration of violence.
5. The impact of individual predictor variables on the outcome variables can be understood individually or in terms of how they interact with other predictor variables. This allows for the analysis of effects where the presence of some variables either *moderates or multiplies the impact* that other predictor variables have on the outcome.

It is important to note that the models developed through SEM are:

- Predictive – in that they examine the likelihood of increased or decreased susceptibility to violence;
- Multivariate – in that they examine the simultaneous impact of different variables on other variables;
- Explanatory – in that the paths between variables indicate significant explanatory relationships in the overall model; and
- Empirical – in that the identified paths between variables represent relationships that have been scientifically verified.

It is also important to note that the models developed through SEM are not:

- Causal – in that no tests of causality are undertaken, and none should be inferred;
- Absolute – in that the models work on the basis of the data at hand, hence are subject to sample considerations and future verification;

- Deterministic – in that the relationships amongst variables are probabilistic (increased or decreased probability of effect); and
- Reliant upon a single measure to determine statistical significance.

They accordingly utilise a number of different measures, each of which relates to a different aspect of the model and the modelling process. Figure 3 (below) shows the following three primary model indices that will be used to determine if the developed predictive models are poor, good or excellent.

A successful predictive model should:

- Identify key risk and protective factors in violence against women and children;
- Identify the key moderating and mediating variables;
- Provide robust predictions and explanations;
- Permit generalisation of model to wider populations;
- Help determine priority areas for policy and programmes; and
- Help identify key areas for monitoring and evaluation.

1.3.2.4 Illustrative Case Studies

A review of the available literature was undertaken to compile a set of qualitative case studies that are illustrative of women's and children's experiences of, and vulnerabilities to, violence in South Africa. Specific case studies were selected to provide further insight into the outcomes of the predictive modelling. Further case studies were compiled to highlight children's experience of the South African government's child protection and related services. The case studies will be included in a separate booklet.

1.3.2.5 Best Practices for Violence Reduction and Prevention

Informed by the conceptual frameworks, as well as the results of the predictive modelling, recommendations for reducing and preventing VAC and VAW that are relevant to the South African context will be presented. These best practices are derived from reviews of documented national and international best practice (that have a strong evidence base).

MODEL INDEX	GOOD	EXCELLENT
Chi-square to df Ratio	<4	<2
CFI	>0.90	>0.95
RMSEA	<0.08	<0.05

Figure 3. Primary Model Indices.



02

VIOLENCE AGAINST CHILDREN: RESEARCH FINDINGS

South African children face violence across the multiple settings in which they live – their homes, schools and communities. The high rates of violence against children in South Africa reflect both the disproportionate vulnerability of this group and the pervasiveness of violence in society more broadly. This section provides a critical review of the existing research and legislation as well as the findings of the structural equations modelling on violence against children in South Africa.

2.1 DEFINITIONS

Children are those persons under the age of 18. This is consistent with the definition of a child used in South African legislation, the South African Constitution and by the United Nations (UN). The definitions of violence and the different forms of VAC measured in South African studies, which will be used for this report, are presented in Table 2. The definitions used in this review follow those used in South African legislation, but are compared or substituted with definitions from the World Health Organization (WHO) where South African definitions are lacking.

2.2 BACKGROUND

South African children face violence across the multiple settings in which they live – their homes, schools and communities. The most prevalent forms of violence include physical violence and homicide, corporal punishment, sexual abuse and rape, emotional abuse, neglect, intimate partner violence (IPV), bullying, gang violence and xenophobic violence. It is likely that the statistics discussed below are only the tip of the iceberg with regard to the true extent of VAC in South Africa. Under-reporting of VAC is a global problem, and is also widely perceived to be the case in South Africa [7], particularly with regard to sexual violence and rape [8]–[11].

2.2.1 Physical Violence and Homicide

The 2013/2014 South African Police Service (SAPS) national crime statistics indicated that children were the victims of 20 302 cases of reported common assault, 16 872 cases of reported assault with intent to inflict grievous bodily harm (GBH), 1 542 cases of reported murder, and 1 626 cases of reported attempted murder. Nevertheless, research has shown that much crime in South Africa goes unreported and consequently the actual rates of VAC are likely to be much higher; especially for cases such as assault [12]. South Africa's child homicide rate is high – a recent study on child homicides indicated that South Africa's child homicide rate (5.5 per 100 000 children under 18 years) is double the WHO's estimated global average (2.4 per 100 000 children under 18 years) [13]. Child abuse and neglect precede nearly half of all homicide cases. The Centre for Justice and Crime Prevention's (CJCP) 2008 National Youth Lifestyle Study (NYLS) reveals

youth are primarily vulnerable to physical assault in the streets (41.3%), with many of these assaults including the use of weapons (34.9%) and being perpetrated by known community members (40%) [14].

2.2.2 Corporal Punishment

To date corporal punishment in South African homes has not been outlawed. Research has shown that more than half (57%) of parents with children under 18 report smacking their children at some point and roughly a third (33%) report using a belt or object to beat their children [7]. Although the law prohibits the use of corporal punishment in schools, it is still widely practised. There is consistent evidence from the CJCP's 2005 National Youth Victimisation Study (NYVS), 2008 NYLS, and the 2008 and 2012 waves of the National School Violence Studies (NSVS) that roughly half of all surveyed learners were caned or physically punished in some manner [14]–[17].

2.2.3 Sexual Violence

With regard to childhood sexual abuse, SAPS national crime statistics show that 25 862 sexual offences against children were reported in 2011/2012, constituting more than 50% of the total crimes against children [18]. A population-based survey in Gauteng found that 25.3% of female participants and 20.4% of male participants had experienced some form of childhood sexual abuse [19], with a study focusing on perpetration indicating similar rates of sexual abuse [20]. A large proportion of sexual VAC takes place within the victim's or someone else's home [21], and is perpetrated by relatives or acquaintances [22]. Some 84% of child rapes are perpetrated by relatives, friends, acquaintances or neighbours of the child. Of the rape of young girls (aged 0–11 years) in Gauteng, 52.1% are perpetrated by a friend, acquaintance or neighbour, and 31.8% are perpetrated by relatives. This proportion is lower during adolescence (12–17 years) with 43.4% of rapes of adolescent girls in Gauteng being perpetrated by a friend, acquaintance or neighbour; and 14.0% being perpetrated by a relative. Strangers or individuals only known by sight to the victim are responsible for 28.6% of adolescent girl rapes compared to 14.6% of the rape of young girls. Thus, young girls are more at risk of being raped by a relative and adolescent girls are more at risk of being raped by a stranger or someone they know only by sight [22].

2.2.4 Emotional Abuse

Prevalence rates for emotional abuse reported in the literature range from 11.9% for severe emotional abuse [23]

1 Although the Schools Act (1996) and the National Education Policy Act (1996) ban corporal punishment, they do not provide a definition of corporal punishment. In 2000, the then Minister of Education released a document explaining why corporal punishment is banned in classrooms, and provided alternatives to corporal punishment – this is the document from which the provided definition is sourced.

to 35.5% for lifetime experience of emotional abuse [24]. Reports of childhood emotional abuse, where witnessing IPV was included as a measure of emotional abuse, was 54.7% for women and 56.4% for men participating in the Stepping Stones HIV intervention in rural Eastern Cape [25]. When broken down into types of emotional abuse, 13.3% of women

and 9.8% of men reported being called names by family members and 30.6% of women and 9.8% of men reported being insulted or humiliated by a family member in front of others. Among orphans and vulnerable children (OVC), one in four (25%) report being called names, such as dumb or lazy, or being threatened to be kicked out of the home [26].

TYPE OF VIOLENCE	DEFINITION	SOURCE
VIOLENCE	The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.	WHO [4]
CHILD ABUSE OR MALTREATMENT	All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.	WHO [4]
CHILD ABUSE	Any form of harm or ill-treatment deliberately inflicted on a child... [including] assaulting a child or inflicting any other form of deliberate injury to a child; sexually abusing a child or allowing a child to be sexually abused; bullying by another child; a labour practice that exploits a child; or exposing or subjecting a child to behaviour that may harm them emotionally or psychologically.	Children's Act (No. 38 of 2005)
NEGLECT	A failure in the exercise of parental responsibilities to provide for the child's basic physical, intellectual, emotional or social needs.	Children's Act (No. 38 of 2005)
PHYSICAL ABUSE	Any act or threatened act of physical violence. The intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development or dignity.	Domestic Violence Act (No. 116 of 1998) WHO [5]
SEXUAL ABUSE	Sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted; encouraging, inducing or forcing a child to be used for the sexual gratification of another person; using a child in or deliberately exposing a child to sexual activities or pornography; or procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.	Children's Act (No. 38 of 2005)
EMOTIONAL, VERBAL AND PSYCHOLOGICAL ABUSE	A pattern of degrading or humiliating conduct towards a complainant, including (a) repeated insults, ridicule or name calling; (b) repeated threats to cause emotional pain; or (c) the repeated exhibition of obsessive possessiveness or jealousy, which is such as to constitute a serious invasion of the complainant's privacy, liberty, integrity or security.	Domestic Violence Act (No. 116 of 1998)
EMOTIONAL MALTREATMENT	Emotional maltreatment includes the failure of a caregiver to provide an appropriate and supportive environment, and includes acts that have an adverse effect on the emotional health and development of a child.	WHO [4]
CORPORAL PUNISHMENT	Any deliberate act against a child that inflicts pain or physical discomfort to punish or contain him/her. This includes, but is not limited to, spanking, slapping, pinching, paddling or hitting a child with a hand or with an object; denying or restricting a child's use of the toilet; denying meals, drink, heat and shelter, pushing or pulling a child with force, forcing the child to do exercise.	Department of Education [6, p.6] ¹
DOMESTIC VIOLENCE	This includes: physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour towards the complainant; where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the complainant.	The Domestic Violence Act (No. 116 of 1998)

Table 2. Key VAC Definitions.

Primary caregivers and relatives are the main perpetrators of emotional abuse [27], suggesting that the home is the most likely setting for emotional abuse.

2.2.5 Neglect

There is limited knowledge on the extent of child neglect in South Africa, compared to other forms of child maltreatment. SAPS figures for 2012/2013 show 2 758 reported cases of neglect and ill-treatment of children [28]. Other research estimates more than half of children experience neglect, with 53% of women and 67.1% of men in Gauteng having reported experiencing neglect during childhood [19]. Physical hardship during childhood, including not being washed, having dirty clothes, never being warm, or not having enough to eat, was reported by 46.8% of men and 55.8% of women in the Stepping Stones study [25]. In this study, emotional neglect, including living in different households at different times, adults not knowing where the child was when outside the home, or parents being too drunk to take care of the child, was reported by 39.7% of men and by 41.6% of women.

When considering the issue of child neglect it is important not to underestimate the role of poverty in creating situations of deprivation, such as not having enough to eat. This requires distinguishing between deprivation due to poverty and deprivation due to neglect by parents. It is a subtle and complex distinction and requires further exploration, yet is

an important one in terms of prevention and intervention strategies. The former requires household level poverty alleviation, while the latter often requires intensive family support or child removal, and sometimes economic assistance is also required [29].

2.2.6 Intimate Partner Violence

The high overall rates of IPV in South Africa suggest that many children are subject to and/or witness this abuse [30], [31]. Data from Gauteng reveals 30.5% of women and 26.2% of men reported witnessing maternal abuse during childhood [19]. Similarly, in a study on childhood abuse among university students, 22% of students reported that their father had hit their mother [32]. Slightly higher statistics are reported among rural South African youth [25].

Children may also be exposed to IPV within their own intimate relationships. Recent research has shown high rates of physical, sexual and emotional IPV victimisation and perpetration among Grade 8 learners (see Table 3). Slightly lower rates were reported in a national survey; 15.1% of learners, between the ages of 16 and 20, reported having experienced physical IPV in the last six months, with no significant difference between girls and boys [33]. Some 13.5% of learners reported ever having perpetrated physical IPV, with significantly more boys (15.3%) reporting assaulting their partner compared to girls (11.7%).

	EMOTIONAL IPV	PHYSICAL IPV	SEXUAL IPV
GIRLS (VICTIMISATION)	33.9%	39.1%	7.5%
BOYS (PERPETRATION)	31.2%	20.3%	11.0%

Table 3. Rates of IPV Victimisation and Perpetration Among Grade 8 Learners [34].

	BULLIES		BULLY VICTIMS	
	MALE	FEMALE	MALE	FEMALE
CAPE TOWN ^a	27.7%	16.4%	42.2%	31.5%
DURBAN ^a	17.8%	13.8%	35.6%	24.9%
PORT ELIZABETH ^a	20.1%	10.7%	24.3%	18.8%
MANKWENG ^b	33.0%	16.1%	44.5%	30.8%

Note: ^aUrban ^bRural

Table 4. Prevalence of Bullying in Urban and Rural Locations [36].

2.2.7 Bullying

Although violence in schools extends beyond cases of bullying, bullying remains a significant contributor towards learners' experiences of violence. The 2012 NSVS shows that 13% of secondary school learners report having been bullied at school [15]. Investigating bullying among Grade 11 students from rural schools in the Eastern Cape, Mlisa et al. found prevalence rates of 3.9% for bullying, 16.49% for victimisation and 5.45% as bully-victims (children who had been both victims and perpetrators of bullying) [35]. Slightly higher rates of victimisation and perpetration were found among Grade 8 students in Cape Town, Durban, and the rural area of Mankweng in the Limpopo Province, and Grade 9 students in Port Elizabeth (see Table 4).

2.2.8 Gang Violence

Children may be exposed to gang violence either as perpetrators or as victims [37]; however, it is difficult to accurately determine the prevalence of child membership in gangs due to a lack of data or records and the fact that gang membership is constantly changing [38]. Surveys show that nationally, 19.4% of learners report being a member of a gang and 21.2% report being approached to join a gang³. Gang membership is not significantly associated with age, however; it is associated with grade. Learners in Grade 8 (22.4%) are significantly more likely to report gang membership than learners in Grade 11 (16.5%) [33]. The rates differ between provinces, with the Western Cape having the lowest rate (14.5%) and KwaZulu-Natal (KZN) the highest rate of reported gang membership (21.9%) [33]. Comparatively, learners in the Eastern Cape (16.7%) are the least likely to have been approached to join a gang, while learners in Gauteng are the most likely to have been approached (26.1%) [33]. With regards to child victims of gang violence, between 2001 and 2010, 63 (38.7%) gunshot wounds seen at the Red Cross Children's Hospital in Cape Town were as a result of being caught in crossfire and eight (4.9%) gunshot wounds were as a result of intentional shootings by gangsters [39]. Similar statistics emerged from other studies. Shields et al. [34] found, in their study conducted in Cape Town, that more than 50% of the children in their study had seen someone hit or kicked by gang members; more than 40% had seen someone threatened or attacked with a sharp weapon; and 43.1% had seen someone shot by gang members.

2.2.9 Consequences of Violence against Children

Exposure to violence has multiple negative consequences for children and their families. The public health impact

is significant, with substantial cost to society. Beyond the immediate risk of fatal or non-fatal physical injuries, experiencing or witnessing violence has a known impact on a child's cognitive, social, psychological and emotional development. Some of these effects include (a) changes in brain structure and function [40]–[42]; (b) behavioural responses, such as sleep disturbances and eating problems; (c) responses indicative of poor emotional regulation, such as temper tantrums and excessive anger [43], [44]; (d) psychosomatic responses, such as stomach problems and headaches [43], [45]; (e) academic and social difficulties at school [43], [46]; (f) aggression and depression; (g) Post Traumatic Stress Disorder (PTSD); (h) risk-taking behaviour, such as alcohol abuse, substance abuse and risky sexual behaviour; (i) difficulties in peer and intimate partner relationships [25], [30], [47]–[52]; and (j) HIV and other sexually transmitted infections (STIs) [25], [51], [53].

These significant effects on children and their families impose a further cost to society. This cost is incurred by government through health care for the treatment of victims, by law enforcement and the criminal justice system for prosecuting offenders, and by child social services for the protection of children who have been victims of, and those who are vulnerable to, violence. There is also the broader, long-term cost to society through the intergenerational transmission of violence and the lowered productivity, absenteeism and poorer quality of life resulting from the effects of violence suffered by workers in their childhood [4], [54].

Childhood exposure to violence plays a role in further victimisation and the intergenerational transmission of violence. Children, particularly boys, who have experienced or witnessed violence may be more likely to become perpetrators of violence in the future [55]. Children living in violent contexts can be socialised into accepting violence as a legitimate way of dealing with conflict, consequently using violence themselves and contributing to the cycle of violence. On the other hand, girls exposed to sexual abuse in childhood are more likely to be victims of sexual and physical abuse, including IPV, in the future, introducing a cycle of re-victimisation [56]. This intergenerational cycle and re-victimisation contributes to sustained or increased levels of violence within society [54].

2.3 LEGISLATIVE FRAMEWORK

South Africa has an exemplary constitutional and legal framework regarding child rights. The rights of South African children are entrenched in international, regional, and domestic legislation and policy frameworks. While these provide for the comprehensive protection of children's safety and wellbeing,

³ These responses related to the six months preceding the study.

in reality there is often significant disconnect between policy and practice. In assessing South Africa's readiness for the prevention of child maltreatment, a UN-based study found that whereas one of South Africa's key strengths was its legislation and policy, one of the key weaknesses was the *implementation* of this legislation [57].

2.3.1 Preventing Violence in the Home

2.3.1.1 Children's Act

The Children's Act 38 of 2005 provides the foundational layer of prevention of VAC and early intervention programmes as well as a system to identify, refer, support, care for and rehabilitate children who have suffered violence. The Children's Act focuses on reducing the potential for abuse and neglect. It calls for early childhood development services including programmes to improve parenting skills and promote non-violent discipline; and it provides for psychological, rehabilitation and therapeutic programmes for children. According to the Act, provincial Members of the Executive Councils for social development "must" provide and allocate funds for such programmes in each province⁴.

In addition to these programmes the Act sets out that a Children's Court conducting a childcare and protection inquiry can order a parent, caregiver or a child to undergo a prevention or early intervention programme to address (potential) threats to the child's safety⁵. This includes ordering a parent to attend substance abuse rehabilitation, counselling, mediation or a parenting-skills course on positive, non-violent forms of discipline. The court can also order that the child attend counselling or rehabilitation sessions, and that the state provide this service to the child and family⁶ or, if the service is not available in the public sector, that the state pay a private service provider to do so.

In terms of violence prevention, the law has two serious gaps. The first is that the law does not prohibit parents from using violence (corporal punishment) to discipline their children. The second is that while the state has a clear legislative mandate to ensure the provision and funding of prevention and early intervention programmes, the mechanism for funding the service providers who deliver these services is not legislated and is relegated instead to a policy document of unclear legal status (i.e. the Policy on Financial Awards for Services Providers). In terms of this policy, the government sub-contracts non-profit organisations (NPOs) to deliver the bulk of the prevention and early intervention programmes but only partially fund these NPOs. The result is that programmes are

limited in number, varying in quality of service depending on whether the NPOs are able to source additional funding.

The Department of Social Development has taken steps to build capacity of provinces to plan services. In 2014, all but one of the provinces used standardised tools to produce profiles of children's needs and the full range of child protection services as legislated for in the Children's Act. However, the consensus is that the requirement for this to be done annually, as per the Act, is not feasible. In future, these profiles will contain specific plans of action to ensure that action is taken to address the gaps between needs and service provision but at present most of the provincial departments lack the expertise to do this level of analysis [58].

2.3.1.2 Social Assistance Act

The primary tool to support children living in families with insufficient financial means is the provision of government grants, in particular the Child Support Grant (CSG) and, for disabled children, the Care Dependency Grant (CDG). These grants, provided for in the Social Assistance Act 13 of 2004, have substantially improved children's wellbeing. The CSG has had positive effects on children's food security and nutrition, health, access to early childhood care and education, and educational outcomes [59]–[61]. Receipt of the CSG, especially in the earlier years of the child's life, also reduces a number of risky behaviours of the child such as multiple sexual partners, early pregnancy and alcohol and drug use [62], [63].

While the grants have a positive influence on these factors, it is difficult to measure or estimate the grant's effect on preventing VAC. Children living in poor households are at an increased risk of violence despite the receipt of grants. One problematic aspect of the CSG is that the amount of the grant is not enough to reduce the impact of poverty. The amount of the grant does not meet the requirement of "adequacy" specified under international law and is not linked to any rational basis such as a poverty line or the costs of caring for a child. Other implementation challenges of the CSG include:

- Specific barriers for especially vulnerable categories of children (e.g. infants; children of mothers under 20 years of age; orphans; etc.);
- Misinterpretation and lack of awareness regarding the eligibility criteria for the CSG (e.g. means test; school enrolment as a requirement; etc.);
- Applicants' lack of documents required for the grant application; and
- Legal limitations in the Social Assistance Act [64].

⁴ Section 146(1) of the Children's Act.

⁵ Section 46(1)(g) subsections (i), (ii), (iii), and section 46 (1)(h) sub-sections (iii), (vi) and (viii) of the Children's Act.

⁶ Section 46(1)(h)(viii) of the Children's Act.

These barriers prevent a high number of children in poverty from accessing the CSG. A recent study by SASSA and UNICEF estimates that 2.35 million income-eligible children had been excluded from the CSG [60]. A similar situation exists regarding the CDG for disabled children. Although research has shown that the CDG improves standards of living for both children with disabilities and their broader households [65], substantial numbers of eligible children are not receiving the CDG, and they are thus being excluded from benefits provided the CDGs [64], [66].

Although families can receive the CSG for children, the current social assistance system does not provide any type of support for “able-bodied” persons between the age of 18 and 59 [67]. As there is no financial support for unemployed parents, grant income for children goes into a general household budget. The government has made a commitment to address this gap since it was highlighted by the Taylor Committee in 2002 [68], but the Comprehensive Social Security Policy is yet to be published.

2.3.1.3 Family Policy

South Africa currently lacks a targeted family policy. While the White Paper on Families [69] aims to provide programmes, projects and plans to for the promotion of family wellbeing, it asserts that the “nuclear family” is the most common type of family in South Africa [69, p. 16]. Whereas most children live in households where there are two or more co-resident adults, in 2012 only 34.8% of children lived with both parents, whilst 42.2% lived with only one, and 23% lived with neither – these patterns are consistent from 2002 to 2012 [70]. This is significant if parental co-residence is a protective factor in reducing violence. Furthermore, children in the poorest households are least likely to live with both parents, leaving them doubly exposed. What is needed is an explicit policy that recognises and supports single parents and extended families to care for children.

2.3.2 Preventing Violence in Schools

Schools are microcosms of the communities in which they are located [15]. Targeting safety at schools is therefore part of preventing VAC in the community. The Education Laws Amendment Act 31 of 2007 [71] provides measures to curb the presence of drugs and dangerous objects in schools. The definition of “dangerous objects” includes explosives, firearms, knives and anything that can “cause bodily harm to a person or damage to property”⁷.

⁷ Section 4 of the Education Laws Amendment Act.

⁸ Section 9 of the Education Laws Amendment Act.

⁹ Section 9 of the Liquor Act.

One shortcoming in the design of the law is that school principals are given the power to carry out body searches and urine tests if there is reasonable evidence of illegal activity, and if it is in the best interest of that child or any other child in the school⁸. Searches and testing without the provision of social services to help children change their behaviour, or to find the underlying cause for the child’s behaviour, can result in exposing the child to more harm than the risk-taking behaviour itself. It is therefore essential that programmes to provide drug-abuse counselling and rehabilitation, and interventions for children found carrying dangerous weapons, are provided [72].

The Department of Basic Education has developed policies and strategies to prevent and combat alcohol and drug use as well as violence at schools [73], [74]. It appears, however, that until now the relevant laws and policies have not had the desired effect. Research shows that more than 15% of learners found it easy to access alcohol at school and almost 12% of learners thought they could easily access drugs such as *tik*, mandrax, crack cocaine or ecstasy at school [15]. Nine per cent of learners claimed it would be easy to access a gun at school [15]. These numbers suggest that violence prevention efforts at schools need to be increased and that children who experience violence at school must receive appropriate social services such as counselling.

2.3.3 Combating Substance Abuse

Children are at an increased risk of violence if they live in households and/or communities where they are exposed to alcohol and drugs. South Africa’s attempts to address alcohol and drug use have thus far been of limited success.

As outlined above, according to the Children’s Act a Children’s Court can order a parent, caregiver or a child to participate in early intervention programmes, including substance abuse rehabilitation. There is no data on the number of such court orders and their effects on children. In addition to the Children’s Act, several laws aim to reduce the risk of alcohol and drug abuse both in the family and/or the community.

The Prevention of and Treatment for Substance Abuse Act 70 of 2008 only came into force in March 2013. It provides for a co-ordinated strategy and outlines possible services to reduce the supply of and demand for substances that can be abused, such as drugs and alcohol. The Act references prevention and early intervention services as well as supportive measures that are specifically aimed at children and families, but it fails to initiate or create an obligation for the development of such

programmes. Given that this law only came into effect recently, little is known about its implementation and its impact on VAC.

Alcohol advertising is regulated by the Liquor Act 59 of 2003⁹. The alcohol industry is also self-regulated by the Code of Commercial Communication of Alcohol Beverages. The problem is that the anti-abuse provisions rely heavily on the implementation of anti-abuse programmes by the manufacturers and distributors of alcohol. Government acknowledges that the majority of the industry-based programmes are not evidence-based and cannot be evaluated. It also acknowledges that there is a clear conflict of interest in requiring the industry, whose objectives are to maximise profits, to run such programmes.

In September 2013, as part of its attempts to combat alcohol abuse Cabinet approved the Control of Marketing of Alcohol Beverages Bill, but to date it has not been published for public comment. In May 2015, the Department of Trade and Industry published recommendations for the amendment of the Liquor Act [75], which include:

- Giving the Minister of Trade and Industry the power to restrict liquor advertising;
- Raising the minimum drinking age from 18 to 21;
- Regulating when and where alcohol can be sold (e.g. not in close vicinity to schools); and
- Establishing a government-managed fund to combat alcohol abuse, to which industry would contribute.

2.3.4 Supporting Children who have Experienced Violence

The Children's Act provides for and regulates the identification, reporting, referral, investigation and follow-up of instances of child maltreatment. In doing so, it provides for the first layer of investigation and support by social service professionals. If the investigation by the Department of Social Development (DSD) or the designated child protection organisation reveals abuse or neglect, this may lead to a court-ordered early intervention programme; the removal of the alleged offender; or the immediate removal of the child to temporary safe care. The second layer of intervention is provided for by the Children's Court where judicial intervention is necessary to secure the child's care and/or protection. If the court finds that the child

is in need of care and protection, it can issue a child protection order (e.g. preventing a person from having contact with a child) or a treatment order¹⁰. Even where the child is not in need of care and protection, the court can issue an order, that is placing an obligation on the state to provide prevention and early intervention services to the child's family [76].

Reports of child abuse or maltreatment can reach social service professionals in various ways. Interestingly, the Children's Act also creates a statutory obligation for a range of practitioners to report physical or sexual abuse or neglect¹¹, and provides them with a risk-assessment framework¹². The report needs to be made to a designated child protection organisation, the provincial DSD or a police official. There is no room for discretion on the basis of the child's best interests. The Children's Act also makes provision for anyone to report any form of harm or maltreatment that may render the child in need of care and protection.

2.3.5 Interpretation of the Law

The Children's Act provides a detailed definition for children who are in need of care and protection. The definition includes a child who "has been abandoned or orphaned and is without any visible means of support"¹³. One of the Act's major weaknesses is the lack of clarity surrounding the phrase "without any visible means of support". As a result, judgments issued by the High Court [77], [78] have interpreted this phrase as including children living with family members in poverty. Therefore, an orphaned or abandoned child living with poor grandparents is deemed to be a child in need of care and protection and placed in 'alternative care' with that grandparent.

Due to the very high number of orphans living with relatives in poverty in South Africa (more than 1.1 million based on 2011 statistics), this interpretation is placing undue pressure on the child protection system. The result is that children who have been abused or maltreated are waiting unacceptably long periods of time to access urgent child protection services [79], [80], while caregivers of orphans are not able to access much-needed adequate social assistance timeously [81]. In many instances, orphaned children wait more than three years to get support due to the inability of the over-burdened child protection system to respond to the demand. What is needed is a mechanism to recognise and support family members caring for orphans that is not reliant on the scarce resources of social workers and Children's Courts.

¹⁰ Section 156(1)(k) of the Children's Act; section 46 of the Children's Act.

¹¹ Section 110 of the Children's Act.

¹² Regulation 35 of the Children's Act.

¹³ Section 150(1)(a) of the Children's Act

¹⁴ Budlender D & Proudlock P have analysed the budget for children's social services every year since the Children's Act was enacted. The series can be accessed at: http://ci.org.za/index.php?option=com_content&view=article&id=493&Itemid=185

2.3.6 Implementation Challenges

In addition to the flawed interpretation of the law, which leads to an overburdening of the child protection system, a number of implementation challenges further undermine its effectiveness. One problem is the inadequacy of funding for child protection services. While it is difficult to assess spending allocations across the different types of services covered under the “child care and protection sub-programme”, comparisons between the predicted cost of implementing the child care and protection programme and the amounts allocated show that it has been continuously under-funded since 2007/08¹⁴. This is compounded by the fact that some provinces fail to spend their allocations. According to the Financial and Fiscal Commission, “[t]otal unspent funds by Social Development Departments over the four-year period (2007/2008 – 2010/2011) amounted to R1.2 billion, with unspent funds in 2010/2011 accounting for more than half this amount (R690 million)” [84, p. 13]. Provincial DSD departments are thus not fulfilling their responsibility to channel the funds available to the NPOs that deliver services on their behalf.

The shortage of social service professionals trained in child protection is another barrier to the provision of child protection services. The DSD is providing bursaries for social work students, and the National Treasury has allocated additional funding to the provinces to employ graduates to address this problem [85]. However, provincial DSD claim that the amounts allocated are insufficient to absorb all the graduates and reach the national norm of 1 social worker per 3 000 “clients” [86, p. 33].

Another concern is that child protection is not covered in detail in the undergraduate training curriculum. Consequently, most of these students do not graduate with knowledge of child protection and are therefore expected to learn it on the job. This raises questions around the quality of services provided to children.

Other implementation challenges include:

- *The lack of availability of documents:* The DSD has produced a number of useful policy documents and guidelines aimed at guiding service providers on how to interpret and implement the Act, but many service providers in need of guidance are unaware of these guidelines, or unable to obtain a copy.
- *The lack of inter-agency reporting:* Despite the requirement for inter-agency reporting, police fail to refer child abuse and neglect to social services because many detectives lack the ability and skills to investigate family

circumstances adequately [13]. Inter-agency referrals are essential to prevent VAC of the siblings of child victims.

- *The lack of provincial planning:* The Children’s Act places an obligation on each of the provincial MECs to establish profiles of the demand for child protection services; audit the available services; and develop a provincial strategy to ensure that there are sufficient child protection services to meet the needs of children in the province. Whilst most provinces have compiled profiles covering all services, most lack any kind of adequate plan of action to address the gap between the demand for, and supply of, child protection services [58].

2.3.7 Criminal Law

The Criminal Law (Sexual Offences and Related Matters) Amendment Act 38 of 2007 (Sexual Offences Act) comprehensively reformed the law on sexual offences. It introduced a number of new offences that are specifically targeted at protecting children from sexual violence¹⁵. Therefore, the Act does not only protect children from “general offences” such as rape and sexual violation, but also from other forms of sexual abuse such as sexual exploitation and sexual grooming of children. In addition, the Sexual Offences Act creates a reporting obligation for anybody who has knowledge of a sexual offence having been committed against a child. Unfortunately, this reporting obligation is inconsistent with the reporting obligation set out in the Children’s Act (discussed above), which creates uncertainty and confusion for criminal justice personnel, health care workers and social service professionals.

The Sexual Offences Act aimed to strengthen protective measures available for child victims and witnesses in the court process by amending the Criminal Procedure Act 51 of 1977. The Criminal Procedure Act provides for special protective measures, to reduce secondary trauma, by allowing child victims to testify in private and/or through the use of an intermediary in a separate room linked to court via closed circuit television (CCTV)¹⁶. If they are used by the courts, these mechanisms protect the child’s dignity and privacy, reduce secondary traumatisation and psychological stress, and improve the child’s ability to give credible evidence [87, p. 12].

According to the amendments introduced by the Sexual Offences Act, courts are now required to enter into the court record reasons for refusing to use these protective measures in respect of victims and witnesses under the age of 14 years¹⁷. One problem with this amendment is that the requirement to record reasons for refusing protective measures only for

¹⁵ Chapter 3 of the Sexual Offences Act.

¹⁶ Section 153(3), 158(2)(a) and 170A of the Criminal Procedure Act.

¹⁷ Sections 158(5) and 170A(7) of the Criminal Procedure Act.

children under the age of 14 years creates the impression that children above 14 years do not require special protection during court proceedings. In addition, the reality is that criminal courts are not child-friendly; CCTV and intermediaries are often not available; and child victims and witnesses are seldom provided with therapeutic support to endure the criminal process [22]. The result is a low conviction rate, with perpetrators not being held accountable, and children being exposed to secondary trauma and the continued risk of further violence and abuse.

Further challenges in the criminal justice system include poor investigation by the police; a lack of sufficient specialised units in the police and prosecuting authority and the courts.

In light of these systematic flaws it is not surprising that violent crimes against children are not properly investigated and prosecuted [13], and rape cases in particular seldom result in a conviction [22]. Moreover, where courts convict violent child offenders, their crimes attract only light sentences, and the minimum sentencing legislation is not consistently applied. Therapeutic support for child victims and witnesses involved in criminal trials is largely non-existent. Providing children and their caregivers with therapeutic support before and during the trial would greatly improve the child's ability to give credible evidence in court. This in turn would improve the conviction rate as well as possibly assist the child in the healing process. A study in the Western Cape found that most children received only an initial debriefing, and unsurprisingly, six months after the first initial debriefing more than 70% of children still presented with partial or full-symptom PTSD [88].

The Judicial Matters Second Amendment Act 43 of 2013 amends the Sexual Offences Act to provide a legal framework for the establishment of specialised sexual offences courts. While the new Act safeguards the ongoing provision of specialised sexual offences courts it is weak from an implementation perspective [89]. The legislation is framed very broadly and fails to place a duty on the Minister of Justice and Correctional Services to establish these courts. It does not provide direction on the pace of implementation of the courts; does not require the department to provide resources for the courts; and it sets no standards in terms of infrastructure, staffing or support services to victims. Without these, there is no guarantee that sexual offences courts will reduce secondary victimisation and improve conviction rates.

Children are often co-victims when their caregivers experience domestic violence. The Domestic Violence Act 116 of 1998 aims at protecting victims and their family members from domestic violence by allowing them to apply for a protection order at a magistrate's court. Furthermore, the Domestic Violence Act obliges police officers to refer victims of domestic violence to shelters. The Act does not, however, specify whose statutory duty it is to provide and fund shelters. In practice the

majority of shelters are run by NPOs with partial funding from provincial departments of social development.

According to the Minimum Standards on Shelters for Abused Women [90], the national DSD is required to fast-track the establishment of shelters. There are currently too few shelters for women and children experiencing domestic violence, and the inadequate funding of shelters negatively impacts on the availability and quality of services needed by women and children while housed in a shelter. It is also concerning that the Minimum Standards policy document fails to recognise children as co-victims, given that it deals primarily with service provision for women and contemplates the needs of children in terms only of schooling and child care.

2.4 CONSTRUCTING A CONCEPTUAL FRAMEWORK FOR VAC: REVIEW OF EXISTING RESEARCH

The primary focus of this review is to provide a critical analysis of existing literature on the risk and protective/resilience factors for VAC in South Africa in the context of the home, school and community. This review aims to summarise and assess the scope, methodology and quality of research on VAC in South Africa, and thus to identify gaps or accomplishments in the literature. Identifying these factors will clarify existing knowledge on the risk and protective factors for VAC in South Africa, and contribute to the development of evidenced-based, effective interventions to reduce and prevent it.

The review (a) highlights the magnitude of VAC in South Africa; (b) outlines the methodology and model that will be used to frame the discussion on risk and protective factors; and (c) reviews the literature on risk and protective factors in South Africa at the individual, relationship, community and societal levels respectively.

The primary inclusion criteria for this review was literature published post-2000 that addressed risk and/or protective factors for VAC in South Africa. General search terms, used in various combinations, included: *children, infants, adolescents, youth, risk factors, protective factors/resilience factors, predictors, violence, abuse, maltreatment, South Africa*. Material accessed included qualitative and quantitative work in the form of peer-reviewed journal articles, reports, working documents, presentations and unpublished theses. The reference lists of retrieved studies were used to identify additional relevant research, as was expert knowledge of the area.

2.4.1 Overview of the Evidence Base in South Africa

A review of the available literature in South Africa reveals a lack of population-based representative data on the risk and protective factors operating in the local context. In addition, protective factors have not been studied as extensively as risk factors, although identifying and understanding protective factors is considered to be equally important in developing prevention strategies [91]. This is also true of research in other middle- and low-income settings, as well as high-income contexts [92].

A large proportion of the studies addressing issues around VAC in South Africa utilise qualitative research designs, whilst there are only a limited number that utilise quantitative research designs. Although qualitative studies are useful for exploring individual experiences or themes and suggesting potential links between risk and/or protective factors and violence, they do not establish the empirical relationship between such factors. Qualitative studies provide an in-depth understanding of the problem for that particular setting or group but cannot be generalised to the whole population and do not allow one to establish causation. In addition, a large proportion of both quantitative and qualitative studies in South Africa tend to be small-scale, or community- or locality-specific, and therefore not representative [16]. Further, many studies examining the problem of child or youth violence include young adults over the age of 18 years [93], [94]. This may make it difficult to extricate those factors relevant to discussions of children. Therefore, large-scale population-based community studies are critical to develop an evidence base to understand risk factors.

Most prevalence data on VAC in South Africa is either from the SAPS national crime statistics, which is known for under-reporting, or from victim surveys, which are also flawed [9]. Victim surveys are particularly weak at measuring crimes like sexual abuse and rape, which requires the disclosure of personal information to a stranger and generally do not directly sample children. Researchers using such surveys acknowledge, “they do not offer any of the supportive environmental factors that might normally be required in exploring the extent or nature of ... crimes” [9, p. 4]; however, these are often the only source of information.

Despite the above-mentioned weaknesses, there are a number of exceptions. For example, the CJCP’s 2005 NYVS [17] and the 2008 and 2012 NSVS [15], [16], the 1998 and 2003 South Africa Demographic and Health Survey, and the Medical Research Council’s (MRC) National Surveys on Youth Risk Behaviour [33], [95] provide nationally representative data on youth violence. These studies, however, are thought

to under-report experiences of violence, particularly GBV. Dedicated VAC or GBV studies may obtain the most accurate prevalence rates. Other useful studies include the University of the Witwatersrand Reproductive Health and HIV Research Unit National Youth Survey [96] and the Gender Links’ Gender Based Violence Indicators Project conducted in Gauteng, the Western Cape, KwaZulu-Natal and Limpopo [19]. The latter study, although conducted with adult women, asked participants questions regarding their childhood experiences of violence. CJCP and UCT also conducted a nationally representative study of children’s experiences of maltreatment and other forms of violence. This data will be available this year (2015).

The majority of South African quantitative studies are cross-sectional in design, measuring a specific point in time. The design of these studies means that it is not possible to draw conclusions on the temporal relationship between risk or protective factors and violence, which requires a longitudinal study design. Two of the only longitudinal studies on youth in South Africa are the Cape Area Panel Study (CAPS), a longitudinal study tracking youth and young adults from 2002 – 2006, and the Birth to Twenty (BT20) study, a multidisciplinary study tracking the progress of urban children from Soweto, Johannesburg [97]. Although both studies have collected data on violence-related outcome measures, there are few published papers or reports based on the data that have examined these issues in relation to prediction of risk/protection. The papers presented from the BT20 dataset have primarily focused on child health, early childhood development and mental health outcomes.

Over and above these larger, national studies, there are numerous small-scale or community-specific quantitative and qualitative studies on VAC in the home, school and neighbourhood settings in South Africa. Such studies, when well conducted, can help strengthen our understanding of the risk and protective factors operating in the local context and thus better inform the recommendations on the reduction and prevention of VAC in South Africa. While acknowledging the limitations and the problem with generalising the findings of these studies, they have also been included in this review.

The focus of many of the studies on VAC has been on sexual abuse, while physical abuse and emotional abuse have largely been neglected. The studies addressing sexual abuse have typically relied on adult self-reported incidence of abuse from childhood, namely retrospective recollections. The recall bias and subsequent reliability of these recollections has been raised as an issue of concern [23], [29]. As much of the research on child sexual assault relies on adult recollections of incidents during childhood and it is unlikely that incidents before the age of three would be accurately recalled, the rape of very young children may not be included in the data. Researchers from

the University of Oxford and UCT [23] have undertaken some of the only work on risk and protective factors for emotional abuse using current child self-reporting, although a small number of other studies have addressed emotional abuse to varying degrees [98], [99].

Previous literature has identified numerous risk and protective factors operating at each level of the socio-ecological model. In the following sections the factors operating at each level, namely the individual, relationship, community and society, are critically discussed. This is done through analysing how the following questions are answered in the available South African literature:

1. What are the most relevant risk and protective factors that relate to VAC in South Africa at the individual, relationship, community and societal levels?
2. To what extent are these risk and protective factors supported by sufficient evidence?

2.4.2 Individual Level Risk Factors

2.4.2.1 Gender

There is consistent evidence across a number of national and provincial studies that girls in South Africa are at a much higher risk of being sexually assaulted than boys, but boys are

at a higher risk of being victims of physical violence (see Table 5). The varying prevalence rates reported in these studies is suggestive of the problem of differing definitions and methods used across studies. Nonetheless, the studies included in Table 5 generally indicate a much higher prevalence of sexual violence amongst girls than boys. However, with regards to physical abuse the studies generally indicate a slightly, but not necessarily significantly, higher prevalence amongst boys.

A nationally representative mortuary-based study not only indicated a higher overall homicide rate amongst boys than girls, but also showed that rape homicide was almost exclusively a problem affecting girls [13]. Sexual assault was suspected in 25.3% of girl homicides and only 1.5% of boy homicides. In Durban and Cape Town, a study investigating multiple victimisation of adolescents found that male adolescents had experienced a significantly greater mean number of acts of physical violence¹⁸ [100]. There is limited research on sexual violence against boys in South Africa and this knowledge gap needs to be addressed [101].

With regards to VAC in schools, gender is related to being a victim of bullying at school. Across a number of studies, prevalence rates show that males experience higher levels of bullying than females, both as victims and perpetrators [14], [36], [102] although none of the studies that examined this used regression or modelling to test whether gender was a significant predictor of being bullied. Other studies have found that gender does not predict bullying victimisation or perpetration [35].

		TYPE OF VIOLENCE			
		PHYSICAL		SEXUAL	
STUDY	LOCATION	BOYS	GIRLS	BOYS	GIRLS
[15]	NATIONAL	7.0%	5.8%	1.4%	7.6%
[25]	EASTERN CAPE	94.4%	89.3%	16.7%	39.1%
[103]	GAUTENG	88%	74.3%	25.3%	20.4%
[104]	WESTERN CAPE (STELLENBOSCH)	-	-	42.56%	10.63%
[105]	WESTERN CAPE	54%	46%	-	-
[24]	MPUMALANGA & WESTERN CAPE	25.2%	31.2%	3%	6%

Table 5. Prevalence of Physical and Sexual Abuse by Gender.

¹⁸ Physical violence included being threatened with a weapon, hit or shot, stabbed, beaten up or stolen from.

2.4.2.2 Age

Certain age groups are at a higher risk for experiencing certain types of violence. The only nationally representative mortuary-based study conducted in South Africa indicated that the highest proportion of child homicide in South Africa was amongst children below five years (39.6%) and those between 15 – 17 years (41%). The primary causes of this homicide are different between the two groups. Homicide of children below five years largely occurs in the context of abuse and neglect. Comparatively, the majority of teenage homicides occur among males due to interpersonal violence such as physical fights following from arguments between peers; which are a display of pro-violence masculinity [13]. Other research shows children between 12 and 14 are most likely to be victims of theft compared to older children [9] and that experiences of violent crime at school peaks at the age of 15 – 16 years, with children 14 years and younger and 17 – 18 years experiencing slightly lower levels of violent crime at school [15].

Age interacts with gender. In children under the age of five, the homicide rate appears to be similar for boys and girls. Norman et al. report homicide rates of 14.0 per 100 000 for boys and 11.7 per 100 000 for girls [106]. However, it has been suggested that the National Injury Mortality Surveillance System (NIMSS) data on which these rates are based is over-representative of urban areas and includes interpersonal violence, which may inflate the reported rates. Mathews et al. report homicide rates of 7.6 per 100 000 for boys and 8.3 per 100 000 for girls in the national child homicide study, with the majority of child abuse related homicides falling into this age group (73.8%) [13]. Nonetheless, in children aged 15 – 17 years, the homicide rate is higher in boys (21.7 per 100 000) than in girls (4.6 per 100 000), indicating that boys are an especially high-risk group [13]. These age-related rates of homicide reflect international findings [53].

There is fairly consistent evidence as to the effect of age on bullying at school. Younger students experience higher levels of bullying than older students, with a higher proportion of Grade 8 learners being victims and perpetrators of bullying than older learners [36], [102]. Studies that have not found that age is a significant predictor of bullying, have only investigated behaviours in a single grade [35].

In South Africa, adolescents compose a large proportion of not only the victims, but also the perpetrators of violent crimes. A national survey of learners in secondary schools found that roughly 90% of threats, sexual assaults and thefts, and 69.8% of assaults, were committed by other learners [15]. Older adolescents (>16 years) have been shown to be significantly more likely to perpetrate violence within their intimate relationships than younger adolescents (<16 years) [33], [107].

2.4.2.3 Substance Use

Substance use by children frequently emerged as a factor that put children at risk of victimisation and perpetration. Morojele and Brook found frequency of alcohol and marijuana use among urban adolescents to be a significant predictor of multiple experiences of physical victimisation [100]. In the same sample, frequency of drug use, experience of victimisation, discrimination, rebelliousness and tolerance of deviance were significantly correlated [108]. Alcohol abuse in rural South African youth has been shown to be associated with emotional neglect in women and sexual abuse in men and women [25]. However, it is not clear whether the abuse preceded the alcohol use or the alcohol use preceded the abuse as participants, aged 15 – 26 at the time of the study, which relied on recollections of abuse before the age of 18 but reported current and past-year alcohol use. Similarly, Dunkle et al. found a significant association between substance use and child sexual assault before the age of 15 among women aged 16 – 44 presenting for antenatal care at four health centres in Soweto [56]. In-depth, longitudinal, nationally representative research is required to further explore this association.

Substance use is significantly associated with the perpetration of violence, including problem drinking associated with the rape of an intimate partner and drug and alcohol use associated with the rape of a non-intimate partner among male youth aged 15 – 26 years [109]. Drug use is significantly associated with rape perpetration by adult men (>18 years) [110]. Qualitative studies support these findings. In Ward et al.'s child participation study in support of the Children in Organised Armed Violence (COAV) Cities Project, children mentioned access to drugs as a key motivation for joining gangs [111].

2.4.2.4 Vulnerable Groups

Certain groups of children may be particularly vulnerable to violence, including children with disabilities and children living on the streets.

Children with Disabilities

It is difficult to accurately determine the prevalence of children with disabilities in South Africa, owing to different definitions of disability and different tools to measure disability used by studies that have attempted to examine this issue [54]. It is estimated, however, that currently there are approximately one million children with disabilities living in South Africa [112]. The international literature identifies children with disabilities as being at an increased risk of exposure to violence compared to children without disabilities [113]. Girls with disabilities experienced a significantly greater prevalence of sexual abuse than boys with disabilities. This is reflective of the

gender difference in the prevalence of sexual abuse in children without disabilities in South Africa, yet, the prevalence of other types of maltreatment did not differ by age, gender or population group.

Between group comparisons, however, revealed that children with different types of disabilities were at risk for different forms of maltreatment: (a) children with physical and mental disabilities experienced higher rates of sexual abuse than non-disabled children; (b) children with learning disabilities experienced higher rates of neglect; and (c) children with multiple disabilities experienced higher rates of sexual abuse than physical abuse [114]. As this was a cross-sectional study that aimed to examine differences in the types of abuse reported by children with different types of disabilities, the conclusions that can be drawn from these findings are limited. The analyses mentioned here simply highlight differences in the prevalence of abuse between the disabled and non-disabled and between different types of disability.

Examination of odds ratios confirmed that multiple-disabled children are at a significantly higher risk of sexual abuse than non-disabled children, and also showed that children with one disability were at a significantly higher risk of neglect than non-disabled children. However, as the author acknowledged, more sophisticated analyses would be needed to further examine the potential risk factors operating in this context [114].

There is very little published research on the increased vulnerability of children with disabilities in South Africa. One of the most comprehensive studies on the issue is an unpublished Master's thesis that addressed the differences in the prevalence of abuse (physical abuse, sexual abuse and neglect) between children with and without disabilities presenting at the Teddy Bear Clinic in Johannesburg from 2000 to 2007 [114]. The study confirmed in the results of international research in this area, finding a significantly greater prevalence of sexual abuse and neglect, but not physical abuse, amongst children with disabilities compared to those without.

It is also important to note that confounding variables, such as socio-economic status, may affect the clarity of the relationship between disability status and abuse [114]. In addition, the population presenting at the clinic was not reflective of the general population, on a national or provincial level. There is a need for nationally representative quantitative studies to be conducted on the issue of VAC with disabilities to investigate whether the relationships identified above are generalisable.

Children Living on the Streets

There is limited research on street children in South Africa. Two key mixed-method studies on street children include (1) a situational analysis of street children in Durban, including quantitative (health survey and HIV testing) and qualitative (participatory workshops and interview) components [115], and (2) a survey of street children in Cape Town and

Johannesburg, including focus groups with street children, a mini-census and survey using semi-structured interviews, and in-depth interviews with key informants [116]. Earlier research has addressed the factors leading to children ending up on the street and conceptual issues surrounding street children [117].

Violence emerged as a factor that contributed to children ending up on the streets. Street children frequently named violence in the home, including physical punishment, domestic violence, poor family relationships and abuse, as a push factor contributing to them leaving home [115], [116], [118]. Furthermore, children indicated that a significant push factor for leaving shelters was due to being abused or bullied by other residents [118]. Research also shows the role orphanhood, through the loss of one or both caregivers, can play in children opting to live on the street [115], [116]. Gender may play a role here, with boys being more vulnerable to ending up on the streets than girls [115], [118]. Although not supported by reliable quantitative data, these studies suggested that gender is a risk factor for children ending up on the streets, where they are potentially more vulnerable to violence.

Qualitative accounts of life on the streets identified abuse by police and security staff as one of the main problems faced by boys [116]. Girls cited the same problems, but girls also frequently mentioned abuse by boys as a problem they faced on the streets. More detailed information obtained through a health survey, revealed 67.3% of children surveyed had been hurt or abused whilst on the street, most frequently these instances of violence were stabbings, motor vehicle accidents, and assaults; and two children reported having been raped. It is not clear how these rates of violence compare to the rates of violence experienced by children not living on the streets.

The only evidence of the increased risk of violence facing children living on the streets relates to bullying. A study investigated the risk and protective factors for bullying victimisation in a sample of isiXhosa-speaking youth aged 10 – 19 from high-poverty neighbourhoods in Cape Town [119]. It was shown, both independently and after adjusting for the effects of covariates (gender, age, SES, and clinical level internalising disorders), that children living on the streets were significantly more likely to be bullied. In a multiple regression model including all significant risk factors and covariates, however, living on the streets was no longer significantly associated with bullying.

While some of this research is out-dated, these studies contribute to our understanding of the dynamics underlying the street child phenomenon in South Africa. This evidence, although predominantly based on individual accounts given by children during informal interviews, seems to support the significant role that violence in the home plays in placing

children at risk for ending up on the streets. Once on the streets, children may then be vulnerable for further victimisation. There is little quantitative research on the increased risk of violence faced by street children compared to children not living on the streets and what factors may protect street children against such violence. Consequently, there is need for nationally representative studies to be conducted on the risk factors for, and protective factors against, experience of violence by street children in South Africa.

2.4.2.5 Other Characteristics

Additional factors that predict violence at school are academic achievement and rewards for school involvement [35]. Moderate to high rewards for conventional involvement was associated with bullying, moderate rewards for conventional involvement and low/moderate/ high academic achievement were associated with bully victimisation, and high academic achievement was associated with being a bully-victim among rural Grade 11 youth. The authors note that this seems to suggest “a culture where peers victimize achievers, and that adolescents may be protected when they receive no attention from teachers” [35]. This conflicts with findings in the international literature but implies that the school may be the most effective site for interventions to address bullying.

2.4.2.6 Risk Factors for Corporal Punishment

Evidence suggests that school type (primary vs. secondary), location (urban vs. rural) and province, but not gender, may be significant individual level predictors of corporal punishment in South African schools. The 2008 NSVS found that nearly three quarters (70%) of primary school learners, compared with just less than half (47%) of secondary school learners, were victims of corporal punishment at school. The 2008 NSVS and 2008 NYLS found that learners at schools in rural areas were significantly more likely to experience corporal punishment than learners at school in urban and metropolitan areas respectively [15].

There is conflicting evidence as to which provinces experience the highest level of corporal punishment. The latest statistics suggest the highest rates of corporal punishment in secondary schools occur in KwaZulu-Natal [15], whereas previous study results have found that the highest rates of corporal punishment occur in the Eastern Cape [14], Free State (secondary schools) and Northern Cape (primary schools) [16]. It appears that corporal punishment is least likely to occur in the Western Cape [17], [21].

Teachers and school principals with higher levels of education may be more likely to use alternate forms of punishment that are non-violent compared to educators and principals with lower levels of education [16]. Although these results are

somewhat consistent across the CJCP national studies, only frequencies and simple between-groups comparisons, and not regression or other forms of modelling, were performed on the data. Thus, it is not possible to identify whether these are strong predictive factors for youth victimisation in schools. Such analyses would provide valuable information on whether these factors operate as risk factors in school settings.

2.4.3 Relationship Level Risk Factors

2.4.3.1 Family and Peer Substance Use

The abuse of alcohol and other substances by a child's family and peers is a risk factor for VAC. Individual level substance use was discussed in an earlier section. South Africa's alcohol consumption rates per head (of the population who are drinkers) are some of the highest in the world [120]. Peer alcohol and marijuana use and parental cigarette and alcohol use, were found to be significant predictors of multiple physical victimisation amongst male and female 12 – 17-year-olds in urban Cape Town and Durban [100].

Using the same sample of urban teenagers, Brooks et al. found that parental drinking and marijuana use, and peer drinking, smoking, and use of marijuana and other illegal substances to be significantly correlated with frequency of illegal drug use [108]. As child substance use has been shown to significantly predict victimisation and perpetration, parental and peer substance use may operate indirectly through increasing the child's use of these substances, to increase their risk of experiencing violence. Mlisa et al. found, however, that family alcohol, smoking and other drug use were not significantly associated with bullying victimisation or perpetration [35]. Having a parent with a drug or alcohol problem has also been found to significantly predict physical abuse [93]. These findings regarding the association between substance abuse and child maltreatment are highlighted in a number of studies and are reflective of global norms [31], [94], [121]–[123].

2.4.3.2 Family Structure and Functioning

The relationship between family structure and functioning and child maltreatment was mentioned frequently in the literature, although the evidence was conflicting. Family functioning was found to be a significant predictor of child verbal and physical maltreatment, with OVCs living in households with poor family functioning more likely to experience maltreatment than children living in households with better-functioning families [26]. Living with a step-parent was associated with abuse in a number of studies, including severe emotional and physical abuse [23] and sexual abuse [124]. A larger number of caregiver changes also increases the risk of severe emotional and physical abuse [23].

Single-parent households have also been identified as a risk factor for abuse. A Stellenbosch-based study using a sample of children who had experienced trauma presenting at a Youth Stress Clinic found that having a single, divorced, or widowed parent was significantly more likely in victims of child sexual assault than children who had not been victims of child sexual assault [104]. Some have hypothesised that this relationship exists as the financial and emotional stress faced by single parents can lead to their taking out this frustration on their children. This would only be the case, however, if the parent were the perpetrator. In some cases the abused child is living in a single-parent household because their primary caregiver left the partner who perpetrated the abuse [31].

Madu and Peltzer did not find a significant difference in the presence or absence of a father in the home between children who had and had not experienced sexual abuse [124]. In addition, research on the risk factors for physical and verbal maltreatment among OVC found that caregiver marital status was not significantly associated with child maltreatment, but having one or both parents in the home was a significant predictor of child maltreatment [26]. It is more likely to be family processes than family structure per se that are the pertinent risk factor; however, the evidence suggests that weak family structures (e.g. single-parent homes) place additional stress on caregivers and increase risk for abuse.

2.4.3.3 Orphans and Child-Headed Households

The HIV/AIDS pandemic has resulted in a growing number of orphans and child-headed households in South Africa. There were approximately 3.85 million orphans in South Africa in 2011, largely due to the loss of parents as a result of HIV/AIDS [125] but also due to the high levels of male homicide in the country [126]. Whereas orphans have traditionally been absorbed by the extended family, with the AIDS-related orphan crisis in South Africa there is now concern as to whether the extended family network is still able to provide support [127], [128]. The experiences of orphanhood are compounded for children who live in child-headed households without an adult caregiver¹⁹. There were roughly 47 000 child-headed households in South Africa in 2011 [125]. While the number of child-headed households in the country is relatively low (<0.5% of all children), the particular vulnerability of such children compared to children living in mixed-generation, households makes them an focus of special concern [125]. However, there is little research in South Africa on the relationship between orphanhood, child-headed households, and exposure to violence.

A likely dynamic explaining the relationship between orphanhood and exposure to violence is the increased burden placed on non-parent caregivers, which increases orphans' risk of abuse [26]. A population-based study in Soweto found that children with deceased parent(s) were significantly more likely to face abuse, with perpetrators less likely to be from the same household [130]. Orphans were also more likely to go hungry a few times a week, not eat before school and not be supervised while playing, compared to children with two living parents [130]. Only 0.05% of households in the study, however, were classified as child-headed households. Further, this study defined children as those under the age of 16 years, which differed from the definition used in this report. The death of one or both parents has also been shown to impact negatively on child outcomes, including education [128], and increases children's risk of living in households with less financial resources [131]. Poverty and poor supervision may then place these children at risk for exposure to violence.

2.4.3.4 Households with Chronic Illnesses

Along with parental mortality and orphanhood, children living in HIV-affected households or in households with adult(s) with chronic illnesses emerged as a group of children that may also be particularly vulnerable to maltreatment. A recent review of risk factors for child abuse in Africa found consistent evidence of the relationship between household illness and child abuse [132]. This is supported by the findings of five South African studies; that children living with a chronically ill adult were more likely to report abuse/maltreatment, particularly if that illness was HIV/AIDS and if the child was dual-affected by AIDS orphanhood and caregiver AIDS sickness [23], [26], [27], [130], [133]. It appears, however, that while having a caregiver or household member with AIDS and AIDS orphanhood may predict emotional and physical abuse, there was no significant relationship between household AIDS illness/AIDS orphanhood and sexual abuse [133]. This was supported by findings from the only large-scale longitudinal prospective study examining risk factors for physical, emotional and sexual abuse in South African children [27]. Although not nationally representative, it provides some of the most reliable evidence of the risk for maltreatment facing children from "sick households".

These studies shed light on the mechanisms underlying the relationship between household illness and abuse. A number of studies found a relationship between household AIDS-illness and poverty [27], [133]; poverty mediated the relationship between abuse and household AIDS-illness to varying degrees [27]. Interestingly, one study found that the relationship

¹⁹ Children living in child-headed households in South Africa are not always orphans; research shows that the majority of these children (92.1%) have at least one living, but absent, parent [129].

between household chronic illness and maltreatment lost significance when caregiver psychosocial factors²⁰ and family functioning²¹ were taken into consideration [26]. This suggests that caregiver mental health and family functioning may partially explain the relationship between having an ill household member and risk of maltreatment. In other words, chronic illness may contribute to mental health issues and family dysfunction; as a result of these difficult situations, caregivers may be more likely to maltreat children [26, p. 5]. Having an AIDS-unwell caregiver, caregiver disability and AIDS orphanhood were significant health-related risk factors for physical and emotional abuse in a series of univariate logistic regression analyses. When entered in a multivariate regression, caregiver disability was the only significant predictor of abuse, suggesting that the relationship between abuse and living in an AIDS-affected household functions via the disability status of the caregiver [23].

It appears that children from sick households may be more vulnerable to physical and emotional, but not sexual, abuse than children from healthy families. Further, those who are dual-affected by AIDS orphanhood and caregiver AIDS sickness are particularly vulnerable. A probable relationship that places these children at a higher risk of child maltreatment than other children is the increased burden placed on caregivers, which predisposes orphans and children living in households with chronic illness to abuse [26].

The findings that poverty, caregiver mental health, and family dysfunction mediate the relationship between household chronic illness and child maltreatment also suggest that poverty-alleviation efforts and social and emotional support for caregivers of children living in households with chronic illnesses such as HIV/AIDS may help to protect against abuse. This work seems to suggest that physical and emotional abuse have different underlying mechanisms to sexual abuse. However, this finding may be specific to AIDS-affected households in low-income communities. More robust research is needed to investigate the particular vulnerability of these groups of children and what factors may put them at risk of or protect them against abuse and other types of violence.

2.4.3.5 Family History of Criminality

Children who have been a victim of violence within the home or have a history of family criminality may be more vulnerable to victimisation. The NSVS reported that learners whose family members had been incarcerated were more likely to experience violence at school [15], [16]. Having a parent who had been incarcerated was particularly strongly associated

with being a victim of violence and threats of violence at school compared to having a sibling who had been incarcerated. In addition, learners who had experienced violence at home, including assault, sexual assault or robbery, were significantly more likely to have experienced violence (threats of violence, assault, sexual assault and robbery) at school [15]. Mlisa et al. did not find that family domain factors, including family history of antisocial behaviour, had any effect on bullying victimisation or perpetration among children in rural parts of the Eastern Cape, however [35].

2.4.3.6 Discipline Practices

Harsh or inconsistent discipline is well established as a significant risk factor for perpetration of violence, on the part of the child experiencing that form of discipline. Corporal punishment and physical abuse have been shown to consistently predict violent behaviour, such as aggression and other externalising behaviours [134], [135] and perpetration of domestic violence and intimate partner femicide (IPF) [123]. According to Bandura's Social Learning Theory, when children experience physical punishment they learn that physical violence is a normal way to alter others' behaviour [136] and to resolve conflict.

In South Africa, inconsistent discipline has been found to significantly predict child physical and emotional abuse – that is, parents who use inconsistent discipline are also far more likely to abuse their children physically and emotionally [23]. These may, however, be interconnected behaviours. International research on parenting suggests that physical violence is sometimes a response to ineffective discipline – a final resort [29]. Prevalence statistics from local research also indicates that mothers, older parents, and previously married single parents may be more likely to use corporal punishment as a parenting method. However, it is important to note that the finding that mothers are more likely to use corporal punishment could be reflective of the fact that a large proportion of mothers are the primary caregivers and thus over-represented; rather than that they are predisposed to be more violent towards their children [137].

2.4.3.7 Family Conflict and Domestic Violence

Family conflict or violence has been found to be a significant predictor of physical and emotional abuse amongst vulnerable children, predominantly orphans from deprived communities in Cape Town [23]. In a sample of undergraduate university students, perceived IPV (defined as having seen a parent hit or beat up another parent) was found to significantly predict

20 Caregiver mental health was measured using the negative feelings subscale of the WHO Quality of Life instrument, which measures sadness, depression, and worry.

21 Family functioning was measured using the Family Assessment Device.

child emotional abuse and physical abuse [32]. Reports of childhood abuse were based predominantly on retrospective information of events before the age of 17 years in the latter study, which is true of many studies on child abuse in South Africa. However, the sample population was relatively young in this study ($M = 23.8$ years, $SD = 5.14$ years), which may improve the reliability of the recollections. Although parental abuse was not a significant predictor of sexual abuse in this study, an earlier study among grade 11 and 12 high school students found a significant difference between sexually abused and non-abused participants in terms of the variable 'violence at home not seldom' [124].

The relationship between family conflict/domestic violence and VAC operates in a number of ways. Mothers and caregivers who are abused by their partners are at a greater risk of consequently abusing their children [31]. Mothers and caregivers exposed to IPV are at an increased risk of suffering from Post-Traumatic Stress Disorder (PTSD) and depression and as a result they are often less emotionally capable of responding to the needs of their child [138]. This emotional unavailability can result in a disorganised mother-child attachment, which can subsequently lead to increased emotional vulnerability of the child [139]. However, if a child exposed to IPV has a parent who engages in positive parenting and has a strong, healthy relationship with their child, this can moderate the impact of the child's exposure to IPV [139].

In addition, exposure to domestic violence in childhood has been identified as a potential risk factor for later victimisation and perpetration, although this has only been addressed qualitatively in South Africa. Research suggests that boys observing their mothers being victims of domestic violence are more likely to become abusive and violent, while girls who observe domestic violence are more likely to become involved in abusive relationships when they are older [31], [55], [140].

2.4.3.8 Other Caregiver-Related Factors

Untreated mental health problems have been shown to have a significant impact on caregivers' ability to care for their children. Evidence from international studies shows that parents with poor mental health are at increased risk of abusing or neglecting their children [141], [142] and being emotionally unavailable for their children, which has increased negative mental health outcomes for both girls and boys [143]. A study conducted amongst high school students in Mpumalanga indicated that of students whose parents had psychiatric disorders, 30.3% reported sexual abuse and 27% reported physical abuse [93]. While this study's findings support international literature on the link between psychiatric disorders and child abuse, the reliability of these

findings are questionable due to the fact that identification of parental disorders was based on self-report and the reported age range of the high school learners (11 to 28 years) indicated that sample included young adults over the age of 18 years. Caregiver mental health²² has been found to impact on experiences of verbal and physical maltreatment by OVC [26]. Children whose caregivers reported more frequent negative feelings were significantly more likely to experience maltreatment.

2.4.3.9 Bullying

Bullying is not only a type of violence experienced by children; it may also act as a risk factor for further violence, either as a victim or as a perpetrator. The NSVS suggests that bullying creates vulnerability for further victimisation at school; learners who are bullied at school (56.5%) are significantly more likely to be victims of other forms of violence at school, compared to those who had not been bullied (17.1%) [15]. This is supported by evidence that both bullies and bully victims are more likely to engage in certain violent, anti-social and risk-taking behaviours than learners not involved in bullying [102]. Multiple risk factor regression models have showed that bullies were more likely to be involved in fighting and theft, and bully victims were more likely to be involved in fighting, suicide, and theft. However, these results are limited to Cape Town and Durban. One of the few longitudinal studies examining issues around violence in schools found that bullying leads to higher school dropout rates among high school learners in Cape Town but did not draw the connection between bullying, dropout rates and violence [144].

2.4.3.10 Delinquent Peers

Peer pressure can contribute to school-based violence [145]. Having "delinquent" peers (peers who have been involved in drug-related activity or violent behaviour) was shown to put South African secondary school learners at risk for victimisation at school. For instance, a study among Grade 8 and 11 students at government schools in Cape Town and Durban examined the association between certain risk behaviours and bullying [102]. Logistic regression analysis of individual risk factors found that (a) bullies were more likely to be involved in alcohol and cannabis use than controls and (b) bully-victims (involved in bullying as both a victim and perpetrator) were also more likely to be involved in alcohol and cannabis use than controls. In a multiple risk factor model, alcohol use, but not cannabis use, remained significant for bullies and bully-victims. However, the study relied on self-report measures and no definition of bullying was provided, which may have confounded the results. Having peers involved in violent behaviour is particularly strongly associated with

²² Mental health was measured using the WHO Quality of Life instrument (negative feelings subscale), which measures the frequency of feelings of sadness, depression and worry in the previous four weeks.

being a victim of violence at school, but learners who are acquainted with people at school who buy, sell or use drugs, or bring weapons to school, are also more likely to be victims of violence at school [15].

2.4.4 Community and Societal Level Risk Factors

2.4.4.1 Violence and the Availability of Weapons and Substances in the Community

The proportion of South African children who report that alcohol, drugs and weapons are easily accessible in their neighbourhoods is frighteningly high (see Table 6). The availability of weapons and substances in children's neighbourhoods and schools places children at increased risk of victimisation and perpetration of violence across all the settings in which they interact (home, school and community). South Africa has one of the highest rates of firearm-related homicides in the world. However, few studies have empirically investigated the association between firearm availability and VAC. This relationship is supported by qualitative evidence

that access to all forms of weapons at school is a cause of school violence [146]. With regards to quantitative evidence, a small number of studies provided some support [15]. In the CJCP's National Youth Offending and Resilience Study, a greater proportion of youth offenders reported that it would be easy to access firearms than non-offenders (40.3% vs. 8.1%) [147]. Similar evidence from the NSVS shows a quarter (24.1%) of learners knew peers who brought weapons, including firearms, to school. A relatively larger proportion of those that had been victims of crime compared to those learners who had not been victims of crime, knew peers who brought weapons to school.

As with access to firearms, knowing people in the community who use drugs and the general availability of drugs and alcohol in the community may act as a risk factor for victimisation and perpetration. Drug availability has been found to be a significant predictor of multiple physical victimisation amongst urban adolescents [100]. In the CJCP's National Youth Offending and Resilience Study, a greater proportion of youth offenders reported knowing community members who smoked dagga, sold drugs or bought drugs than non-offenders [147].

	PRIMARY SCHOOL	HIGH SCHOOL
EASY TO GET ALCOHOL	31.3%	64.1%
EASY TO GET DRUGS	14.1%	74.0%
EASY TO GET A GUN	11.3%	17.9%
EASY TO GET A KNIFE	12.8%	62.1%

Table 6. Self-Reported Ease of Access to Alcohol, Drugs and Weapons in Learner's Neighbourhood (n = 12 793 learners) [16].

Offenders were significantly more likely to indicate that it was easy or very easy to access dagga than non-offending youth (74.9% vs. 48.3%), but there was no difference between the groups with regard to ease of access to alcohol. The relationship between neighbourhood drug activity and access to alcohol has been reiterated by qualitative studies. The study by Ward et al on gangs and community violence regarded drugs as one of the main causes of gang fighting and violence. A number of children mentioned eliminating drug activity and easy access to alcohol for underage youth and gangs in their neighbourhoods as a means of reducing gangsterism [111]. Both the 2008 and 2012 NSVS have consistently found a link between learners from 'disorganised' communities, in which they are exposed to violence and there is easy access to drugs, alcohol and firearms, and victimisation at home and at school [15], [16]. A significantly larger proportion of learners who

reported that they lived in neighbourhoods in which there was a lot of fighting and crime, also reported experiencing violence at home as compared to learners who did not report living in neighbourhoods characterised by fighting and crime [16].

Similar significant findings emerged for experiencing violence at school. This relationship between violent communities and violent schools has been emphasised on many occasions in the literature, including both qualitative [146] and quantitative studies [119]. In investigating community and school level bullying victimisation in vulnerable children, Cluver, Bowes, and Gardner found unique significant associations between bullying victimisation and physical or sexual abuse in the home, living in a home with domestic violence, and living in a violent community, after controlling for the effects of covariates and other significant risk factors in multiple regression

analyses [119]. The presence of gangs in the community on violence perpetrated in schools is frequently mentioned in the literature, but data regarding the direct effect of gangs on violence in schools is largely absent.

2.4.4.2 Gangs

There is a dearth of contemporary empirical research on gang violence in South Africa. Of the work that has been conducted, little has directly addressed the risk and protective factors for youth involvement in gangs and gang violence. In addition, existing research has predominantly been conducted on Coloured gangs in the Western Cape, with little work on black township or *tsotsi* gangs [148]. Of the work that has been conducted on gangs in African townships, much is now out-dated, having been conducted and published before 2000 [149], [150]. Thus, there is a need for empirical research on gang violence, particularly in provinces with high levels of gang activity other than the Western Cape, and on gangs operating in black African townships. This research should examine the factors that put children at risk for and protect against their involvement in gang activity and exposure to gang violence in these high-risk areas.

The only research that has examined these factors, a national survey, showed that males were significantly more likely to be involved in a gang than females (23.6% vs. 15.5%) [33]. This was qualified by race, with more Coloured, Black and Indian male learners reporting gang membership than Coloured, Black and Indian females, but no difference between white male and female gang membership. Younger learners (Grade 8, 22.4%) were also more likely to be involved in gangs than older learners (Grade 11, 16.5%). Males were significantly more likely to have been approached to join a gang than females, but there was no significant difference by race, grade, or age.

The risk factors for gang activity have also been addressed qualitatively in South Africa. A study undertaken by the Human Sciences Research Council (HSRC) as part of the Children in Organised Armed Violence (COAV) Cities Project conducted focus groups with children in various Cape Town communities with high gang activity and identified a number of risk factors [111]. The factors identified by children at the individual level included dropping out of school, drug addiction, revenge, and identity formation during adolescence. At the relationship level, children viewed poor family environment such as domestic violence, drug use and having family members who are gangsters, as well as having peers who are gangsters, as factors that may contribute towards children getting involved in gangs. At the community/societal level, children reported poverty, poor neighbourhood policing, high levels of drug activity in the community, high levels of violence in

the community, a lack of alternative recreational activities, and poor television role models. Although some factors identified in this study, such as a lack of leisure activities and a dysfunctional family environment, are frequently cited as increasing vulnerability to gangs in the literature [54], there is a lack of quantitative data on risk and protective factors for gang involvement and gang violence amongst children in South Africa to support these findings.

2.4.4.3 Harmful Cultural and Traditional Practices

Although traditions and customs are an important part of cultural and social identity for many South Africans, some practices are potentially harmful and operate outside the confines of the law. However, there is little published literature or reliable statistics on the extent of the problem and the factors that may put South African children at risk of, or protect against, the potential harm caused by these practices.

Harmful Traditional Practices Affecting Girls

Traditional practices that put girls in South Africa at risk of harm include *ukuhlolwa* (virginity-testing) and *ukuthwala* (bride capture). The way *ukuthwala* is currently practised is widely condemned as it is seen to sanction forced and child marriages. This practice is in contravention of South African legislation and the constitutional rights of women and girls [151], [152]. In response to reports of forced marriages of young girls to older men in the Eastern Cape²³ and the increasing involvement of violence and sexual assault in the abductions, the government has taken steps to investigate the manner in which this practice and others that impact the rights of women and girls are occurring.

According to Section 12 of the Children's Act (2005), girls above 16 years may undergo virginity testing, provided they consent to this. However, virginity testing can be problematic on a number of grounds. Firstly, as it is only directed at girls and focuses on sexuality and virginity, it can be viewed as discriminatory [54], [152]. Secondly, it impinges on the rights of girls to privacy dignity, equality, and bodily integrity [152], [153]. In fact, virginity inspections are included in the WHO's definition of sexual violence [4] and can thus be seen as a form of child sexual abuse [154].

As part of government's response to the harmful way in which these practices are being carried out, a number of dialogues have been held with key stakeholders in traditional communities in KwaZulu-Natal to discuss *ukuthwala* and *ukuhlolwa* and the ways in which they could be eliminated or regulated within the confines of the law [151], [152].

²³ On 6 April 2009 *The Herald* newspaper reported that more than 20 schoolgirls are forced to drop out of school every month in the Eastern Cape due to *ukuthwala*.

In addition, mandated by the Department of Justice and Constitutional Development in 2009, the South African Law Reform Commission hosted a round table discussion with various stakeholders and undertook a review of the legislation surrounding the practice [155]. While government's position on these practices appears clear and there have been efforts to bring these customary practices in line with to the Constitution and law [153], [155], there is no empirical published literature on the potential risk and protective factors. However, it is evident that these practices disproportionately affect the lives of girls under the age of 18 years and vulnerable and marginalised girls in traditional, rural communities [152].

Male Circumcision

Violence related to the practice of traditional male circumcision and initiation is the principal practice that puts boys in South Africa at risk of harm. Medical circumcision forms part of the South African government's HIV prevention campaign and much of the literature on male circumcision in South Africa, and in other countries, focuses on the relationship between circumcision and decreased HIV transmission [156]. As of August 2013, only one circumcision-related death had been reported since the launch of the government's campaign, during which over a million men between the ages of 15 and 49 have been medically circumcised [157].

However, traditional male circumcision and initiation is widely practised in South Africa, most commonly in the Eastern Cape, Limpopo and Mpumalanga. The number of deaths and mutilations reported in the media resulting from traditional initiation practices is alarming and has caused national outrage. This appears contradictory to research findings. For instance, a review of findings of studies conducted on traditional male circumcision in Eastern and Southern Africa indicated that mortality associated with traditional circumcision was only 0.2% on average [158]. Thus, whereas research indicates low mortality rates in traditional male circumcision and is generally supportive of medical circumcision for the purpose of HIV prevention, it appears that a large number of initiates are being harmed or killed in traditional ceremonies.

From June 2001 to December 2006, the Eastern Cape Department of Health recorded 208 deaths and 115 mutilations out of 2 262 hospital admissions due to initiation practices [159], despite the 2001 passing of the Application of Health Standards in Traditional Circumcision Act in the province. These findings are indicative of the fact that initiation practices are not properly monitored, that legislation is not effectively implemented, and that government does not track the number of deaths and mutilations caused by initiation on a national scale. Consequently, there are no reliable national statistics on traditional circumcision-related injuries and mortality.

2.4.4.4 Violence in the Media

There are a number of connections drawn in international literature regarding the relationship between VAC and violence in the media. For instance, international research has repeatedly shown the connection between exposure to media violence and aggressive behaviour, thoughts and emotions in some children [160]. Longitudinal research in the US has found that identification with aggressive same-sex characters on TV and belief in the realism of TV shows (i.e. that they depict real life) play a role in predicting future aggressive behaviour [161]. Researchers attributed the association between the introduction of TV and increases in larceny to materialism and the portrayal of high standards of living and consumption, pointing to factors such as relative deprivation rather than observational learning or social modelling of violence witnessed on TV [162].

In South Africa, there is some qualitative and anecdotal evidence that violent male role models from movies play a role in constructing the identity of male gang members in South Africa [148], [150] but there is little quantitative work that has addressed violent media as a risk factor for VAC. One study found that viewing violent television was a significant predictor of multiple physical victimisation (being threatened with a weapon, hit/shot with a weapon, stabbed, beaten up, and/or stolen from) [100]. The study was conducted with adolescents in urban households in Cape Town and Durban. Nonetheless, such a cross-sectional study was not able to investigate the long-term effects of childhood viewing of violent television on later victimisation or perpetration. It does suggest a tentative connection between violent television and being a victim of violence in urban South African adolescents, although the dynamics underlying this relationship are not clear.

2.4.4.5 Social Norms and Values

When social values, patriarchal norms, and violent masculinities are reflected in the gender perceptions and dynamics within the home, school, or community, there is an increased risk of children being exposed to violence [13], [31]. Some of these values and norms operating in South Africa include that (a) men have the right to exert power and control over women and children, (b) children must display unquestioning subservience and obedience to adults, particularly men, and (c) domestic violence and abuse are private matters that must be kept within the home [8], [54]. In post-1994 South Africa, dominant ideals of masculinity are frequently implicated in the normative use of violence against women and children [110], [163].

While it is difficult to quantify values and norms, numerous qualitative studies have explored the ways in which these

values and norms create vulnerability for violence. These studies contribute to a contextualised understanding of violence in South African communities. For instance, an exploration of the social context of rape in South Africa and Namibia identified dominant patriarchal ideology, age, and social hierarchies of men versus girls as some of key ideas making children vulnerable to rape [8]. This fed into the use of rape as a means of control and punishment over girls and the idea that rape strengthens a perpetrator's masculinity and power. Similar notions of masculine superiority, violence as the exercise of patriarchal rights, and violence as a means of discipline and defending male dignity have been linked to intimate partner violence amongst urban isiXhosa youth [164]. Violent forms of masculinities, adopted to gain respect and power, have also been linked to intimate partner homicide [123].

2.4.4.6 Social Myths

There have been attempts to explain the phenomenon of infant and toddler rape in South Africa in relation to the "virgin cure", also referred to as the "virgin myth". The "virgin myth" posits that sex with a virgin will cure HIV/AIDS [165]. However, authors dismiss this connection, citing (a) the infrequency with which this is given as a motivation for rape in research and anecdotal service provider evidence and (b) the failure of child rape cases to increase concurrently with the HIV/AIDS pandemic [154]. The rape of the very young is not a new phenomenon and occurs fairly frequently in South Africa [165].

However, there is a lack of theoretical and empirical research on the issue of the "virgin cure", particularly in relation to infant and toddler rape. In a study examining HIV/AIDS risk amongst men at a sexually transmitted infection (STI) clinic in Cape Town, a fairly small proportion of men with no history of sexual assault (27%, $n = 77$) and of men with a history of sexual assault (20%, $n = 18$) indicated that they endorsed the belief that "a person can get rid of AIDS by having sex with a virgin" [166]. However, participants' history of sexual assault was asked in reference to sexual assault against a woman, and there was no significant difference between men who had and men who had not perpetrated sexual assault. This lack of evidence means it is difficult to determine the role that social myths such as the "virgin cure" play in sexual VAC, the most significant factors underlying infant and toddler rape, and whether these are different or similar to the risk factors for sexual assault of older children.

2.4.4.7 Poverty, Inequality and Unemployment

It is clear that children across all socio-economic groups are exposed to violence and abuse, but the social dynamics of

poverty and inequality have been identified as some of the key predictors of violence across countries [4], [167], including South Africa [168], [169]. South Africa has one of the highest rates of income inequality in the world, with a Gini coefficient of 63.1 in 2009 [170]. In 2011, the unemployment rate was 29.8% [171]. Higher rates of violence are typically seen in communities with higher rates of unemployment and poverty [169], [172]. Although not necessarily reflective of South Africa overall, research in Cape Town has indicated that in some informal settlements male homicide rates were four times higher than in wealthier, well-established communities [173]. A number of other poverty indicators have also been associated with child physical and emotional abuse, including going to bed hungry and unequal food distribution [23].

Socio-economic disadvantage and poverty have been linked to VAC through a number of mechanisms. For instance, children are at a greater risk of being exposed to unintentional danger and experiencing violence when homes are overcrowded and there is a lack of adequate child supervision in the home [53], [54]. Research has shown a high risk of sexual assault and abuse amongst women and their children when the women are economically dependent on their partner [11], [31]. Socio-economic disadvantage can lead to increased parental stress and frustration, which can in turn increase the risk of violence in the family [54]. Lack of employment and poverty are correlated with lower self-esteem and increased levels of frustration [167], [174], which are risk factors for violence. This may place children at risk of abuse where the perpetrator, such as a parent or caregiver, is unemployed. However, there is little reliable statistical evidence linking factors, such as parental/caregiver unemployment, to increased risk of victimisation amongst children in South Africa.

2.4.5 Protective Factors

While dedicated South African VAC studies examining prevalence and risk factors are limited, there are even fewer studies examining factors that might protect children against violence or increase their resilience to its effects. The discussion below draws on this limited research base to identify those characteristics of a child's parents and family, support network, economic resources, and other factors that have the potential to decrease risk of victimisation or reduce adverse outcomes when a child is exposed to violence.

2.4.5.1 Parent and Family Characteristics

Research has shown that VAC is much less common in families that are stable, where there are strong parent-child attachments and where there is good communication between family members [53], [175]. Family organisation significantly moderated the effects of hearing about violence and family

control significantly moderated the effects of police violence in a sample of children living in high-violence communities in Cape Town [38]. When the authors considered additional moderating variables, unknown locus of control (not knowing why events occur), family organisation and family control moderated certain kinds of community violence. However, as the authors acknowledged, the effects were modest in the latter models of moderators and the ability of these factors to moderate the effects of community violence on psychological distress should be interpreted with caution. The authors did not find a relationship between resilience to community violence and parental support, which has been identified as an important protective factor in international studies [176]–[178]. This may be due to problems with the measurement of parental support in this study however, and does not necessarily preclude parental support as an important resilience factor in South Africa.

The findings of a study investigating protective factors for bullying victimisation among AIDS-affected and vulnerable Xhosa-speaking children showed that children who reported a caring environment at home, and particularly those who reported greater sibling and friend support, were significantly less likely to get bullied [119]. Specifically, peer support helped to reduce bullying victimisation of children experiencing physical or sexual abuse at home and domestic violence and sibling support helped to reduce bullying victimisation for children experiencing physical or sexual abuse at home. This is indicative of the interplay between the home, school and community settings in determining children's experiences of violence and that children who are victimised in one setting are also more likely to be victims of violence in other settings. This study is useful in that it is a community-based study that sampled vulnerable children who may not be captured by other school-based surveys.

There is additional evidence that family coping resources can protect against the adverse effects of community violence, family victimisation²⁴, family violence, and political violence. Results of the BT20 study found that the effects of violence on children's attention, aggression and anxiety-depression at age five were moderated by maternal distress [47]. In other words, mothers' ability to regulate their own emotional distress was important for their children's psychological response to violence, which suggests maternal adjustment or coping may buffer children's experiences of violence at a young age. However, it is not clear from the study whether these effects (a) would continue as children mature or (b) are applicable to children growing up in South Africa today. The country's political and social environment was considerably different when this data was collected in the early to mid-1990s, during which ambient community and political violence were arguably

more intense [47]. This study also found that individual child resilience (personal adaptability and frustration as measured by a subscale of the South African Child Assessment Schedule) mitigated the effects of violence on oppositional behaviour, somatic complaints and academic motivation [47].

2.4.5.2 Social Support and Support for Caregivers

Due to the importance of family and parent characteristics in protecting children against violence, social support for caregivers and families is argued to be one of the greatest protective factors that leads to increased resilience in children exposed to violence [54]. Social support was shown to significantly moderate the effects of gang violence amongst children living in Cape Town townships [38]. In this study, social support referred to having people at school, family members or peers with whom the child could talk and receive advice. For example, children were asked to respond to the statement, "At school, there are adults I can talk to who care about my feelings and what happens to me."

There is extensive evidence in the international literature that parenting programmes have been shown to be protective against child maltreatment. Whereas there is a well-established evidence base with regards to parenting interventions in high-income countries, there have been few trials of parenting interventions in low- and middle-income countries [179], [180]. However, positive parenting has been shown to act as a significant protective factor for severe child emotional and physical abuse [23]. In South Africa, there are as yet no large-scale parenting programmes with an evidence base that indicates that they protect children against abuse from their parents or caregivers. However, at least three randomised controlled trials are in progress, and thus a local evidence base is in the process of being built.

2.4.5.3 Economic Opportunities and Social Assistance Grants

As poverty and unemployment are significant risk factors for violence, increasing skills development and providing employment opportunities to unemployed parents may help to reduce levels of violence [4]. Meinck et al. found that having at least one person in the household in employment acted as a protective factor for severe physical and emotional abuse in vulnerable children [23]. The IMAGE study highlighted the role that economic empowerment of women can play in reducing their risk of exposure to IPV [181]. The microfinance programme used in this study was associated with increased economic wellbeing, empowerment, and social capital, and decreased controlling behaviour by intimate partners and IPV. This may, in turn, decrease the risk that the children of women

²⁴ Victimisation was defined as the experience of violence by members of a child's household around the child's birth in 1990 and when they were five years old in 1995.

who have benefited from the programme will be exposed to this form of violence and increase the likelihood that their children will benefit from improved wellbeing. However, this requires further exploration within the context of VAC.

There has been a marked increase in the percentage of children who have had access to social assistance grants since 2003. Figures from 2013 indicate that approximately 11.3 million children are accessing the child support grant, with another 0.5 million children receiving the foster care grant [125]. Access to social grants, including the Old Age Pension, Child Support Grant and Foster Care Grant, have been associated with increased school attendance [182], [183] and better nutrition [184]. While there is evidence that access to social grants can lead to improved education and health outcomes of household members, no studies have directly explored the relationship between access to social grants and decreased levels of VAC.

It has been suggested that grants, particularly the child support grant, may act as a protective factor and indirectly reduce child maltreatment and neglect and enhance child welfare through helping vulnerable families meet the basic needs of their children [57]. In a recent case-control study, Cluver et al. found that receipt of the child support grant or foster child grant was significantly associated with reduced incidents of risky sexual behaviours of transactional sex²⁵ and age-disparate sex²⁶ among adolescent girls, but not boys [185]. Such sexual behaviours are often motivated by poverty and economic need. Receipt of grants may act to protect adolescent girls not only from risky sexual behaviours but also from sexual victimisation related to poverty and risky sexual behaviours.

In transactional and age-disparate sexual relationships, power inequalities frequently exist between adolescents and older male or wealthier partners who provide financial support [185], [186]. In contrast, Carey et al. found that child sexual assault victims were significantly more likely to have a family member receiving a disability grant than children who had not been victims of child sexual assault [104]. This latter finding may be the result of a child being inadequately supervised due to parental disability, which therefore leaves the child vulnerable to the risk of victimisation by relatives, acquaintances or strangers.

2.4.5.4 Other Protective Factors

A small number of studies have empirically addressed protective factors for exposure to community violence in South Africa. Using structural equations modelling, a Cape Town-based study found that involvement in after-school

activities and school support significantly influenced resilient responses to community violence, protecting against the negative sequelae of violence exposure such as anxiety, depression and conduct problems [187]. Further, attending a sport, music, or dance group and school support was not found to be significantly associated with bullying victimisation among OVC [119].

A study in five Cape Town townships investigated the factors that moderate and mediate the effects of school, neighbourhood, gang and police violence on primary school children's psychological distress [38]. Perceived safety was the only significant mediating variable for all types of community violence. This suggests that a child's feelings of being safe plays an important role in buffering the psychological distress that results from exposure to community violence.

The HSRC, as part of the COAV Cities Project, undertook a qualitative study, in which they conducted focus groups with children in various Cape Town communities with high gang activity [111]. The interview included questions addressing what might help children get out of gangs and make their communities safer. The central protective factors that emerged from these discussions were (a) poverty alleviation through employment, (b) community cohesion, (c) lower neighbourhood crime and drug activity, (d) higher levels of school enrolment, (e) more religious institutions and (f) access to recreational facilities and extra-mural activities. There is, however, no empirical evidence to support the role these factors would play in protecting against gang violence and other forms of organised armed violence in this and other communities in South Africa. Additional research is needed to explore these factors further.

A number of the studies that investigated protective/resilience factors were conducted in high-violence township communities in Cape Town, which limits the generalisability of these results. Townships are unique due to their relatively high levels of violence and (compared to wealthier areas) the fact that they are still poor and largely racially segregated. However, taken together these studies appear to provide consistent evidence of factors which may operate in similar communities with high levels of violence. Schools and family environments in particular can foster resilience. Individual child factors also appear significant. Creating feelings of safety in children may be particularly important in helping them to cope with violence. Building pro-social attitudes and resilience may be further routes to creating resilience in response to community violence [175]. However, more research is needed, particularly in high-violence communities outside Cape Town and in other provinces in South Africa.

²⁵ Transactional sex was defined as sex in exchange for money food, shelter, school fees, transport or money.

²⁶ Age-disparate sex was defined as having a sexual partner more than five years older.

2.4.5.5 Factors Protective against Youth Offending

While factors that protect against child victimisation are important, attention has also been paid to factors that protect against youth *offending* in South Africa. One of the most comprehensive studies of the risk and protective factors for youth criminal offending is the CJCP National Youth Offending and Resilience Study [147], [188]. Results of a logistic regression identified a number of significant predictors of non-offending in a sample of 12 – 25-year-old offending and non-offending youth, where the former were those who had committed offences including armed robbery, housebreaking, rape, murder, theft, assault, possession of illegal substances, and fraud. The key factors that were found to enhance youth resilience to criminal and violent offending at the individual level were (a) gender (females were more likely to be non-offenders than males in the study), (b) attitudes intolerant of violence (specifically, not believing that people who have hurt them deserve to have bad things happen to them), (c) not having been the victim of crime, (d) abstinence from alcohol and other drugs, and (e) education (having completed matric, having a positive attitude towards schooling in terms of regarding school as important, and wanting to obtain good marks and progress to tertiary education).

At the relationship (peer and family) level, youth were less likely to offend if they (a) had interaction with non-delinquent peers (i.e. friends who have never been arrested, dropped out of school, been suspended from school, consumed illegal substance, nor stolen a motor vehicle), (b) did not know anyone at school who carried a gun, (c) were not exposed to criminal role-models within their family, (d) did not have a family member who had engaged in criminal behaviour (e.g. stealing, selling stolen goods, mugging and assaulting) in the past year, and (e) lived in a non-violent family environment where family members hardly ever lost their tempers, did not resort to physical violence when they became angry, and where parents did not employ corporal punishment to discipline their children. At the community level, the key resilience factor that emerged was not having access to firearms within the neighbourhood.

These results reiterate the importance of the family and school environments in protecting against violence. They also indicate the role that lack of access to firearms, drugs and alcohol play in creating resilience, in terms of individual abstinence from such substances and not being exposed to firearms and substances through peers and the community. The apparent similarity between the factors creating resiliency to victimisation and protecting against perpetration, imply that interventions targeting these factors may be successful in addressing both victimisation and perpetration.

2.4.6 Summary and Conclusion

While the rights of the child are comprehensively addressed within South Africa's legal framework, in reality many children in South African are exposed to high rates of violence in their homes, schools and communities. Factors at the individual, relationship, community, and societal level intersect to increase or decrease the likelihood that a child will experience violence. Certain gaps were identified in the literature including the lack of nationally representative studies, large-scale population-based community studies, and longitudinal cohort studies. However, despite these gaps, an analysis of the available literature on risk and protective factors for VAC in South Africa was able to identify several key factors and relationships.

At the individual level, age, gender and substance use were found to contribute to the increased likelihood of a child's victimisation. Further, membership in certain vulnerable groups can increase the risk of experiencing violence. These groups include children with disabilities and street children.

At the relationship level, substance use by a child's family and peers was identified as a risk factor for VAC. Further, poor family structuring and functioning were associated with child maltreatment and increased vulnerability to violence. For example, orphans and children living in child-headed households; living in households affected by chronic illnesses, such as HIV-affected households; living in families with family members who had been incarcerated; and living with a caregiver with untreated mental health problems. Harsh and inconsistent discipline practices, and family conflict and violence were also associated with physical abuse. Peer-related risk factors included bullying, as a risk factor for experience or perpetration of other forms of violence, and having peers involved in delinquent behaviour. Research findings suggested that the risk of corporal punishment differed between school type (primary vs. secondary), location (urban vs. rural) and province. Corporal punishment was more prevalent in primary schools and in rural areas.

At the community and societal level, risk factors for victimisation and perpetration included the availability of weapons and substances. Further, children identified risk factors for engagement in gangs to include poverty; poor neighbourhood policing; high levels of drug activity in the community; high levels of violence in the community; a lack of alternative recreational activities; and poor television role models. Factors associated with poverty and inequality, such as maternal economic dependence; overcrowded homes; and parental stress and frustration were also found to place children at increased risk for VAC.

Various cultural and traditional practices are potentially harmful to children when they are not properly regulated and function outside the ambits of the law. These practices include *ukuhlolwa*, *ukuthwala* and traditional circumcision ceremonies (that are not medically regulated). There is a lack of empirical evidence investigating the risk and protective factors associated with these practices. However, the high rate of traditional circumcision related injuries and deaths points to the urgent need to thoroughly investigate and regulate these practices.

When various social norms such as patriarchy and violent, dominant and controlling masculinities are present in the family, school and community settings, children are at increased risk of exposure to violence. The social construct that women and children should be subservient and obedient to men and that violence and abuse in the home is a private matter exacerbates the risk of children experiencing violence. Further, it places them at risk for internalising a social norm, which increases the likelihood of future IPV victimisation (if a girl) and future IPV perpetration (if a boy).

In terms of legislation, the failure to implement legislation consistently and effectively has resulted in there being little deterrence for perpetrators and lack of confidence in the justice system for victims. Consequently, it can be argued that there is a high level of under-reporting of incidents of VAC.

Comparatively, certain protective factors also emerged. At the individual level, protective factors against child/ youth offending included attitudes intolerant of violence and revenge; not having been a victim of crime; abstinence from alcohol and drugs; and education (having completed matric and having a positive attitude towards school). Relationship level factors identified as protective against offending included interaction with non-delinquent peers; not knowing anyone at school who carried a gun; not being exposed to criminal role-models within their family; not having a family member who had engaged in criminal behaviour in the past year; and living in a non-violent family environment.

Relationship level factors identified as protective against victimisation and/ or the consequences of VAC included stable families with strong-parent child relationships; family coping resources, such as maternal regulation of emotional distress; social support for caregivers and families; and skills development and employment opportunities for unemployed parents. Other protective factors included child involvement in after school activities and the availability of recreation facilities. At the community level, lack of access to firearms was found to be a protective factor.

Despite these findings, there are a number of significant gaps in the South African literature. These gaps limit our understanding of the dynamics that determine victimisation and perpetration. There are certain key areas in which there is a need for high quality, broad scale quantitative research and longitudinal, cohort studies. Areas of research that

require further exploration include prevalence of, and factors associated with, emotional abuse; the nature and extent of the violence facing street children and children with disabilities nationally, and the risk and protective factors for this violence; *tsotsi* gangs in Black townships and gang violence across the country; potentially harmful traditional practices; the impact of violence in the media; and whether social assistance grants mediate the risk for VAC. In addition, there is need for more research on factors protective against childhood victimisation and offending.

In conclusion, there is a significant lack of longitudinal research, which is essential for identifying the temporal relationship between risk and protective factors and experiences of violence. Cross-sectional data, on which most of our knowledge about risk and protective factors is based, only allows the identification of a relationship between factors at one point in time.

2.5 STRUCTURAL EQUATIONS MODELLING: VAC

The data vetting process indicated that the most appropriate and available data sets for SEM were the Cape Area Panel Study (CAPS) and the National Youth Lifestyle Survey (NYLS) data sets.

2.5.1 Cape Area Panel Study (CAPS)

2.5.1.1 Overview and Motivation

The CAPS was initiated in 2002, and is a longitudinal (panel design) study of young people in Cape Town. The intention of this survey was to investigate the multidimensional nature of the lives of the young men and women especially in relation to educational, psychological, familial, sociological, economic, and community considerations as these young people transition from childhood through adolescence and into adulthood.

The first iteration of CAPS was conducted in 2002 and comprised a sample of approximately 4 750 respondents aged at the time between 14 years and 22 years old. Five successive waves of the survey have been conducted between 2002 and 2009. In addition to the youth interviews, CAPS also collected data from households by interviewing adults and other household members. CAPS also accumulated data on suburbs and neighbourhoods from a variety of sources, such as Statistics SA.

The panel nature of the survey offers considerable benefits, particularly expanding the coverage of potential determinants

variables as likely explanations of violence victimisation and perpetration. In this regard:

1. It permits a more rigorous examination of the temporal nature of determination: it allows us to investigate how early childhood conditions relate to later adolescent and adult behaviours.
2. It enables a better test of how violence victimisation early in life leads to violence perpetration in later years.
3. The greatest challenge with panel studies is attrition, but the CAPS retained a sufficient longitudinal sample to enable robust data for modelling.

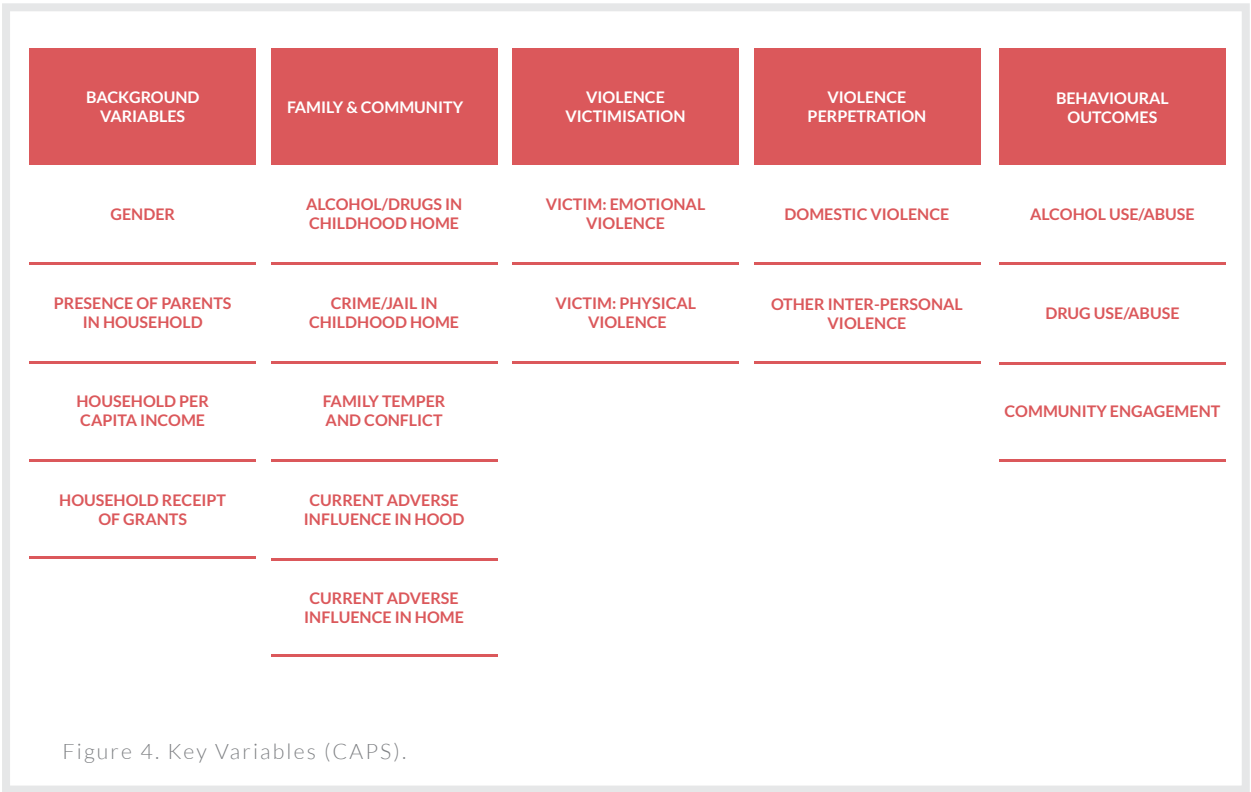
The CAPS is based on a robust measurement methodology, which gives sufficient focus and attention to all aspects of variable measurement, ranging from conceptual development through to operationalisation and coding. Due consideration is given to question phrasing, structure and formatting, as well as to appropriate response formats for different types of questions. Items employed have been subject to stringent development and vetting processes, including piloting and cognitive testing. CAPS also benefits from a high quality

operational methodology which covers all aspects of fieldwork ranging from training of interviewers through field back checks to data coding and processing. The net result of this rigour in measurement and operations is greater confidence in both the process by which the data is collected, collated and processed as well as the content of the returned information.

The CAPS data is a representative sample of youth in a defined location (Cape Town). However, the robust nature of the research design (panel study), together with the sound conceptual measurement, produces a dataset, which had high integrity for internal validity testing. Internal validity testing relates to the building and testing of theoretical and conceptual models. The multivariate modelling of the determinants of violence victimisation and perpetration falls within the ambit of theory development and testing, and accordingly, the dataset provides an optimum proving ground for developed models.

2.5.1.2 Key Variables (CAPS)

The key variables from the CAPS that were identified as having relevance for VAC are listed in Figure 4 below and described in more detail in the sub-section below.



Background/Base Variables

GENDER	The gender of the child (male/female).
PRESENCE OF PARENTS	The presence of no parents, father only, mother only, or both parents in the household in which the respondent lives. (Note: Absence of parents does not imply the respondent is an orphan).
HOUSEHOLD PER CAPITA INCOME	The per capita income for the household (obtained from the adult household survey).

Family and Community Variables (Intermediate Variables)

ALCOHOL/DRUGS IN CHILDHOOD HOME	Whether or not there lived in the home of the respondent (up to age 14 years) anyone who was a problem drinker or alcoholic and/or who used street drugs.
CRIME/JAIL IN CHILDHOOD HOME	Whether or not there lived in the home of the respondent (up to age 14 years) anyone who spent time in a jail or prison.
FAMILY TEMPER AND CONFLICT	The extent of conflict in the family as determined by the frequency with which family members lost their temper and resorted to violence when angry.
CURRENT ADVERSE INFLUENCE IN HOME	(At Wave 5 – 2009) whether or not any adult member of the family (in the past 12 months) used illicit drugs, did anything that could have got them into trouble with the police, such as stealing, selling stolen goods, mugging or assaulting someone and/or had been in jail.
CURRENT ADVERSE INFLUENCE IN HOOD	Whether or not the respondent personally knew people who live in the neighbourhood who sold or dealt in drugs, stole from other people, and was or had been in jail.

Outcome Variables: Violence Victimization

EMOTIONAL VIOLENCE	The frequency with which an adult swore, insulted and put down the respondent (child) and acted such that the child was afraid that s/he might be physically hurt.
PHYSICAL VIOLENCE	The frequency with which an adult grabbed, slapped or threw something at the respondent (child) and/or hit the child so hard that s/he had marks or was injured.

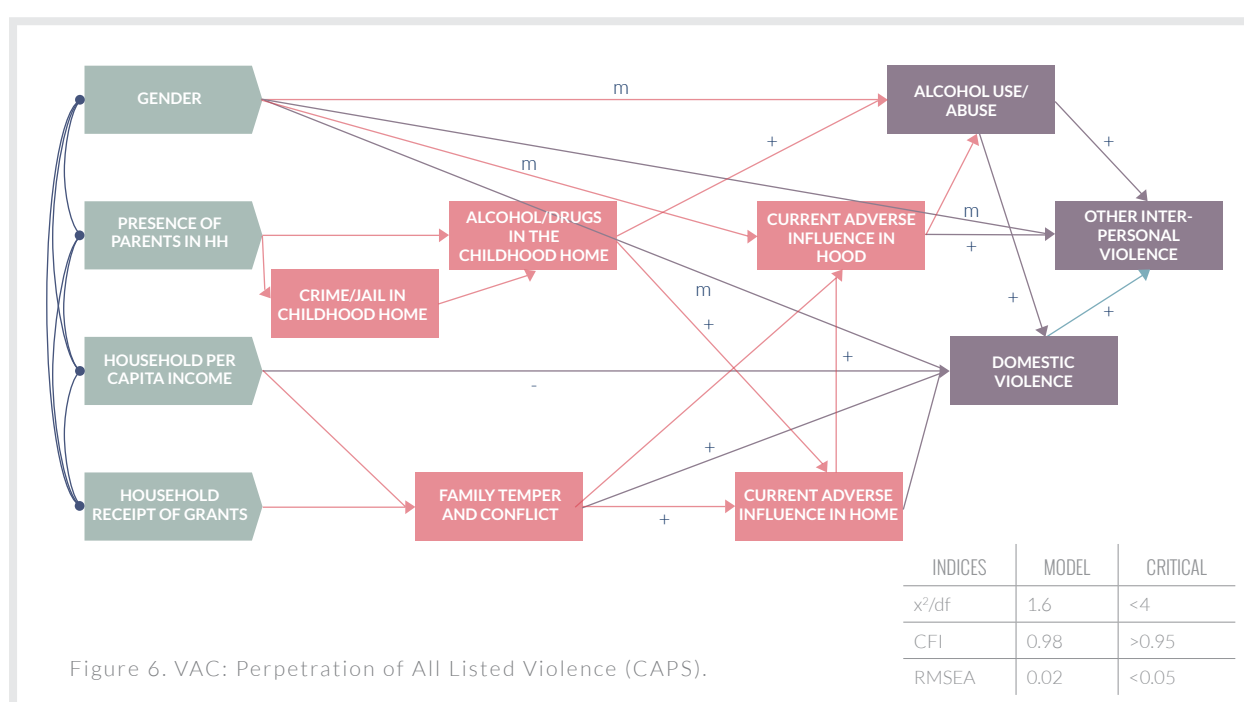
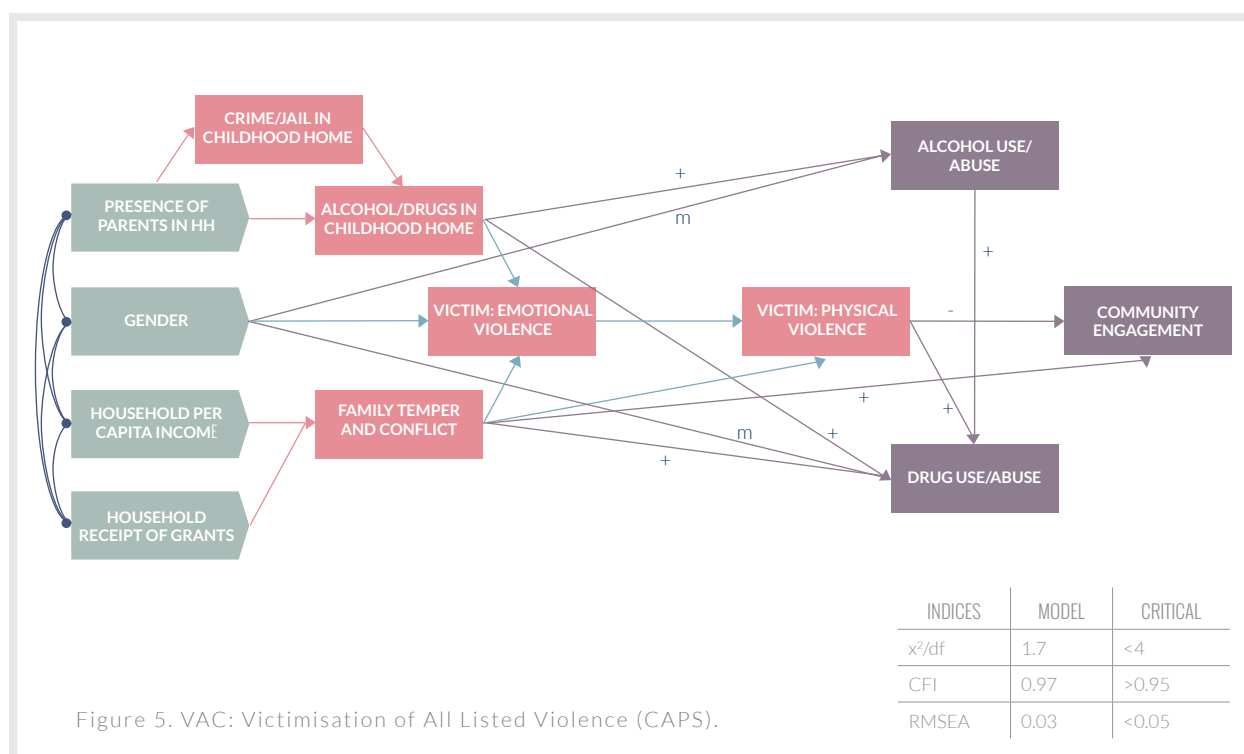
Note: The CAPS data does not have reliable data on reported sexual violence

Outcome Variables: Perpetration of Violence

DOMESTIC VIOLENCE	The frequency with which the respondent (adolescent/young adult) had hit or physically assaulted a girlfriend/boyfriend/partner or any person in his/her family.
OTHER INTERPERSONAL VIOLENCE	The frequency with which the respondent (adolescent/young adult) had hit or physically assaulted a friend, neighbour, stranger or someone they did not know well.

Behavioural Outcomes

ALCOHOL ABUSE	The use and abuse of alcohol by the respondent over a number of years.
DRUG ABUSE	The use and abuse of drugs such as dagga, <i>tik</i> , etc. by the respondent over a number of years.
COMMUNITY ENGAGEMENT	Membership in community-based groups, sports or recreational clubs (e.g. art, dancing, book or soccer club, etc.) or charity or volunteer organisations.



2.5.1.3 CAPS SEM Key Findings

Risk/Protective Factors: Base/Background Variables

- **Family Structure** – A critical factor is the presence or absence of one or both of the parents in the household. Children living in households where none of their parents are present are at the highest risk for violence, while those with one parent present are at moderate risk and those with both parents present at lowest risk. Clearly, having both parents at home to look out for children is a strong defence against children becoming victims of violence, as well as for children perpetrating violence.
- **Household per Capita Income** – Children from households with scarce financial resources are significantly more likely to experience violence in some form as well as to eventually perpetrate it.
- **Gender** – Males are significantly more likely than females to be victims of physical violence while females are significantly more likely to suffer emotional and sexual violence. Males are at greater risk for perpetrating all forms of violence.

Risk/Protective Factors: Intermediate Variables

- **Presence of Drugs and Crime in Household** – Children living in households where they are exposed to drugs/ alcohol and crime as a result of the presence of some household member are at greater risk for violence. Additionally, such influences also work to place them at greater risk for substance use and abuse, which also leads to greater risk of violence.
- **Family Temper and Conflict** – Households with heightened temper and conflict resorting to violence place children at greater risk for suffering violence as well as perpetrating it. The temper and conflict is an indication of the pervasive impact of poverty on family life and dynamics.
- **Current Adverse Influences in Neighbourhood [Hood]** – As with exposure to adverse influences in the household, greater exposure to community members who are involved in drugs/alcohol and/or crime places children at greater risk for violence, both as victim and perpetrator. Boys are significantly more likely than girls to associate with such persons in the community and thus are more vulnerable to suffering violence and at greater risk for perpetrating it.
- **Alcohol Use and Abuse** – Children who use and abuse alcohol are at higher risk in terms of perpetration of violence. Alcohol use/abuse is most affected by exposure to these substances in the household and exposure to it in the community. Boys are at much higher risk than girls.
- **Drug Use** – Children who use drugs are at higher risk in terms of perpetration of violence. Drug use is most affected by exposure to these substances in the household and exposure to it in the community, as well as the experience of violence. Boys are at much higher risk of drug use than girls.

- **Community Engagement** – Children from households with higher levels of conflict are more likely to escape such conflict by engaging with community structures. However, those who have suffered physical violence as a result of this family conflict are significantly less likely to do so. Greater participation in such structures could serve as a protective factor by removing the child from a high-conflict family situation, even if temporarily.

Risk/Protective Factors: Victimisation and Perpetration

- Girls are significantly more likely to perceive and report emotional violence than are boys.
- Girls are at significantly greater risk for sexual violence than are boys.
- Both boys and girls appear to be at equal risk for suffering physical violence at home, though boys are at greater risk for such violence outside the home.
- Children who have suffered some form of violence at home are at a greater risk for experiencing violence outside the home.
- Children who have suffered some form of violence are significantly more likely to perpetrate violence against others, be it in the home, the community or at school.
- Perpetration of violence appears to begin in the home and extends outside the home into the community.
- Boys are significantly more likely than are girls to perpetrate all forms of violence, even when all other determinants are held constant.

2.5.2 The National Youth Lifestyle Survey (NYLS)

2.5.2.1 Overview and Motivation

The NYLS undertaken by the CJCP was designed to provide a national probability sample of all youth in the country aged between 12 and 22 years of age in 2008. The sampling frame for the study was based on the 2001 national census data and was obtained from Statistics South Africa. Following the completion of the fieldwork, the obtained sample was reweighted using the census 2001 data to ensure sufficient sample-population congruence with the cohort of youth aged 12 to 22 years. A preliminary analysis of the data indicates that there is sufficient sample-population congruence to merit application of the dataset for SEM.

The final sample as employed for SEM is 4 079 respondents. The NYLS is a cross sectional survey and thus carries all the associated risks and limitations of such a design. All data was obtained directly from respondents, including household characteristics. The NYLS is not a panel design survey and as a cross sectional survey carries all the risks and limitations associated with such research designs. Principal amongst these are the difficulty for understanding temporal effects in attitudes, behaviours and experiences, i.e. being able to

determine which are antecedents and which are outcomes. Allied to this is the problem of inflated variable relationships often seen in such designs. Variables are more closely related than they would be otherwise because they have all been measured at the same point in time.

However, as the use of cross sectional surveys for modelling purposes is relatively common practice in the extant literature, there is little reason not to use the NYLS data for this purpose, provided that the abovementioned critical limitations are properly acknowledged.

According to the CJCP, the NYLS was designed to provide a national probability sample of all youth in the country aged between 12 and 22 years of age. The sampling frame for the study was based on the 2001 national census data and was obtained from Statistics South Africa. The sampling design was multistage with stratification for demographics and location. Following the completion of the fieldwork, the obtained sample was reweighted using the census 2001 data to ensure sufficient sample-population congruence with the cohort of youth aged 12 to 22 years.

An initial analysis of the data indicates that there is sufficient sample-population congruence to merit application of the dataset. However, a proportion of the measures in the NYLS are poorly worded and the measurement of the intended attitude/behaviour is subsequently compromised. While some of this measurement error can be reduced in the case of composite variable development by eliminating the particular item from the scale, this is not the case where single items are the only measures of that repeat measurement of the same behaviour or attitude but in a somewhat different guise or formulation. It is unclear why this repetition exists, or indeed what the single item repeats was intended to measure considering

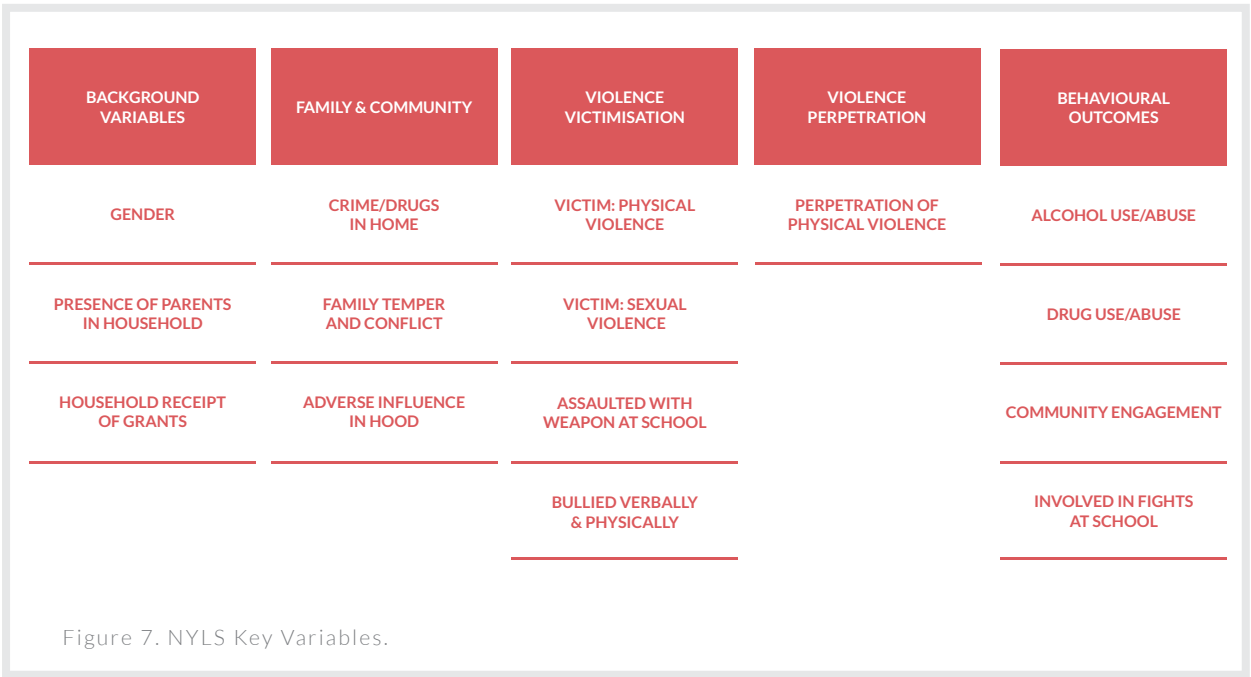
that entire clusters of items elsewhere in the questionnaire were designed to do so in much greater detail and with better conceptual integrity. The data issues do not disqualify the NYLS from inclusion in the modelling process, but they do qualify the application of the data for such purposes.

As the measurement of victimisation is a core component of the VAC, it was decided that only those variables, which employed clusters of items with sufficient conceptual integrity, would be employed for the modelling process. The response formats for some of the items in the NYLS were not optimised given the particular construct being measured by the item/s. In some instances this was due to a binary response format (Yes/No) while in other instances it referred to intervals employed in frequency formats. To minimise any problems as a consequence of the binary response formats, new composite variables were developed using the COUNT procedure. In the instance where frequency intervals were variable, the composite variable was either rescored or weighted to correct identified or potential problems in measurement.

2.5.2.2 Key Variables (NYLS)

The key variables derived from the NYLS are listed in Figure 7 below and described in more detail in the sub-section below. Many of the same base/background and intermediate (family and community) variables that were used in relation to CAPS were used to construct models with the NYLS. The principal difference relates to the outcome variables for violence victimisation, particularly sexual violence. Bullying also features prominently in this data set.

A variety of models were constructed with the NYLS data, three of which are presented as figures 8, 9 and 10 below.



Outcome Variables: Violence Victimisation

PHYSICAL VIOLENCE	This variable was measured by way of the following item (Yes/No): "Can you tell me if someone has ever attacked you physically, or hurt you, using any kind of weapon or their hands, without taking anything from you? (Please <i>DO NOT</i> include any times when your parents might have hit or hurt you for something you have done wrong)".
SEXUAL VIOLENCE	This variable was measured by way of the following item (Yes/No): "Has anyone ever forced you to have sex; kissed, touched or felt your body without your consent; tried to insert their penis or other foreign objects into places you were not happy with; forced you to touch them in places you were not happy with; or forced you to behave in any other sexual way?"

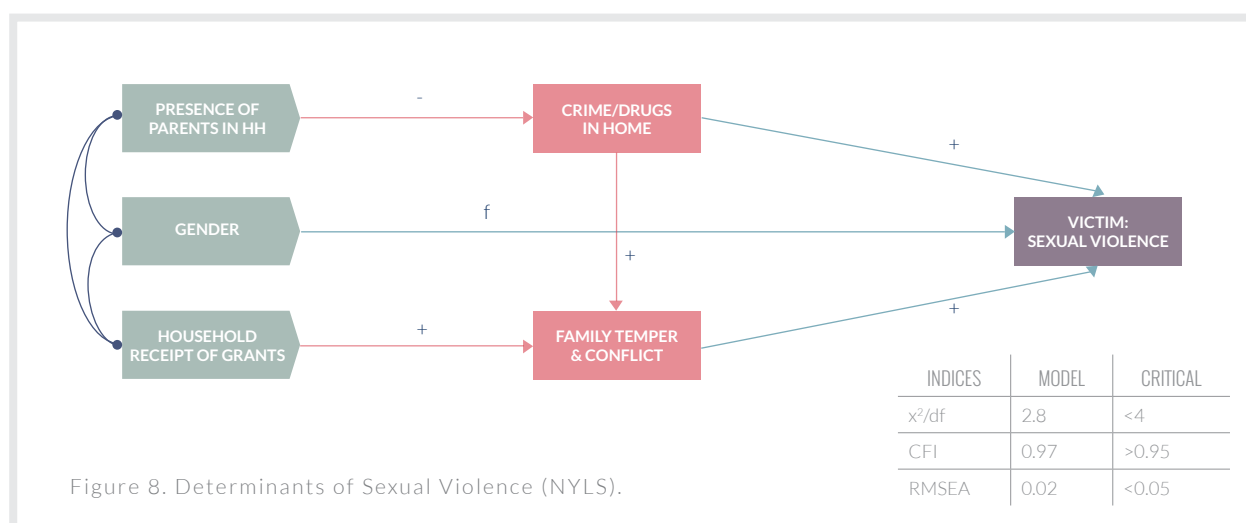


Figure 8. Determinants of Sexual Violence (NYLS).

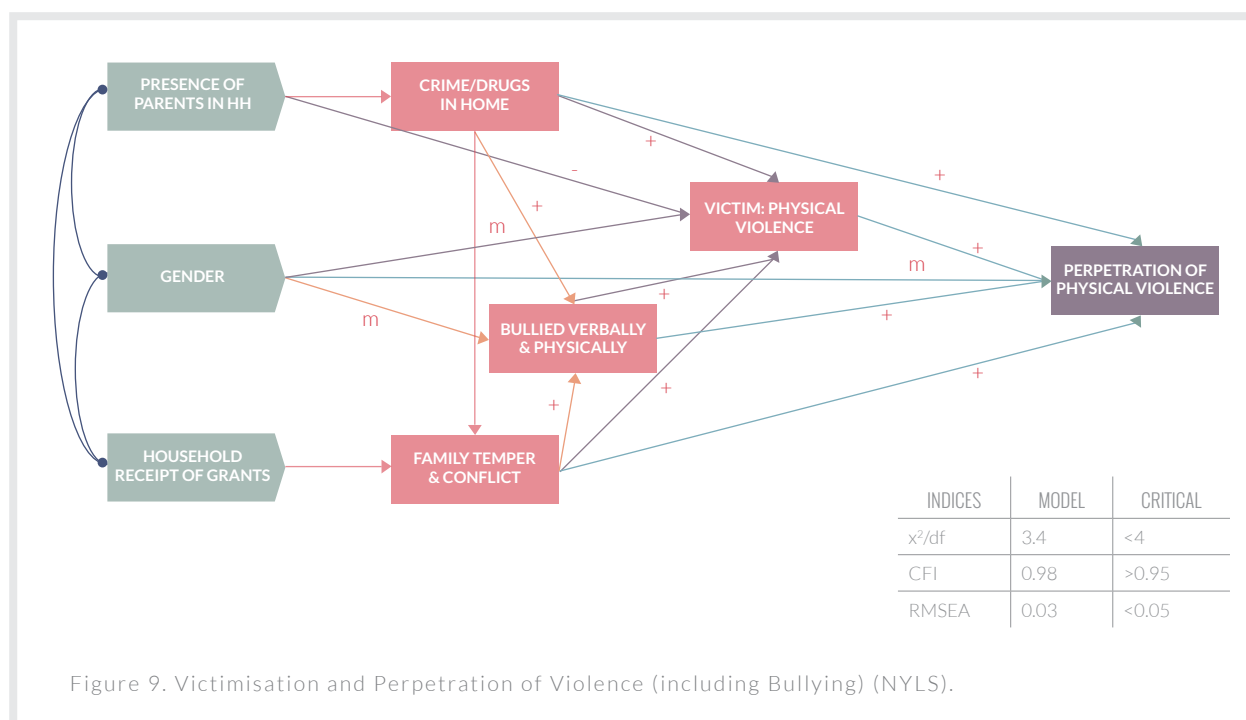
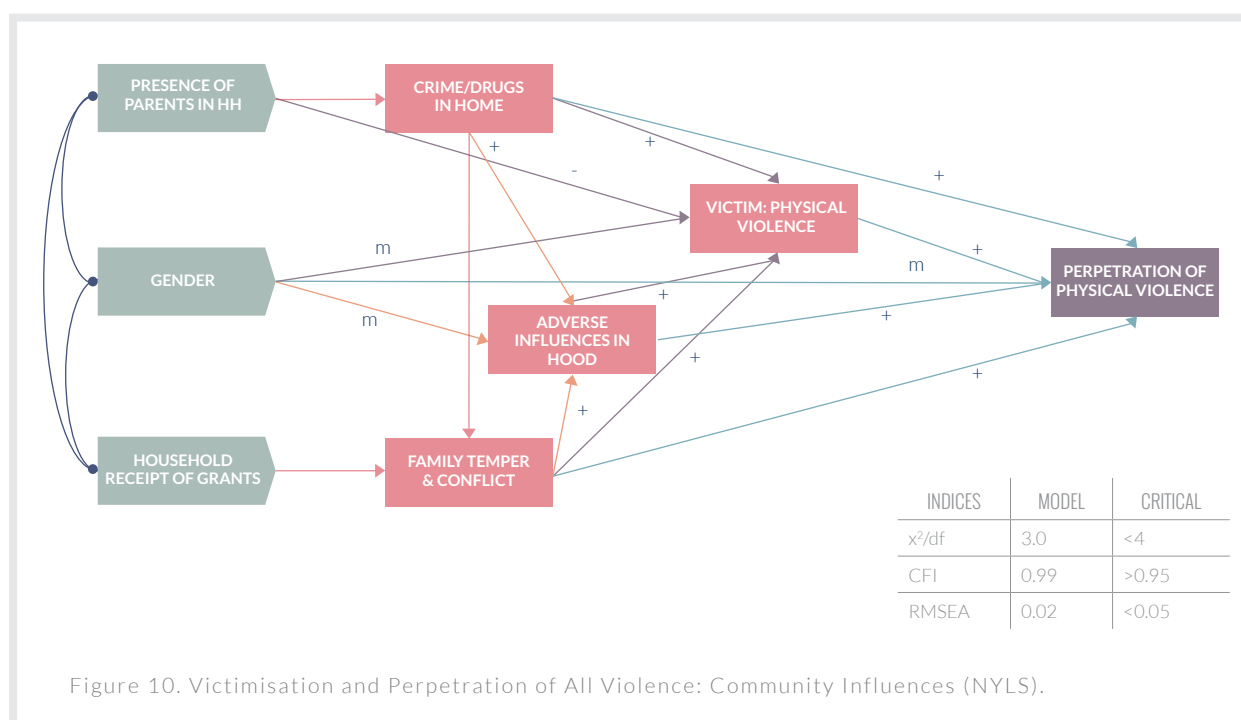


Figure 9. Victimization and Perpetration of Violence (including Bullying) (NYLS).



2.5.2.3 NYLS SEM: Key Findings

Risk/Protective Factors: Base/Background Variables

- **Family Structure** – A critical factor is the presence or absence of one or both of the parents in the household. Children living in households where none of their parents are present are at the highest risk for violence, while those with one parent present are at moderate risk and those with both parents present at lowest risk. Clearly, having both parents at home to look out for children is a strong defence against them becoming victims of violence, as well as for them perpetrating violence.
- **Household Indigence (poverty proxy)** – Children from households with scarce financial resources are significantly more likely to experience violence in some form as well as to perpetrate it.
- **Gender** – Males are significantly more likely than females to be victims of physical violence while females are significantly more likely to suffer emotional and sexual violence. Males are at greater risk for perpetrating all forms of violence.

Risk/Protective Factors: Intermediate Variables

- **Presence of Drugs and Crime in Household** – Children living in households where they are exposed to drugs/ alcohol and crime as a result of some household member

present are at greater risk for violence. Additionally, such influences also work to place them at greater risk for substance use and abuse, which also leads to greater risk of violence.

- **Family Temper and Conflict** – Households with heightened temper and conflict resorting to violence place children at greater risk for suffering violence as well as perpetrating it. Such family temper and conflict is an indication of the pervasive impact of poverty on family life and dynamics.
- **Current Adverse Influences in Hood** – As with exposure to adverse influences in the household, greater exposure to community members who are involved in drugs/ alcohol and/or crime places children at greater risk for violence, both as victim and perpetrator. Boys are significantly more likely than girls to associate with such persons in the community and thus more vulnerable to suffering violence and at greater risk for perpetrating it.
- **Alcohol Use and Abuse** – Children who use and abuse alcohol are at higher risk in terms of perpetration of violence. Alcohol use/abuse is most affected by exposure to these substances in the household and exposure to it in the community. Boys are at much higher risk than girls.
- **Drug Use** – Children who use drugs are at higher risk in terms of perpetration of violence. Drug use is most affected by exposure to these substances in the household and exposure to it in the community, as well as

the experience of violence. Boys are at much higher risk than girls in this regard.

- **Community Engagement** – Children from households with higher levels of conflict are more likely to escape such conflict by engaging with community structures, but those who have suffered physical violence as a result of this family conflict are significantly less likely to do so. Greater participation in such structures could serve as a protective factor by removing the child from a high-conflict family situation, even if temporarily.

Risk/Protective Factors: Victimisation and Perpetration

- Girls are significantly more likely to perceive and report emotional violence than are boys.
- Girls are at significantly greater risk for sexual violence than are boys.

- Both boys and girls appear to be at equal risk for suffering physical violence at home, though boys are at greater risk for such violence outside the home.
- Children who have suffered some form of violence at home are at a greater risk for experiencing violence outside the home.
- Children who have suffered some form of violence are significantly more likely to perpetrate violence against others, be it in the home, the community or at school.
- Perpetration of violence appears to begin in the home and extends outside the home into the community.
- Boys are significantly more likely than are girls to perpetrate all forms of violence, even when all other determinants are held constant.



03

VIOLENCE AGAINST WOMEN: RESEARCH FINDINGS

South Africa is said to have one of the highest rates of gender-based violence in the world. Research shows that a woman is killed every eight hours by an intimate partner, while as many as 42% of men have admitted to perpetrating IPV. The prevalence of non-intimate partner rape is also worryingly high. This section provides a critical review of the existing research and legislation as well as the findings of the structural equations modelling on violence against women in South Africa.

3.1 DEFINITIONS

Women are considered to be all females over the age of 18. The main forms of violence against women (VAW) measured in South African studies are defined in Table 7 (opposite page). Where available, the definitions used in this review follow those used in South African legislation.

3.2 BACKGROUND

It is difficult to estimate the true extent of VAW in South Africa owing to the interrelated problems of a lack of reliable national prevalence estimates for intimate partner violence (IPV) and non-intimate partner (IP) sexual violence²⁷, and the widely recognised degree of under-reporting of these types of violence. For instance, South African Police Service (SAPS) data shows that 0.3% of women in Gauteng report domestic violence (DV) to the police whereas survey data shows that 18.13% of women in Gauteng are victims of DV [103].

Dedicated population-based VAW studies have provided us with a broad idea of the size of the problem. Women reported a high rate of gender-based violence (GBV²⁸) in Gender Links' four-province study, with prevalence rates ranging from 36% in KwaZulu-Natal, 45% in the Western Cape, 51% in Gauteng and 77% in Limpopo [189]. Further, 28.3% of women in the Northern Province, 33.8% of women in the Eastern Cape, and 37.9% of women in Mpumalanga reported having ever experienced IPV [190]. Similarly, in a study conducted with women attending an antenatal clinic in KwaZulu-Natal, 31% had experienced DV [191].

3.2.1 Intimate Partner Violence

IPV is the most predominant form of GBV. A multi-country household survey on DV conducted by the WHO found that globally, women are at greatest risk of violence in their intimate relationships (IRs) [192]. Provincial estimates of victimisation and perpetration are worryingly high (see Table 8 and Table 9). Men in Gauteng and KwaZulu-Natal confirmed higher rates of perpetration of IPV than women reported victimisation [189]. The Gender Links study highlighted the interrelation between different forms of IPV, with participants rarely reporting having experienced or perpetrated only one form of IPV. Among women attending antenatal clinics in Soweto, 55% reported a history of physical or sexual assault from a partner [56].

Women are frequently the victims of multiple types of IPV, with physical, emotional, economic, and/or sexual abuse co-occurring [189], [193]–[195]. Men who commit both physical and sexual IPV are also more likely to do so on many occasions, compared to men who commit only one form of IPV. In the rural Eastern Cape, 89.7% of men who had perpetrated both sexual and physical IPV had perpetrated it on multiple occasions compared to 41.8% of men who had only perpetrated physical IPV and 54.4% of men who had only perpetrated sexual IPV [196].

3.2.2 Emotional Violence

Research has found emotional/psychological violence to be the most common form of IPV in South Africa, with prevalence rates of over 40% [191], [196], [198]. Across provinces, emotional IPV victimisation and perpetration are reported more frequently than other forms of IPV (see Table 8 and Table 9 on page 68).

3.2.3 Sexual Violence

SAPS national crime statistics show that women aged 18 and older were the victims of 29 928 sexual assault cases in 2012/2013 [12]. While the prevalence of sexual violence is high, it is difficult to accurately determine prevalence statistics in South Africa because of the high rate of under-reporting. For instance, research in Gauteng indicates that as few as 1 in 25 women report rape to the police – this includes rape by an IP or a non-IP [103]. It is generally accepted, therefore, that police statistics do not reflect the true magnitude of VAW. Community-based surveys are likely to yield more accurate results.

Gender Links found that sexual IPV was the least reported form of IPV (see Table 8 and Table 9 respectively). For non-IP sexual violence, 12% of women in Gauteng, 6% of women in the Western Cape, 5% of women in Limpopo and 5% of women in KwaZulu-Natal reported non-IP rape [189]. Men reported perpetrating non-IP rape more frequently than women reported experiencing it. Interestingly, a number of studies reported higher rates of non-IP sexual violence than sexual IPV [109], [110], [199].

Gang rape is also common in South Africa. In one study, 20% of men admitted to having been involved in a gang rape incident, either as perpetrators, supporters or witnesses [20], [199]. Lower perpetration and victimisation estimates are reported in other studies [200]–[202].

²⁷ Non-IP sexual violence refers to rape and sexual assault by a non-partner and is used interchangeably with these terms in the report.

²⁸ GBV was defined as “physical, sexual, psychological and economic intimate partner violence; rape and sexual assault by a partner, stranger, acquaintance or family member, experienced by adults and in childhood; and sexual harassment at school or work” [103].

TYPE OF VIOLENCE	DEFINITION	SOURCE
VIOLENCE	"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation".	WHO [4]
VIOLENCE AGAINST WOMEN	"Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".	United Nations Declaration on the Elimination of Violence Against Women (1993)
DOMESTIC VIOLENCE	"Physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into ... residence without consent, where the parties do not share the same residence; or any other controlling or abusive behaviour...; where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the complainant", and which occurs "within a domestic relationship".	The Domestic Violence Act (No. 116 of 1998)
INTIMATE PARTNER VIOLENCE	"Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Such behaviour includes: Acts of physical aggression – such as slapping, hitting, kicking and beating; Psychological abuse – such as intimidation, constant belittling and humiliating; Forced intercourse and other forms of sexual coercion; Various controlling behaviours – such as isolating a person from their family and friends, monitoring their movements, and restricting their access to information or assistance".	WHO [4, p. 89]
PHYSICAL ABUSE	"Any act or threatened act of physical violence towards the complainant".	Domestic Violence Act (No. 116 of 1998)
ECONOMIC ABUSE	"(a) The unreasonable deprivation of economic or financial resources to which a complainant is entitled under law or which the complainant requires out of necessity, including household necessities for the complainant, and mortgage bond repayments or payment of rent in respect of the shared residence; (b) the unreasonable disposal of household effects or other property in which the complainant has an interest".	The Domestic Violence Act (No. 116 of 1998)
SEXUAL ABUSE	"Any conduct that abuses, humiliates, degrades or otherwise violates the sexual integrity of the complainant".	The Domestic Violence Act (No. 116 of 1998)
RAPE	"All forms of sexual penetration without consent, irrespective of gender".	Sexual Offences and Related Matters Amendment Act (No. 32 of 2007)
SEXUAL ASSAULT	"All forms of sexual violation, without consent" including inspiring the belief in a victim that they will be sexually violated.	Sexual Offences and Related Matters Amendment Act (No. 32 of 2007)
EMOTIONAL, VERBAL AND PSYCHOLOGICAL ABUSE	"A pattern of degrading or humiliating conduct towards a complainant, including (a) repeated insults, ridicule or name calling; (b) repeated threats to cause emotional pain; or (c) the repeated exhibition of obsessive possessiveness or jealousy, which is such as to constitute a serious invasion of the complainant's privacy, liberty, integrity or security".	Domestic Violence Act (No. 116 of 1998)

Note: *According to the Domestic Violence Act (No. 116 of 1998) persons are in a domestic relationship when they are married; cohabit, or have previously done so, "in the nature of marriage"; are the parents of a child or persons who hold parental responsibility for a child; are family members; are persons who are engaged, dating or in a customary relationship, whether actual or perceived; or share or have recently shared a residence.

Table 7. Definitions of the Types of Violence against Women in South Africa.

PROVINCE	INTIMATE PARTNER VIOLENCE				
	ALL	SEXUAL	PHYSICAL	EMOTIONAL	ECONOMIC
GAUTENG	51%	18.2%	50.5%	65.2%	28.5%
LIMPOPO	51%	6.9%	23.0%	31.0%	13.0%
KWAZULU-NATAL	29%	9.7%	20.9%	22.7%	13.9%
WESTERN CAPE	44%	13.9%	26.7%	39.1%	13.2%
NORTHERN PROVINCE	-	-	19.1%	-	39.6% ^a
EASTERN CAPE	-	-	26.8%	-	51.4% ^a
MPUMALANGA	-	-	28.4%	-	50.0% ^a

Note: ^aPercentages refer to past year experience of violence. All other percentages refer to lifetime experience of violence

Table 8. IPV Victimization of Women in Seven Provinces [189], [197].

PROVINCE	INTIMATE PARTNER VIOLENCE				
	ALL	SEXUAL	PHYSICAL	EMOTIONAL	ECONOMIC
GAUTENG	78%	18.8%	33.1%	43.7%	22.3%
LIMPOPO	44%	12.1%	25.9%	36.1%	14.2%
KWAZULU-NATAL	46%	15.4%	30.4%	36.4%	19.8%
WESTERN CAPE	35%	4.7%	18.9%	28.6%	7.2%

Table 9. Perpetration of IPV by Men in Four Provinces [189].

3.2.4 Physical Violence and Homicide

According to the SAPS national crime statistics for 2012/2013, women were the victims of 83 394 incidents of common assault, and 55 320 incidents of grievous bodily harm (GBH) [12]. Much of this physical violence takes place within intimate partner relationships (IPRs). Across studies, physical IPV is one of the most commonly reported forms of IPV. Table 8 provides provincial estimates for physical IPV victimisation. In the national South African Stress and Health (SASH) study, 31% of participants reported physical IPV in their most recent relationship [203]. Slightly lower lifetime and past-year physical IPV perpetration and victimisation rates were found in the national South African Social Attitudes Survey (SASAS); 9.5% of female participants reported ever experiencing physical IPV, with 6.7% reporting past year victimisation [204]. A number of provincial studies with men have confirmed high rates of physical IPV perpetration [20], [196]. A slightly lower proportion of men (8.3%) reported ever perpetrating physical IPV in the SASAS [204] (see Table 9 for additional provincial estimates).

The most extreme form of physical violence is homicide. Intimate partner femicide (IPF) was the leading form of

femicide (female homicide) in South Africa in 2012/2013 [121]. SAPS national crime statistics show that there were a reported 2 671 cases of attempted femicide and 2 266 cases of completed femicide, during this period [12]. Since 1999, there has been a significant decrease in overall femicides in South Africa, but an increase in the proportion of those committed by IPs and an increase in the proportion of non-IP rape homicides. The 2nd National Female Homicide Study estimates that 57% of all femicides in 2009 were due to IPV, an increase from the 1999 study [205]. Although South Africa has seen an overall decrease in femicides over time, there has been no decline in rape homicides; suggesting that rates of sexual violence remain high over time in South Africa [206].

3.2.5 Economic Violence

There is a dearth of research on economic violence/ abuse in South Africa. That which has been conducted indicates that rates of economic IPV vary between provinces (see Table 8 and Table 9). The rates reported for victimisation in the Eastern Cape, Mpumalanga and the Northern Province in Table 8 refer to both economic *and* emotional abuse, while the statistics for specific acts of economic abuse are shown in Table 10.

ACT OF ECONOMIC VIOLENCE	EASTERN CAPE	MPUMALANGA	NORTHERN PROVINCE
PREVENTED FROM WORKING	5.9%	8.1%	3.7%
EVICTED FROM HOME	5.3%	9.0%	3.6%
HAS NOT PROVIDED MONEY TO RUN THE HOME OR LOOK AFTER CHILDREN BUT HAS MONEY FOR OTHER THINGS	10.2%	15.7%	10.1%

Table 10. Prevalence of Acts of Economic IPV [207].

3.2.6 Consequences of VAW

VAW is widely recognised as a significant public health concern owing to the extensive short- and long-term consequences. In South Africa, IPV accounts for 5.4% of the total disease and injury burden for women and 10.9% of all Disability Adjusted Life Years (DALYs) [208]. Beyond the immediate physical injuries resulting from IPV, IPV also places women at risk of HIV infection [195], [209], [210]. Exposure to physical and sexual IPV accounts for 7% of the HIV/AIDS burden in South Africa [208]. South African literature has also drawn associations between various forms of IPV and depression, anxiety, suicidal thoughts and tendencies, emotional distress, substance abuse and smoking [198], [203], [211]–[213]. Among South Africans exposed to violence, a nationally representative study revealed that for women, rape was most strongly associated with later development of PTSD [214]. A limitation of this study was that it did not delineate between IP and non-IP rape and therefore one cannot determine whether there is a stronger association between (a) IP rape or (b) non-IP rape and the later development of PTSD. The findings of these studies, with regards to the association between VAW and psychosocial disorders, are consistent with international literature [215]–[217]. Psychosocial disorders contribute to the considerable burden of disease attributable to VAW. A more comprehensive understanding of the risk and protective factors for VAW in South Africa is needed in order to strengthen the response to this crisis.

3.3 LEGISLATIVE FRAMEWORK

South Africa has one of the most progressive and gender-equitable constitutions in the world and has numerous laws and policies designed to protect, promote and uphold the rights of women [189], [218]. At the international level, the ratification of a number of conventions contributes to protection against violence for women in South Africa. These include: the Convention on the Elimination of all forms of Discrimination Against Women of 1979; the International Convention on Civil and Political Rights of 1966; the African Charter of Human and Peoples' Rights of 1981; and the Maputo Protocol of 2003.

At the national level, various legislative measures have been introduced to protect the rights of women. When effectively implemented, the following may help to protect women from violence: the Constitution of the Republic of South Africa (No. 108 of 1996); the Firearms Control Act (No. 60 of 2000); the Domestic Violence Act (DVA) (No. 116 of 1998); the Sexual Offences and Related Matters Amendment Act (SOA) (No. 32 of 2007); the Labour Relations Act (No. 66 of 1995) and Code of Good Practice on Handling Sexual Harassment Cases; the Protection from Harassment Act (PHA) (No. 17 of 2011); the Promotion of Equality and Prevention of Unfair Discrimination Act (No. 4 of 2000); and the Employment Equity Act (No. 55 of 1998) [218], [219].

3.3.1 Firearms Control Act

In response to both SAPS and public concerns about firearm crime and the problematic nature of firearm control in South Africa, Parliament initiated an overhaul of firearm legislation in the late-1990s. The Firearms Control Act (FCA) (No. 60 of 2000) was subsequently formulated, which eventually became fully operational in 2004 with the promulgation of its requisite regulations. It was amended in 2006, principally to address technical deficiencies and administrative oversights.

The FCA included the introduction of more rigorous firearm licencing requirements, such as: extensive background checks of applicants; an increase in the legal minimum age to possess a firearm to 21 years; a reduction in the number of licensed firearms and rounds of ammunition that an individual may possess; and the requirement that firearms be stored in secure safes. Penalties for licensing infringements and firearm misuse also became more stringent. In addition, all licence applicants were required to successfully complete a written test relating to firearm legislation, as well as undergo prescribed training and pass a practical test on the safe handling of a firearm with an accredited service provider. License holders were also required to renew their firearm licenses every five years.

It has been suggested that the Firearms Control Act (No. 60 of 2000) may have provided a measure of protection against violence since it came into effect mid-2004. Findings from the 2nd National Female Homicide Study show a decrease in the

overall number of femicides, a smaller decrease in IPFs, and a significant decrease in IP and non-IP firearm-related homicides from 1999 to 2009 [121]. The latter finding in particular points to the potential efficacy of the Act in reducing firearm-related homicides and femicides and calls for increased effort to assess the impact and implementation of the Act. However, it is not clear whether the Act is responsible for the decrease. Unfortunately, although there was a decline in these rates for a period, over the last two years South Africa has witnessed an increase in homicide rates [220]. It would be important to further investigate the factors behind this increase, as well as whether there has been a similar increase in femicides.

3.3.2 Domestic Violence Act

The DVA (No. 116 of 1998) was promulgated in 1999 in response to the limitations of the previous legislation²⁹ and the high levels of DV in South Africa [221]. The Act provides a definition of DV which includes “physical abuse, sexual abuse, emotional, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, entry into the home without the complainant’s permission, and any other abusive, controlling behaviour” [222]. The Act aims to offer extensive protection to DV victims through the issuing of protection orders and the arrest of abusers if they violate these orders [221], [223]. Further, it calls for the referral of victims to shelters, counselling and medical care where necessary [221], [223]. A limitation of this provision, however, is that while the DVA obliges the police to find shelters and counselling services for victims, but neither the Department of Social Development (DSD) nor the Department of Health (DOH) is mandated to provide these services. As a result, there are insufficient shelters and counselling services for victims [223].

A report published in 2010 indicated that both SAPS and the Department of Justice and Constitutional Development (DoJ&CD) had failed to fulfil many of their duties with regards to the DVA [223]. Many DV victims who apply for protection orders are never granted them, with fewer than half ever qualifying for them. This has been particularly noted in the Western Cape. Other departmental failures include (a) inadequate record-keeping of DVA cases at many police stations, (b) inadequate training of policemen and court officials concerning the DVA, (c) secondary victimisation by court officials, (d) failure to issue regular reports, and (e) lack of police accountability for failure to adequately intervene in DV cases.

3.3.3 Sexual Offences and Related Matters Amendment Act

In *Carmichele v Minister of Safety and Security* the South African Constitutional Court remarked that “in relation to dignity and

freedom and security of the person few things can be more important to women than freedom from the threat of sexual violence” [224]. The SOA (No. 32 of 2007), redefined rape and sexual assault and drew together all sexual offences under one law [225], [226]. The Act expanded the definition of rape from penile penetration of the vagina to include “all forms of sexual penetration without consent, irrespective of gender” [227]–[230]. The SOA also replaced the definition of indecent assault with sexual assault, defined as “all forms of sexual violation, without consent” [227], [230].

The SOA focuses on an integrated approach to managing sexual offences through an intersectoral implementation of the SOA and the National Policy Framework on the Management of Sexual Offences [228], [231]. The Act upholds a victim-centred approach by outlining various services for victims including post-exposure prophylaxis (PEP) and counselling, and mandatory HIV testing for offenders [223], [225], [226]. It also includes a specific focus on the vulnerability to sexual offences faced by individuals with mental disabilities [223], [231]. The government, however, has been slow in implementing this legislation, with the National Policy Framework on the Management of Sexual Offences only being adopted in 2013 [225], [231]. Furthermore, the SOA has not been uniformly implemented and there have been failures to systematically establish Sexual Offence Courts across the country [223], [225].

3.3.4 Implementation Challenges

While there has been a strong push for gender equality in South Africa post-1994, the legislation, such as the DVA, and policies that address dominant patterns of gender-unequal behaviour and VAW have been poorly enforced [223]. In one study, a large proportion of male and female participants perceived that there had been an increase in the incidence of DV, that they had less freedom of movement and were less physically safe than during Apartheid [218]. Across provinces, failure by the police to comply with the DVA or effectively deal with DV complaints has resulted in an under-reporting of IPV incidents [189].

Reasons for police non-compliance with the DVA include (a) a lack of understanding amongst the police concerning the DVA and their obligation to implement it; (b) a lack of available printed copies of the DVA and National DV Regulations amongst police; (c) poor record-keeping; (d) gaps in police data concerning the relationship between victim and perpetrator and gaps in femicide data; (e) delays in disciplinary action for police who fail to comply with the Act; (f) failure to notify the Independent Police Investigative Directorate (IPID) of non-compliance; and (g) a culture of silence around DV [189].

²⁹ Namely, the Prevention of Family Violence Act, which did not address violence by cohabiting and same-sex partners.

There is also a high level of under-reporting of VAW crimes in South Africa, owing in part to the widespread lack of confidence in the police and the South African criminal justice system [232]. In the KwaZulu-Natal sample of the Gender Links study, women reported their experiences of physical IPV and non-IPV rape more frequently to medical facilities than to the police [202]. Under-reporting contributes to continued VAW perpetration as perpetrators do not fear the consequences of their actions [189].

This lack of confidence is understandable, with recent figures indicating that there is only a 7% conviction rate for rape in the Western Cape and 4% conviction rate in Gauteng [22], [233]. In Gauteng, women (18 years and older) fare worse at the hands of the criminal justice system compared with girls (younger than 18 years) [22]. Vetten et al. identified failures at all levels of the system, including inadequate case investigation and prosecution – 46.8% of reported cases of rape led to arrests and only 14.7% of cases were brought to trial. Further, only 4.1% of reported cases of rape of women resulted in perpetrator conviction, compared with a conviction rate of 10.1% for reported cases of rape against girls.

There has also been a failure in offering an integrated approach to addressing VAW across government departments [218]. Gender Links highlighted the lack of coordination between the government and civil society organisations that are working to combat VAW, noting an insufficient allocation of resources for effective implementation, monitoring and evaluation of the 365 Day National Action Plan to End GBV [189].

Not all forms of sexual violence are classified as crimes in South Africa. Some sexual harassment, for example, is considered as an issue of misconduct and is dealt with in terms of labour law, and institutions' disciplinary codes. For example, sexual harassment is dealt with under the Employment Equity Act (No. 55 of 1998) as a form of discrimination [234]. The National Economic and Development Labour Council (NEDLAC) issued under section 203 (1) of the Labour Relations Act (No. 66 of 1995) a Code of Good Practice on Handling Sexual Harassment Cases [235]. This code focuses on eradicating sexual harassment in the work environment.

The Protection from Harassment Act (PHA) (No. 17 of 2011) was introduced to ensure “effective remedy against such behaviour” for victims of harassment [236]. This includes victims of stalking and electronic harassment. This Act provides an additional element of protection to that provided under the DVA. Since the introduction of the DVA, electronic communication has evolved considerably; as well as the use of it as a medium of abuse. Limited research has been conducted on the use of the internet and electronic communication as a medium by which women in South Africa are abused [237]. The

increased use of the internet and electronic communication places South African women at increasing risk of cyber harassment and emotional abuse. More research therefore needs to be conducted on the nature and extent of cyber abuse faced by women in South Africa.

3.4 CONSTRUCTING A CONCEPTUAL FRAMEWORK FOR VAW

3.4.1 Overview of the Evidence Base in South Africa

The primary inclusion criteria for this review were drawn from literature published post-2000 that addressed risk and/or protective factors for VAW in South Africa. General search terms, used in various combinations, included *women, risk factors, protective factors, resilience factors, predictors, violence, gender-based violence, abuse, rape, and South Africa*. Material accessed included qualitative and quantitative work in the form of peer-reviewed journal articles, reports, working documents, presentations and unpublished theses. The reference lists of retrieved studies were used to identify additional relevant research, as was expert knowledge of the area.

Our understanding of the factors associated with VAW has been extended owing to a number of well-designed studies using both quantitative and qualitative designs, with a focus on both men as perpetrators and women as victims.

Although the risk factors that influence VAW have received considerable attention in published literature globally, a challenge in South Africa is the lack of comprehensive, reliable, and nationally representative data on risk and protective factors. Other challenges include a lack of consistency across studies, particularly in the use of universal definitions of violence. The studies that have addressed the factors influencing VAW in South Africa have made use of a variety of definitions for the different forms of VAW as well as diverse methods, sampling frames, and analyses. As a result, the comparability of findings across studies is challenging.

In addition, physical and sexual IPV have received considerably more attention than emotional and economic violence, partly owing to the fact that these other forms of violence are particularly difficult to measure. This means that our understanding of emotional and economic VAW is less robust than of physical and sexual VAW. While we know from international literature that certain groups of women may be

particularly vulnerable to violence, including elderly women, refugee and migrant women, and women with disabilities, there is limited understanding of the nature and risk of violence these women face in South Africa.

Through critical engagement with South African studies on VAW, the reliability and plausibility of findings were assessed. Qualitative studies, referred to in the review, provide helpful descriptions and in-depth understanding of the factors associated with VAW; however, such studies cannot determine empirical/statistical associations between factors and experiences of violence. A number of studies reviewed were small-scale, conducted with specific communities in certain locations (e.g. men working in municipalities in Cape Town [193] or women presenting for antenatal care in Soweto [209]), and therefore findings cannot be generalised to the larger population. However, such studies are useful for identifying important risk and protective factors, particularly where study findings are supported by other research.

There are a few key large-scale quantitative studies that provided helpful data. Nationally representative studies which provided useful data for this review include: (a) the 2003 SASAS, which assessed the prevalence and predictors of physical IPV; and (b) the 1st and 2nd National Female Homicide Studies which were conducted by Abrahams et al. in 1999 and 2009 respectively. Key provincial studies which provide evidence on the associated risk factors for IPV and non-IP rape include: (a) the 1998 study conducted in the Eastern Cape, Mpumalanga and Northern Province (hereafter referred to as the three-province study); (b) a randomised control trial (RCT) conducted in the rural Eastern Cape between 2002 and 2003 (hereafter referred to as the Stepping Stones study); (c) a four-province study conducted by Gender Links in KwaZulu-Natal, Gauteng, Limpopo and the Western Cape between 2009 and 2010; (d) a 2009 study conducted by Jewkes et al. in three districts in the Eastern Cape and KwaZulu-Natal (hereafter referred to as the three-district study); and (e) Vetten et al.'s study conducted on the processing and outcomes of rape complaints in the criminal justice system in Gauteng.

The majority of the studies identified in this review were cross-sectional in design and thus were only able to provide descriptive statistics, prevalence estimates or associations between risk and protective factors and VAW at a single point in time; through between group comparisons or regression analyses. There are few nationally representative longitudinal studies, although such studies are better at describing possible cause-effect relationships between risk and protective factors and VAW. The Stepping Stones study has gathered some longitudinal data [199] and a small-scale study with pregnant women in Durban provides longitudinal data mapping the trajectory of IPV over pregnancy and the post-partum period [238].

Previous literature has identified numerous risk and protective factors operating at each level of the socio-ecological model. In the following sections the factors operating at each level, namely the individual, relationship, community, and societal, are discussed. This is done through analysing how the following questions are answered in the available South African literature:

1. What are the most relevant risk and protective factors that relate to violence against women in South Africa at the individual, relationship, community and societal levels?
2. To what extent are these risk and protective factors supported by sufficient evidence?

3.4.2 Individual Level Risk Factors: Victimisation

Individual level risk factors for women's victimisation include previous victimisation, substance use, age, level of education, socio-economic status (SES), gender attitudes and being part of a vulnerable group.

3.4.2.1 Previous Victimisation

South African findings indicate that women who grow up in homes where they are exposed to violence and women who are victimised in other settings are at greater risk for future victimisation. Experiences of childhood sexual assault are significantly associated with experience of physical and sexual IPV and non-IP sexual violence in adulthood [56], [103]. In addition, forced early sexual experiences increase the risk for later revictimisation. Experiencing frequent childhood beatings and observing maternal IPV victimisation places females at greater risk for later experience of IPV and non-IP sexual violence [103], [189], [190]. The reasons suggested for this are that (a) growing up in a violent home increases the likelihood that children will normalise violence and so girls from such homes may have a greater tolerance for IPV; and (b) women who are severely beaten during childhood often have a lower self-esteem, which makes them less likely to leave a violent relationship [190]. These findings correlate with international findings, which indicate that women who are sexually and physically abused as children are at a higher risk of adult re-victimisation [192], [239]–[242].

The finding of a relationship between childhood victimisation and adult re-victimisation needs to be interpreted with caution in case this leads to victim-blaming. International findings provide some helpful explanations for this relationship, including: (a) that Post-Traumatic Stress Disorder (PTSD), following child abuse can cause victims to be slower at

perceiving imminent danger, which increases the risk of re-victimisation; (b) the relationship between childhood sexual abuse and an increase in consensual adolescent and adult sexual behaviour, which can in turn increase the risk for sexual assault; and (c) that child abuse victims may be more likely to use substances to deal with past traumas, which increases their vulnerability to sexual risk-taking behaviour and future victimisation [240]. The problem of re-victimisation is complex and more longitudinal research on this issue is needed.

3.4.2.2 Substance Use

Numerous South African studies have highlighted the role of substance abuse in increasing a woman's risk for GBV, particularly IPV [94], [186], [209], [243], [244]. The SASH survey found that in comparison with women who had never been abused, those who had been abused were 1.7 times more likely to have previously smoked, 1.9 times more likely to be currently smoking, twice as likely to have previously drunk alcohol, 2.4 times more likely to currently abuse alcohol or sedatives, and 3.8 times more likely to have used marijuana [203]. Most significantly, women who were abused were 48 times more likely to have used marijuana in the previous 12 months.

The Stepping Stones study found that hazardous alcohol consumption was associated with experience of physical and sexual IPV with or without emotional IPV, but was not associated with experience of emotional abuse alone [211]. Drug use³⁰, however, was associated with experience of emotional abuse in combination with physical and/or sexual abuse. In the three-province study, drinking alcohol was associated with past-year and lifetime experience of physical IPV [190]. While the study did not assess whether the level of alcohol consumption affected IPV, it highlighted the fact that heavy drinking is common in South Africa.

Research also points to the relationship between IPV, female drinking and 'punishment' by male partners [164], [190], [243]. Violence against women who drink is sometimes perceived to be justified, as by drinking, women are seen to violate social norms of appropriate female behaviour. IPV is thus seen to be a means to punish women for their 'transgressions' and for perceived infidelity [190], [244]. For instance, 24.1% of men working in three municipalities in Cape Town said that physical IPV was appropriate if a female partner was found drinking [243]. A female partner's use of alcohol significantly predicted a man's physical IPV perpetration.

Heavy social drinking is particularly common in rural farming areas in the Western Cape, owing to the historical legacy of the 'dop system'³¹. Matthews et al. explored the association

between alcohol and femicides in the Western Cape, finding that in 1999, 62% of female homicide victims had a high blood alcohol concentration (BAC) at time of death [94]. Women with a higher median BAC at time of death were more likely to be over 29 years old and either unemployed or have an unknown employment status. They were also more likely to be killed in a public space, in a rural setting, on the weekend and to be killed by an IP. Being killed over the weekend and in a public space was significantly associated with having a high BAC at time of death, highlighting the widespread social acceptance of heavy drinking. In firearm-related femicides women were more likely to be sober, whereas women killed by blunt or sharp force were more likely to have a high BAC at time of death.

Qualitative research in a township setting identified taverns and bars as high-risk venues for VAW [244]. Women who frequent taverns are often subject to verbal and physical abuse by their IPs as a result of their consumption of alcohol and related behaviour. This is often a cyclical relationship, with women who drink becoming aggressive and violent. Sometimes this aggression is in response to male violence and other times it is met with further male violence. Alcohol is described as giving women the courage to respond to violence as well as being used to normalise and accept experiences of violence, with such instances often being 'forgotten' or overlooked the next day.

A limitation of the research on substance use and VAW is that it is unable to identify whether substance use precedes or follows victimisation. Reasons offered for the relationship between alcohol and VAW include: (a) the disinhibiting effect of alcohol which can cause conflict to become violent; (b) that alcohol use increases a woman's vulnerability; (c) that men perceive women who drink alcohol to be more likely to be unfaithful and IPV is used as a means to punish them for sexual infidelity; and (d) that women's substance use is used to cope with the abuse and associated trauma [94], [190], [204], [211], [243]. The latter suggests that substance use is an outcome of IPV or that a possible bidirectional relationship exists between IPV and substance abuse.

3.4.2.3 Age

Findings regarding the association with age were varied. While females of all ages are at risk of violence, women 18 years and older comprise just over half (60.2%) of all female rape victims in Gauteng [22]. Compared to young girls (0 – 11 years), women are at greater risk of being gang raped (20.0% vs. 8.2%). Women are also more likely than teenagers (12 – 17 years) and young girls to be raped by strangers (48.1% vs. 28.6% and 14.6% respectively). Furthermore, compared to the

30 Drugs used included "marijuana, mandrax, injectable drugs, substances that were sniffed, or other substances" [211, p. 866].

31 The DOP system refers to the "...payment of alcohol to farm workers as part of their conditions of service" [245].

rape of young girls, the rape of women is much more likely to be violent (i.e. to involve weapons and lead to injuries).

Some research suggests that younger women are most at risk of violence. With regards to non-IP rape, Gender Links found that a larger proportion of victims in Gauteng were younger women, aged 18 – 29 years (43.75%), than older women aged 30 – 44 years (26.56%) and 45 years and older (29.59%) [103]. There are conflicting findings, however. In Limpopo, while age was significantly associated with non-IP rape, a significantly greater proportion of women aged 30 to 44 years reported having ever suffered non-IP rape, compared to women of other ages [200]. There was no reported association between age and non-IP rape victimisation in KwaZulu-Natal and the Western Cape [201], [202].

While no significant difference was found in lifetime prevalence of IPV across age categories in the Western Cape, there was a higher prevalence of past-year IPV among women aged 18 to 29 years (18%) compared to women aged 30 to 44 years (15%) and women 45 years and older (5%) [201]. Further, younger pregnant women aged 17 – 25 years in rural KwaZulu-Natal were at greater risk of DV than older women [191]. Comparatively, Gender Links found no difference in the prevalence of IPV (both lifetime and previous 12 months) between the different age categories in Gauteng [103], Limpopo [200] or KwaZulu-Natal [202]. Findings suggested that, except perhaps for the Western Cape, women of all ages in South Africa are equally vulnerable to IPV [189].

Lack of research, particularly nationally representative research, makes assessing the relationship between age and VAW, challenging. Provincial studies generally indicate that women in their twenties are the most vulnerable, particularly to non-IP rape, but that there is no significant association between age and IPV.

3.4.2.4 Education and Socio-Economic Status

General Household Survey (GHS) data highlights the gendered nature of poverty in South Africa [246], with female-headed households being significantly more likely to be poor (53.9%) than male-headed households (31.7%). Female-headed households are also more likely to be receiving lower incomes, have no employed individual in the home, and be receiving social grants. This is partly owing to the historical legacy of women being denied the same access to education and economic resources and opportunities as men, a problem which persists. Further, single mothers often bear the double burden of economic and caregiver responsibilities, which restricts employment opportunities. Low SES women may be at particular risk to poor policy implementation, including protection from DV [218].

SES generally refers to an individual/ family's social and financial position compared to others. SES indicators can include education, income, employment status, occupation, household assets and/or food poverty. Findings regarding the association between education and VAW victimisation are mixed. Although Gender Links found no significant association between the two [189], [200], [201], a number of other studies found women with low levels of education to be at greater risk for IPV [190], [191], [204]. In the three-province study, women with no post-school education were significantly more likely to have experienced all forms of IPV [190].

Of participants who had experienced physical abuse in the past year, 3.7% had some post-secondary education, 15.6% had higher secondary education, 19.3% had lower secondary education and 35.8% had primary school education. In a small study conducted with women attending government antenatal clinics in rural KwaZulu-Natal, women with a very low level of education (i.e., no education or only primary school education) were at a higher risk of DV [191]. These findings may be skewed as women who are poorer and have lower levels of education are more likely to use government facilities. They correspond, however, with the findings of the three-province study that women with only a primary school education or less are at greater risk of IPV victimisation.

Beyond education, other indicators of low SES place women at a greater risk of certain types of violence. For instance, women in the lowest income bracket in South Africa (< R1 000 per month) are more likely to experience physical IPV [204]. Unemployed women are also at greater risk of psychological, physical, and sexual DV [191]. Unemployment can be disempowering, which can place women at greater vulnerability to exploitation in relationships. In addition, conflict over scarce resources in poorer households can trigger IPV.

Poor education and low SES can also increase the risk for victimisation through increasing the likelihood of engagement in transactional sex (i.e., having sex with a non-primary male partner in exchange for material goods or money). In Soweto, transactional sex is associated with an increased risk of IPV victimisation [186]. Women with post-secondary education are less likely to engage in transactional sex than those with lower levels of education. Living in sub-standard housing and household food insecurity (poverty indicators) are associated with engaging in transactional sex [186].

Possible explanations for these associations are: (a) less educated women generally have fewer employment opportunities and may therefore be in greater need of resorting to transactional sex for survival; and (b) poorly educated women are less able to achieve social status in their community through education or employment and may use transactional sex as a means of appearing successful. Women

who are economically destitute may be more likely to tolerate abuse in transactional sex relationships as they are more dependent on the resources they receive from the relationship [247]. Economic vulnerability can therefore increase the risk of women engaging in transactional sex, which increases their risk for IPV.

Qualitative research supports the finding that poverty increases women's risk for engaging in 'survival sex' (i.e., transactional sex). Participants, in a study by Fox et al., suggested that poor women tend to have more sexual partners in order to gain access to food [195]. Although this was a common perception, only one participant admitted to engaging in transactional sex for this reason. It is problematic to assume that women who engage in transactional sex are always economically vulnerable as some may engage in it for other reasons, such as sexual experimentation [247].

The racialised nature of poverty in South Africa has implications for the findings on race and VAW. The relationship between race and rape may be explained by the confluence of race and SES, with Black African and Coloured women more likely to be from a lower SES background. Studies acknowledged this by, for example, excluding race from regression analyses due to its confounding with low SES [204]. The SASAS found that Black African and Coloured women were at significantly greater risk for experiencing physical IPV [204]. Gender Links found no association between race and the experience of IPV or non-IP rape [189]. The only exception was in Gauteng, where Coloured and Indian women were at greater risk of non-IP rape than Black African or White women [103].

Many South African women live in poverty and various indicators of low SES are associated with violence. There is limited evidence of an association between educational status and VAW in South Africa, particularly with regards to non-IP sexual violence. Less educated women from lower SES backgrounds may be more likely to engage in transactional sex, however, which may increase their risk for IPV. Women who are unemployed or from lower SES backgrounds can have less power in IRs, which increases their risk of experiencing IPV and restricts their option to leave violent relationships. Conflict over scarce resources in poorer households may act to increase the risk of IPV.

3.4.2.5 Gender Attitudes

Local studies present limited findings as to the relationship between views on gender equity and risk of IPV. In the three-province study, having liberal attitudes on women's roles was significantly associated with experience of IPV [190]. Women who had ever been abused were less likely to agree that: (a) a woman should give her husband her earnings; (b) a woman

should obey her husband; (c) a woman needs permission from her husband before she can work; (d) the husband should be the final decision maker in the family; and (e) a husband can punish his wife when necessary.

Women who experienced IPV in the previous year held more liberal attitudes and were also more likely to believe that their husbands should help with the housework. Owing to the cross-sectional nature of this study, one cannot identify whether liberal attitudes preceded the violence, were a consequence of the violence, or whether a bi-directional association existed. The researchers suggested that men might see women's liberal attitudes as weakening their control, which they then try to reassert through violence.

Educated women tend to hold to more liberal gender attitudes while less educated women maintain conservative or traditional views. In the three-province study, there was a significant difference in subservience scores between women in the most and least educated groups [190]. Women's belief that they should be subservient decreased as women's education increased. At each education level, women who had experienced IPV in the past year had lower mean personal subservience scores than women who had not experienced IPV. This suggests that education may provide women with social empowerment, but that empowerment and decreased agreement with subservience may place women at risk of abuse in the short term until a critical level is reached.

Most participants in the Gender Links study, while supporting gender equality, upheld traditional gender norms in the home [103], [189], [200], [201]. These included the perception that the payment of *lobola* (bride price) condones a belief that a wife is a possession of her husband, and that a woman must obey her husband [200]. However, female participants' views on gender norms in the home were less conservative than men [103], [189].

Compared to findings in the three-province study, Gender Links found that in Limpopo women's attitudes concerning sexual entitlement in marriage remained conservative, but that women were less accepting of IPV and support for patriarchal norms was declining [200]. Female participants in Limpopo and KwaZulu-Natal still maintained more conservative gender attitudes compared with female participants in Gauteng and the Western Cape [103], [189], [189], [200]. It was suggested that the higher prevalence of conservative attitudes in Limpopo and KwaZulu-Natal was associated with rural socialisation and cultural factors in these provinces. Although this research highlights that traditional attitudes and beliefs with regards to gender roles are widespread, it does not show a statistical relationship between such attitudes and experiences of violence.

The WHO indicates that IPV is highest in societies where the position of women in the society is transitioning [4]. In societies where: (a) more gender equitable values are beginning to be embraced; (b) women are beginning to challenge traditional gender roles; and (c) more women are becoming educationally, politically, and economically empowered, men may feel that their dominance and power is being challenged. Men may be more inclined to perpetrate IPV in an attempt to maintain power and control in the traditional gender hierarchy [190], [192], [218].

3.4.2.6 Part of a Vulnerable Group

Specific groups of women may be at particular risk for violence, abuse, and exploitation because of their marginal status in society. These groups include lesbian and bisexual women, elderly women, women with disabilities, sex workers, and migrant and refugee women [53]. While for the purposes of this review being part of a vulnerable group has been outlined as a risk factor at the individual level, the existence of vulnerable groups point to issues at the societal level. Individuals are at risk of violence because they belong to particular groups. It is important to emphasise that this vulnerability is not due to some innate problematic quality of the individual, but rather owing to their membership in a group that is stigmatised, excluded and denied their rights. These groups are discriminated against, placing them at increased risk of violence. Through 'othering' of individuals based on their membership in certain groups; communities and societies increase the risk that these individuals will be victimised [248].

Lesbian and Bisexual Women

The South African Constitution upholds the right of homosexual individuals to equality and freedom from discrimination and violence [249]. While lesbian and bisexual (LB) women are legally protected and assured freedom from discrimination in South Africa, in reality many continue to face violence and discrimination [232], [250]. Violence against LB women in South Africa occurs in the context of widespread GBV. These women are also, however, often specifically targeted because of their sexual orientation [219], [251].

Violence against this group is associated with the perception that the LB lifestyle, appearance, and behaviour violates accepted religious, gender, and cultural norms [219]. A particular form of violence experienced by LB individuals in South Africa is 'corrective rape', where LB women are raped as punishment for their behaviour and in order to 'correct' their sexual orientation [251], [252]. Corrective rape is used to threaten the broader LB community to refrain from openly displaying their sexual orientation [252]. Male perpetrators use corrective rape as a means of reinstating patriarchal control and order in their communities and are sometimes

viewed as 'heroes' or 'role models' [219].

The proportion of violent crimes committed against LB women in South Africa is difficult to determine, as one is not required to identify one's sexual orientation or gender identity when reporting to the police [232], [252]. A number of studies, however, have pointed to high rates of violence against members of this community [219], [251], [253], [254]. In 2009, a lesbian and gay support group in Cape Town saw 10 new rape cases per week [251]. A 2010 Southern African study, found that one in four LB women had been raped by a man and one in six had been raped by a woman [253]. Further, Human Rights Watch found that in communities across South Africa, the majority of lesbian, bisexual and transgender (LBT) individuals had experienced repeated verbal abuse because of their gender identity and sexual orientation [219]. Many had also suffered repeated sexual assault. They described living in constant fear of verbal, physical and sexual violence, with the majority being most fearful of sexual violence. It is not clear whether these rates of violence are higher than those among non-LB women.

An association was also found between race and LB victimisation. In the Western Cape, Coloured LB women were significantly more likely to experience all forms of abuse compared to LB women of other races [254]. However, the Western Cape has a much higher proportion of Coloured individuals than other provinces [171]. Comparatively, a 2013 report by the Research Unit of the South African Parliament indicated that across South Africa poor Black lesbian women in townships are at greatest risk of corrective rape [252].

Amongst LB victims, there is a high level of under-reporting of incidents of abuse to the police [219], [254]. Reasons for this include (a) lack of information concerning their rights and regarding redress mechanisms, (b) lack of assistance and support in making complaints, (c) previous negative experiences with prejudiced officials, and (d) lack of trust in the criminal justice system [219]. Some police also discriminate against and victimise LB women [219], [251], [252]. These negative experiences have led to a lack of trust in the police's ability to protect and provide access to redress mechanisms.

While there have been a few small-scale studies conducted on violence and hate crimes against LBT women in South Africa, there is (a) a dearth of representative cross-sectional studies on the prevalence and nature of hate crimes against this group [255]; and (b) a lack of research on the specific risk and protective factors for violence against this group [253]. Consequently, there is a need for additional research, particularly quantitative research, to assess the factors which place LBT women at risk of corrective rape and other forms of GBV [253].

Elderly Women

The Older Persons Act (No. 13 of 2006) (OPA) provides a framework dedicated to upholding and protecting the “safety and security” of older persons and actively addressing elder abuse in South Africa [256], [257]. The Act identifies a number of circumstances in which an older person will require “care and protection”, including if they have been (a) subject to economic abuse (e.g. someone is stealing their old age grant); (b) neglected/ abandoned; or (c) illegally evicted [256]. Anyone working with an older person who notices that this person “is in need of care and protection” is required to report this to the Director General of the Department of Social Development; anyone else who suspects this should report it to a social worker or police official.

According to the OPA, a man is classified as an older person if he is 65 years or older and a woman is classified as an older person if she is 60 years or older [256]. Mid-year population estimates from 2013 approximate 7.8% (4 146 910) of the South Africa population to be 60 years or older [258]. Older persons are widely recognised as a vulnerable group in need of special care and attention. However, violence against the elderly has only recently emerged as a problem that needs to be addressed in South Africa. While there appears to be increased awareness of the problem of elder abuse due to increased programme activities and exposure of cases, and a small number of studies have investigated the living conditions and experiences of older persons [259]–[262], both reliable evidence and data on national prevalence rates are lacking [263].

The gender distribution of this group means that elderly women are particularly vulnerable. Nationally, 60.4% (2 545 797) of the ≥ 60 age group are female [258]. Of the 70 years and older age group, 54.7% of households are female-headed, compared to the 37.5% of households that are female-headed across the population [246]. Over and above the pervasive levels of VAW in South Africa, including physical and sexual abuse, elderly women may be at a particular risk of (a) witchcraft-related violence and (b) economic abuse.

Witchcraft-related violence, where people are attacked or killed on suspicion of being witches, includes the incidence of beating, burning of property, ‘necklacing’ (to have a burning tyre placed around one’s neck), stabbing and stoning³² [264]. These attacks are governed by an age- and gender-bias, with the majority of victims being elderly women. That elderly women, particularly isolated women in rural areas, are at risk of becoming victims of witchcraft-related violence suggests that gender and age are clear risk factors for this type of violence. Besides these individual level factors, there is little understanding of the dynamics underlying this type of

violence. Those who have attempted to investigate the issue suggest a number of intersecting factors. At the community or societal level, (a) cultural beliefs and practices [265], (b) spiritual insecurity [266], (c) poverty [267], and (d) legislative and law enforcement/implementation challenges [265], [268] have been said to underlie this violence.

Lack of awareness and understanding of ageing and dementia appear to contribute to witchcraft-related violence against elderly women. In an isiXhosa-speaking township in Cape Town people frequently ascribed the symptoms of dementia to witchcraft [269]. Government and community organisations have both expressed concern over these incidents. In 2012, the KwaZulu-Natal Premier’s Office stated the need to create awareness around ageing and dementia, to develop programmes to integrate the elderly in the community, and to facilitate intergenerational interaction to remove the stigma associated with old age [270].

Older women are particularly vulnerable to economic violence, aimed at gaining control over their material assets such as pension money or property [271]. For many older persons in South Africa, the Old Age Grant is their main or only source of income. A study in Mpumalanga found that the grant was the main source of income for 77.1% of older persons, and for more women (80.9%) than men (67.3%) [260]. Although the grant can have an impact on poverty reduction and protection among households with older persons [272], the receipt of a state pension increases their vulnerability to violence. Qualitative evidence suggests that older persons feel vulnerable when they collect their pensions [259]. Quantitative evidence is scarce but the above-mentioned Mpumalanga study found that 50.7% of older persons had their grant or money taken from them through theft or mugging [260]. Location seemed to be a risk factor here, with those in rural traditional areas experiencing significantly more muggings than those in urban areas. Older persons may also be at risk from their children and extended families. Some report experiences of extortion, assault and even sexual abuse from their adult children who attempt to gain access to their pensions [273]. There are no reliable national statistics or rigorous research around the financial vulnerability and exploitation of older persons, and older women in particular, in relation to pensions and property ownership. This, however, is an area of significant concern that requires further investigation.

Key factors that appear to underlie elder abuse are poverty, drug and alcohol abuse, unemployment, HIV/AIDS, and the weakening of traditional family structures and values [271], [273]. For instance, elderly women may be easy targets for those looking for money to fund drug or alcohol habits.

32 See <http://www.paganrightsalliance.org/remember-their-names/> for a list of published news reports of witch-hunts from 2000 – 2014.

Researchers voice concern that “older women are at particular risk of abuse or violence through physical weakness, and a lack of economic capacity to care for and protect themselves, and thus to resist violence” [271, p. 20].

While poverty is pervasive across South Africa, older persons are disproportionately affected by it. This is partly owing to HIV/AIDS, which has contributed to a significant change in the traditional family structure. HIV/AIDS has had a considerable impact on older persons through younger adult mortality, subsequent changes in household structure and loss of income. Consequently, traditional care and support mechanisms, whereby the ageing are cared for by their children and extended family, are declining [274]. As a result of HIV/AIDS many older persons are now caring for children with, and grandchildren orphaned by the illness [275]–[277]. The old-age grant is often the household’s main or only source of income, and pensioners may face pressure to use their grant to support their extended family [246]. This dynamic places older people at greater risk of financial exploitation and abuse.

There are no reliable national statistics and no rigorous research around witchcraft-related violence and the financial vulnerability and exploitation of older persons, and older women in particular. The genuine extent of the problem is unclear, due to under-reporting and a lack of accurate records. Furthermore, notably absent from the literature is any attempt to analyse the risk and protective factors for elder abuse to inform policy makers and programmes to address and prevent abuse. These are areas of significant concern that require further investigation.

Women with Disabilities

There is a significant lack of knowledge on the prevalence and nature of disability in South Africa and an even greater silence on violence against persons with disabilities (PWD); however, international literature generally identifies PWD as being at an increased risk of violence [278]. Women with disabilities may be particularly vulnerable to violence due to the intersection of multiple forms of risk, namely disability and gender.

Although empirical international research investigating whether women with disabilities are at a higher risk of violence than women without disabilities is limited, it has shown a higher risk of victimisation among women with disabilities [279], [280]. A number of studies in developed countries have shown the association between disability and IPV [281]–[285]. Women with physical disabilities are at risk of abuse not only from IPs but also from attendants and healthcare providers and are more likely to be abused for a longer period of time than women without disabilities [286], [287]. The “virgin cure”

myth³³ may also place women and girls with disabilities at a higher risk of sexual assault, due to the misconception that women/girls with disabilities are non-sexual and thus virgins [288].

In South Africa, research on disability and violence remains scarce. The 2007 Community Survey estimated that 1.9% of females (915 661) are disabled, compared to 2.1% (1 000 558) of males, showing a decrease from the 2006 Census [289]. The 2012 GHS provides higher prevalence statistics, with 4.8% of men and 5.4% of women aged 5 years and older reporting disability [290]³⁴. The vulnerability of persons with physical disabilities to HIV/AIDS, through increased vulnerability to sexual abuse, has been addressed qualitatively in the literature [291], [292]. In the township of Nyanga in Cape Town, physically disabled youth (15 – 24 years old) discussed instances of rape “as if it were an expected aspect of their existence”. In most cases they had not reported the rape to the police, either because it had been committed by family members or owing to shame and silence around disability and sexuality [292].

The Centre for the Study of Violence and Reconciliation undertook a small-scale, exploratory study on GBV and women with physical, visual and hearing disabilities for which they conducted 14 in-depth interviews with women with disabilities, staff of NGOs and specialist SAPS units in Gauteng [293]. While providing no prevalence statistics or evidence of risk, the authors concluded that women with disabilities are exceedingly vulnerable to GBV and face challenges in their access to support services and the criminal justice system following experiences of violence.

Sex Workers

Prostitution has been defined as “the exchange of any financial or other reward, favour or compensation for the purpose of engaging in a sexual act” [294, p. 10]. Renowned feminist Catharine Mackinnon has argued that sex workers are subject to more violence than any other group of women worldwide [295].

Prostitution is currently criminalised in South Africa, but policy makers are in the process of reviewing the legislation in order to determine how it can be modified to best protect the rights of sex workers [294]. The issue of whether or not prostitution should be legalised has been strongly debated. Those arguing for legalisation have reasoned that legalisation will enable sex workers to benefit from protective labour practices and thereby reduce their health risks and risk of experiencing violence [299].

33 The “virgin cure” posits that sex with a virgin is a cure for HIV/AIDS.

34 These higher statistics are likely due to a change in the questions on disability in the 2011 Census and 2012 GHS compared to previous censuses disability. These questions, which refer to ‘difficulties’ in functioning rather than ‘disabilities’, were tested in two South African studies and found to lead to a much higher disability estimate than traditional questions on disability.

Those against legalisation have argued that prostitution is intrinsically a form of exploitation of women and legalisation will only serve to promote this exploitation. Furthermore, those opposing legalisation highlight the gendered nature of prostitution and argue that prostitution feeds into deeply embedded societal norms of patriarchy, male sexual entitlement, and the objectification and dehumanisation of women [300]. Opponents of legalisation call for: (a) the implementation of measures to protect women from engaging in this activity; (b) the State to address the social inequalities which drive women into sex work; (c) the creation of opportunities and mechanisms to allow for sex workers to leave prostitution; and (d) a focus on reducing the demand side of prostitution by prosecuting clients, pimps and brothel owners [299].

Existing research on violence against sex workers in South Africa has been limited to small-scale studies, many of which are qualitative [300]–[303]. These studies have shed light on the potential risks faced by these women and the mechanisms underlying these risks; however, there is limited empirical evidence to support these discussions. It is often the most disadvantaged women in society who engage in prostitution owing to their restricted educational and employment opportunities and the pressure to provide for their families [300], [302]. A number of South African studies point to the vulnerability of sex workers to high levels of emotional, physical and sexual violence [300], [302], [304]. Some sex workers describe abusing substances to help them cope with the fear of future victimisation and the unpleasantness of their jobs [302], which in turn can increase their vulnerability to further abuse.

Sex workers are particularly vulnerable to physical, sexual and emotional violence from clients and often lack power to negotiate safe-sexual practices [304]. Perpetrators also commonly include IPs and the general public [302]–[304] and sometimes hotel managers, security guards, and the police [300], [303], [304]. Those working on the streets are at particular risk of assault, kidnapping, rape and murder [303], [304]. Sex workers in hotels may be better protected, owing to their access to hotel security, but are not immune from violence at the hands of clients or hotel staff [303], [304]. In a study with sex workers in Hillbrow, Johannesburg, all of the participants reported having been physically, sexually or emotionally harassed and abused by police [304]. Some reported having been forced to pay bribes to police or being treated badly by police when they attempted to report instances of sexual violence. As a result, participants were reluctant to report experiences of sexual violence.

In summary, although sex workers may be at risk of violence from clients and police, research on the particular vulnerability of sex workers in South Africa is limited. Some advocate for the legalisation of prostitution in South Africa on the premise that legalisation will better protect sex workers from exploitation and violence by clients and the police. Conversely, those opposing legalisation argue that evidence from international and local studies indicates that legalisation of prostitution will only exacerbate exploitation and violence against women in society [294]–[298], [300]–[305].

Migrant and Refugee Women

Since 1994, many refugees from across Africa have fled to South Africa [306]–[308]. South Africa's liberal refugee policy and comparatively successful economy in relation to other African states has contributed to this high influx [307], [309]. In December 2013, there were approximately 300 600 refugees and asylum seekers in the country [310].

Refugees' experiences of violence in South Africa are three-fold. Firstly, they can experience violence from other refugees; secondly, they can be exposed to general violence; and thirdly, they can experience xenophobic³⁵ violence [312]. In 2008, a wave of xenophobic violence broke across South Africa, with thousands of foreigners being displaced from their homes and communities and dozens of non-nationals reportedly being killed [172]. Since then, there have been episodic outbreaks of xenophobic violence across the country. The violence from both South Africans and other refugees is often rooted in mistrust, competition for scarce resources and pressure on social services [310], [313]. However, it is very difficult to gain accurate statistics on the number of refugees exposed to violence in South Africa, as refugees exposed to trauma do not always report their experiences [313], [314]. In 2012, Médecins Sans Frontières (MSF) indicated that practitioners at an MSF Clinic in Musina had seen a rise in trauma cases amongst refugees and immigrants since the end of 2011 [315].

Female refugees/migrants appear to be particularly vulnerable to violence owing to their being at the intersection of two vulnerable groups – women and refugees/migrants [316], [317]. Although, there is a lack of data on violence against refugee and migrant women in South Africa, they are thought to be at increased risk of violence and harassment from both partners and non-partners [316]. There are a number of possible reasons for this phenomenon. Firstly, many of these women come from patriarchal societies but are exposed to more gender equitable laws and attitudes on arrival in South Africa and are often required to work to help support

35 Xenophobia has been defined as "attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity" [311].

their families [312], [318], [319]. These factors threaten male control, which can lead to the perpetration of IPV [312]. Secondly, refugees may lack social networks in their new communities and no longer be afforded community protection from IPV [312]. Thirdly, refugee victims of IPV may be reticent to report their experiences to the police owing to fear of authority figures coupled with the fear of being deported if they are in the country illegally [316]. This under-reporting enables a context in which perpetrators can act with impunity [22].

Female refugees/migrants are at risk of non-IP rape owing to the high rates of sexual violence against women in South Africa. They are also sometimes specifically targeted because they are foreign [316]. There are high rates of sexual violence among female migrants and instances of sexual violence while crossing the border into South Africa [312], [320]. Some refugee women have also described being sexually harassed at the Department of Home Affairs (DHA), with some employees of the DHA soliciting sexual favours in return for issuing necessary paperwork [316]. In an unpublished study on barriers to access to mental health care faced by female refugee trauma victims in Cape Town, interviewees described a high prevalence of assault amongst female refugees in the Cape [319]. A counsellor at a refugee centre in Cape Town said that while many of her female refugee clients had experienced multiple traumas prior to and during migration, experiences of sexual violence were highest after arrival in Cape Town [319]. Targeted rape is a weapon of conflict and is a form of xenophobia in South Africa – a way of humiliating, shaming and communicating power over refugees/migrants [316]. As with other types of violence, there is suspected to be a high rate of under-reporting of xenophobia-related sexual violence, as migrant and refugee women are often fearful of scepticism and mistreatment by police.

3.4.3 Individual Level Risk Factors: Violence Perpetration

Individual level risk factors for male perpetration of VAW include childhood adversity and abuse, substance use, psychological state, engagement in other criminal behaviour, age, educational attainment, SES and gender-inequitable attitudes.

3.4.3.1 Childhood Adversity and Abuse

A boy child's family structure and home environment play a role in shaping the likelihood of him growing up to perpetrate VAW. Single-parent households are common in South Africa. Figures from 2013 show that only 32% of children in South Africa live with both their parents, while 39.3% live only

with their mother [125]. Poor parenting, including parental absence (total or frequent absence of mother or father) and lower perceived parental kindness, was significantly associated with rape perpetration in the three-district study [20], [110]. This was particularly the case when the father was absent during childhood or where there was lower perceived paternal kindness. While parental absence was common among perpetrators and non-perpetrators, it was significantly more common among perpetrators. Conversely, the Stepping Stones study found that having lived with *neither* parent was protective against perpetration of sexual IPV [109]. It was suggested that orphans may be more likely to seek emotional intimacy in IRs and as a result are less likely to perpetrate sexual IPV.

Growing up in a violent household, either directly experiencing childhood abuse or witnessing DV, is a significant risk factor for perpetration of VAW [20], [103], [109], [123], [189], [193], [243]. Many of the studies noted a high prevalence of childhood abuse experienced by male participants [20], [103], [189], [189], [243]. For instance, in Limpopo, Gender Links found that 82.3% of men had experienced some form of physical abuse, 62.1% had experienced neglect, and 19.0% had experienced some form of sexual abuse during childhood [200]. In this sample, men who had experienced childhood abuse were significantly more likely to perpetrate IPV. In Gauteng, childhood neglect was associated with later emotional IPV perpetration, childhood physical abuse was associated with later physical IPV perpetration, and childhood sexual abuse was associated with later perpetration of physical IPV, sexual IPV, and non-IP rape. Overall³⁶, men who were abused as children were not only more likely to perpetrate non-IP rape and IPV, but they were more likely to perpetrate IPV more than once [189].

Other forms of childhood victimisation associated with rape perpetration include childhood abuse (physical abuse, sexual abuse, emotional abuse, and neglect); having being bullied or teased; and having been raped by a man [20], [110]. Men who observed maternal abuse or IPV victimisation during childhood, are significantly more likely to perpetrate physical IPV as adults [55], [103], [243]. Abrahams et al. found that having witnessed maternal abuse, significantly predicted physical IPV perpetration in the past year and past 10 years. This was more predictive of IPV than experiencing physical discipline (i.e., corporal punishment) at home [55], [243]. Witnessing abuse was no longer significant, however, when behaviour and relationship conflict variables were taken into consideration.

The association between childhood abuse and subsequent perpetration of VAW speaks to social learning theory [204], [243], [321], [322]. Boys who experience or witness abuse during childhood may perceive violence to be normal and

³⁶ Gender Links did not indicate the proportion of male participants in KwaZulu-Natal who had experienced childhood abuse [202].

acceptable behaviour within relationships, imitating or modelling the behaviour they witnessed or experienced within their own IRs. This creates a cycle of violence, increasing the likelihood that boys will grow up desensitised to violence and regard violence as a legitimate means of resolving conflict [204]. There may also be an association between high levels of childhood trauma and the development of anti-social behavioural tendencies in men, which may also increase the risk of VAW perpetration. A further explanation for this relationship is that childhood adversity has developmental effects, leaving a boy child with a sense of inadequacy and anger, which can later be manifested in sexual violence towards women [109].

It must be noted that owing to the nature of these findings, no linear relationship can be drawn between traumatic childhood experiences and the perpetration of violence. More research is needed to explore the factors that buffer the effects of childhood adversity and protect against the later perpetration of VAW by men who have experienced or witnessed abuse during childhood.

3.4.3.2 Substance Use

Substance use and abuse, particularly alcohol use, is a risk factor for non-IP sexual violence and IPV perpetration. Heavy or problematic alcohol consumption is associated with the perpetration of physical IPV [243], sexual IPV [109], [193], [196], [243], and non-IP rape [20], [109], [110], [199]. During the two years between the baseline and follow-up of the Stepping Stones study, significantly more men who committed rape reported problem drinking compared to men who had not committed rape during this period (34.6% vs. 23.9%) [199]. Mathews et al. found that women with raised BAC at time of death were more likely to have been killed by someone who had a known drinking problem [94]. However, the perpetrator data did not indicate whether the perpetrator was drunk at the time of perpetration. Conversely, other quantitative studies found no strong association between sexual assault perpetration and alcohol use [166] or IPV perpetration and alcohol use [201].

Numerous qualitative studies found an association between alcohol use and the perpetration of sexual violence and IPV [123], [164], [195], [244], [323], [324]. Qualitative research has shed light on the role of heavy drinking and its association with aggressive and violent behaviour, such as demanding sex from a female partner [195]. The use of alcohol provides young men with the 'courage' to physically discipline their female partners and is used to later justify the violence [164]. This suggests that it may not be the actual disinhibiting effect of the alcohol itself that is a risk factor for IPV perpetration but rather that the consumption of alcohol provides a means through which

men justify how or why they become violent (i.e., alcohol as an excuse for violence).

In one study women described their partners as becoming aggressive if they were unable to find money to buy alcohol or drugs, with one participant describing how her husband stole family belongings to pay for his drug habit [323]. In Delft, women described how drinking increased their partners' aggression – the effects of the alcohol, together with the male-dominated environment of the alcohol-serving venues in the township, contributed to male patrons' sense of power and aggression towards women [244]. The normalisation of VAW in this context appears to be associated with social norms around drinking in such venues.

Although by no means excusing male behaviour while under the influence of drugs or alcohol, there are a number of reasons offered for the relationship between alcohol and the perpetration of violence: (a) it reduces inhibitions and may lead men to become violent and aggressive; (b) it makes individuals more likely to focus on short-term benefits of sex compared to long-term consequences; (c) it distorts judgements of what is appropriate behaviour; and (d) social norms excuse anti-social behaviour and violence perpetrated when drunk [20], [103], [195], [204]. Alcohol use may also lead men to engage in risky sexual behaviours, such as not using condoms, which may place women at risk of HIV and further violence [164].

Fewer studies have explored the relationship between drug use and VAW, although some studies report significant associations between drug use and the perpetration of IPV [201], physical IPV [243], sexual IPV [193], and non-IP sexual violence [109], [110], [166], [199]. In an STI clinic in Cape Town men who had used marijuana, mandrax and other drugs, except cocaine, were more likely to have a history of perpetrating sexual assault [166]. In a multiple logistic regression analysis, only dagga use remained as a significant predictor of sexual assault. There is little other research on specific types of drugs that may increase the risk for the perpetration of VAW. The Stepping Stones study found drug use (marijuana, benzene, mandrax, intravenous drugs and other types of drugs) to be associated with non-IP but not IP rape [109]. Drug use lost significance as a predictor of non-IP rape when the effects of risky sexual behaviours and other types of violence were taken into consideration. Similarly, Abrahams et al. found that men who had currently or previously used drugs (marijuana and methaqualone) and/or abused alcohol were more likely to perpetrate physical, but not sexual, IPV [193], [243].

Strong findings regarding the relationship between drug use and rape perpetration emerged from the Stepping Stones study, with a significantly higher incidence of rape perpetration amongst men who had ever used drugs [199]. During the

two years between the baseline and follow-up of the study, significantly more men who committed rape reported ever using drugs compared to men who had not committed rape during this period (52.1% vs. 35.5%). The authors estimated that drug use was responsible for 24% of rapes, suggesting that rapes could be reduced by nearly a quarter if drug use was eliminated. They argued, however, that it was the context of drug use rather than the physiological influence of the drugs that increased the likelihood of rape perpetration. Drug use was associated with bored young men who generally lead a deviant lifestyle, hanging out on the streets where sexual violence and drug use was widely accepted. This was deemed a critical environment for rape perpetration [199].

Alcohol use is a significant risk factor for all forms of VAW perpetration, while drug use is significantly associated with the perpetration of non-IP rape and physical IPV. While the physiological effects of alcohol and drug use can be seen to facilitate VAW, one cannot divorce this risk from (a) the context in which substance use takes place; and (b) the underlying social norms, which normalise and justify VAW under such circumstances. More research needs to be conducted on drug use as a risk factor for VAW perpetration, particularly the association between different types of drugs and specific types of VAW perpetration.

3.4.3.3 Age

In a number of studies, age was associated with the perpetration of sexual violence, with a higher prevalence of rape perpetration among younger men. The age group identified as most at risk of perpetration differed between studies; however, most were below the age of 45 years (see Table 11). These findings could either suggest (a) an increase in rape perpetration over time, or (b) that older men were more reticent to admit to having raped [103]. Other studies, however, did not find this to be a significant association [201], [202].

Comparatively, there was limited evidence to suggest an association between age and IPV perpetration. Abrahams et al. found a significant difference in the mean age of men in Cape Town who reported perpetrating sexual IPV compared to men not reporting such violence (35.6 years vs. 39.5 years) [193]. Younger men were also more likely to report perpetrating physical IPV against their partners in the past 10 years [243]. However, Gender Links reported no significant association between age and lifetime IPV perpetration in Gauteng and Limpopo³⁷ [103], [200].

3.4.3.4 Education and Socio-Economic Status

Some evidence suggests a relationship between education and IPV perpetration. Gender Links did not find an association between education and GBV perpetration [189] except in the Western Cape, where not having completed Grade 12 was significantly associated with IPV perpetration [201]. The national SASAS, however, found that men with lower levels of education were more likely to perpetrate physical IPV [204]. A limitation of this study was that it did not define 'lower levels of education'; thus it is not clear what level of education would increase the risk of or protect against IPV perpetration.

Education and SES are closely connected in South Africa, whereby individuals from poorer SES backgrounds appear to be trapped in a cyclical relationship between poverty and lower educational outcomes. The SASAS found men in the lowest SES income bracket, those earning less than R1 000 per month, to be at greatest risk for perpetrating physical IPV [204]. IPV and femicide perpetration were associated with male unemployment in the quantitative and qualitative literature [94], [190], [327]. The form of employment was also associated with IPV perpetration. Men employed in skilled, semi-skilled and unskilled occupations were more likely to perpetrate IPV than men who worked in professions. Physical IPV perpetrators were most likely to be in unskilled work [55], [243].

AGE (YEARS)	TYPE OF VAW PERPETRATION	LOCATION	STUDIES
<25	Sexual assault (IP and non-IP)	Cape Town	[166]
20-40 ^a	Rape (IP and non-IP)	Eastern Cape and Kwa-Zulu Natal	[20], [109], [110], [199], [325]
18-44	Rape	Gauteng	[103]
30-44	Rape	Limpopo	[200]
28.99 ^b	Serial rape	-	[326]

Note: ^aMost reported first having raped when they were between 15 – 19 years of age (46.5%) [20]. ^bRefers to the mean age of perpetrators.

Table 11. Findings regarding the Age Range of Rape Perpetrators in South Africa.

³⁷ The Western Cape and KwaZulu-Natal reports do not report on the relationship between age and IPV perpetration.

Findings regarding the association between socio-economic indicators (employment, education and income) and non-IP sexual violence were inconsistent. Three studies, including the prospective study on rape perpetration, did not find a significant association – this included the lack of an association with socio-economic status [199], level of education [110] and employment status [166]. Comparatively, a number of studies found that men who had raped had a higher level of education than men who had not raped [20], [199]. In the three-district study, non-IP rape was associated with having a slightly higher SES, with rapists significantly more likely to earn over R500 a month and have occasional work and significantly less likely to have never been employed than non-rapists [20]. This supported the findings of the Stepping Stones study: that men who perpetrated non-IP rape had a higher SES and a greater likelihood of earnings than men who had not perpetrated non-IP rape [109].

In addition to the level of education of the perpetrator, perpetration of sexual violence was associated with higher maternal education in these studies [20], [109], [110]. While these results appear to show the slightly better educational and SES background of men who have raped, rapists in the three-district study were also more likely to report having ever experienced food insecurity due to a lack of money, which is frequently used as an indication of poverty [20].

Findings on the role of socio-economic disadvantage in violence perpetration are mixed. This may be because SES indicators are not always collected or that, when they are, they are used as control variables when examining the effect of other factors on perpetration [328]. Where associations between socio-economic indicators and violence are drawn in the literature, one must be careful to note that men of all socio-economic backgrounds perpetrate violence. Socio-economic disadvantage and poverty, however, can cause increased stress and frustration in the home which can, in turn, increase the risk for IPV [54].

Men who are unemployed or otherwise unable to fulfil traditional provider roles for their families and achieve material markers of success may perpetrate rape and other forms of VAW as a means of attaining dominance and power [328]–[330]. On the other hand, the finding that wealthier, more educated men in some communities are more likely to perpetrate rape suggests that men who are *less* poor in contexts of poverty and low education are likely to take advantage of their status [109]. Higher maternal education is also linked to notions of higher social status. Consequently, such men may act out of a greater sense of power and entitlement and women may feel less able to refuse sex with a man of higher social status in the community.

Findings concerning the association between race and VAW varied between studies but also seemed to support the association between low SES and the perpetration of VAW.

Gender Links found no significant association between race and VAW perpetration [200]–[202]. The exception to this was in the Gauteng sample, where proportionally more Black African men reported perpetration of non-IP rape compared to Coloured and White men [103]. Conversely, others have found that significantly more Coloured men report perpetrating physical IPV [243] and rape [20]. This finding may be explained by the fact that Coloured men only made up less than 5% of the sample in the latter study. Although these studies were representative of the areas assessed (Cape Town and three districts in the Eastern Cape and KwaZulu-Natal), these findings cannot be generalised to the national level. The national SASAS results show that proportionally higher numbers of Black African and Coloured men perpetrated physical IPV compared to White men [204]. Race was excluded from regression analysis in this study, however, owing to its confounding with low SES.

International literature suggests that, while VAW prevalence rates may vary across racial groups, VAW is an issue for all races [192], [331]–[334]. International findings that GBV is higher amongst certain ethnic groups are generally attributed to a number of factors, including: (a) prevalence of stronger patriarchal and gender inequitable norms within certain cultural groups, which tolerate and accept GBV; and (b) structural disadvantage experienced by certain race groups in certain countries, which is associated with an increased prevalence of GBV [192], [332], [334]. As race and SES are strongly correlated in South African society, these findings support poverty/low SES as a significant risk factor for IPV perpetration.

There are mixed findings regarding the association between education, SES and VAW perpetration. Type of employment and a number of indicators of low SES were associated with IPV perpetration. Comparatively, a slightly higher level of education, higher maternal education and SES were associated with the perpetration of non-IP sexual violence [20], [109].

3.4.3.5 Psychological State

There is limited research addressing the psychological state of perpetrators. However, psychopathic traits, namely blame externalisation and Machiavellian egocentricity, and perceiving one's life circumstances as worse than one's peers, were associated with rape perpetration among men in the three-district study [110]. Rapists also displayed significantly lower levels of empathy than men who had not raped. That rapists were significantly more likely to perceive their current life circumstances as worse than that of their peers' contrasts with findings that rapists were more likely to have more educated mothers, a higher level of education and a higher SES. This suggests that while rapists are significantly more likely to perceive their current status as worse than their peers, this does not necessarily reflect reality. It is possible that these perceptions are based on a sense of entitlement.

In the Stepping Stones study, depressive symptoms were associated with the perpetration of two or more episodes of physical or sexual IPV, non-IP rape perpetration, and engagement in transactional sex, after controlling for confounding variables [325]. While depressive symptoms at baseline predicted sexual risk-taking behaviour at 12-month follow-up, it was not clear whether: (a) depressive symptoms increased the likelihood of perpetration; (b) perpetration increased the likelihood of experiencing depressive symptoms; or (c) a combination of both.

An indication of the psychological state of men who commit gang rape is given by the finding that 'boredom' and 'fun' are common motivations given for gang rape [110]. A study comparing South African serial rape characteristics with international findings found that South African serial rapists display less remorse and are more instructional and impersonal compared to serial rapists in Finland and the USA [326].

Apart from the Stepping Stones study, which found depressive symptoms to be associated with VAW perpetration, there was limited evidence associating VAW with mental illness. There was, however, evidence to suggest an association between psychopathic traits and a sense of entitlement in VAW perpetration. These findings are consistent with international literature [335]–[337].

3.4.3.6 Engagement in Other Violent or Criminal Behaviour

A history of, or current involvement in, other forms of violent or criminal behaviour is significantly associated with VAW perpetration. The three-district study found significant differences in violent or criminal behaviour between men who had and men who had not raped a woman or girl. These findings are presented in Table 12 [20]. The finding concerning the relationship between violent or criminal behaviour and rape

perpetration was supported by evidence from other studies. Research with men in Cape Town showed that men who had been involved with a gang, been arrested or spent time in jail, and men who had been involved in physical fights at work or in the community were at least twice as likely, as men who had not been involved in these behaviours, to perpetrate sexual or physical IPV [193], [243]. Involvement in fights outside the home appeared to be particularly associated with IPV. The other violent behavioural variables lost significance when used in a multiple regression model that took into consideration relationship conflict and demographic variables.

There is also an intersection between the perpetration of different forms of VAW. Men with a history of physical IPV perpetration are more likely to have raped a woman; particularly if they have perpetrated more than one incident of physical IPV [20], [110], [199]. Further, men who perpetrate physical *and* sexual IPV are significantly more likely to commit non-IP rape than men who only perpetrate one form of IPV [196].

The perpetration of VAW appears to be one act of violence in a broader pattern of violent behaviour. The normative use of violence to resolve conflicts at work or in the community is associated with IPV in the home, showing that men who use violence as a method to deal with conflict tend to do so across multiple settings. A limitation of the three-district study, referenced in Table 12, was that it did not delineate between non-IP sexual violence (individual perpetrator and gang rape) and sexual IPV. Consequently, one cannot determine whether criminal behaviour is equally a risk factor for all forms of rape [20]. The authors argue, however, that there is little difference in the factors associated with IP and non-IP rape [110]. In addition, there is some conflicting evidence based on SAPS records – Vetten et al. found that only 17.8% of rapists

CRIMINAL/VIOLENT BEHAVIOUR	PERPETRATORS (%)	NON-PERPETRATORS (%)
Gang involvement	22.6%	6.9%
Theft/Robbery (>twice)	58.1%	24.4%
Fight with knives	44.4%	20.2%
Illegal gun ownership	26.1%	6.1%
Ownership of a weapon (other than a gun)	31.6%	16%
Previous arrest	33.3%	20.8%
Previous imprisonment	13.2%	5.5%
Raped a man	9.4%	0.5%
Bullied others at school	59.0%	34.1%

Table 12. Significant Differences in Previous or Current Criminal or Violent Behaviour between Men who have and Men who have not Perpetrated Rape [20].

had previous convictions, with the majority being first-time offenders for any crime [22]. This information was gained from police case dockets and court records, which are notoriously unreliable. Consequently, these findings are not necessarily an accurate reflection of the perpetrators’ criminal past.

3.4.3.7 Gender Attitudes

Attitudes and perceptions regarding gender roles and equality, such as traditional gender roles and acceptance of rape myths, are associated with VAW perpetration. Such attitudes and beliefs are rooted in broader social and cultural norms³⁸, which legitimise and support IPV and non-IP sexual violence. Although comparisons across studies are difficult, as different measures are used, a number of findings support the role that such attitudes and beliefs play in increasing the risk for VAW perpetration (see Table 13).

Some studies identified certain attitudes as particularly salient. Jewkes et al. found that having less gender equitable views was the only attitudinal measure that was a significant predictor of rape perpetration in a regression model [110]. Abrahams et al. found that views on gender equity and the acceptability of violence lost significance in two regression models predicting physical IPV and sexual IPV perpetration respectively, when other relationship variables were taken into consideration [193], [243].

Gender Links included a number of scales measuring gender attitudes but did not investigate the relationship between these attitudes and the perpetration of VAW. Nonetheless, the findings shed light on the prevalence of: (a) personal attitudes towards gender relations and perceptions of gender attitudes in the community; (b) personal attitudes towards sexual

entitlement in a relationship and the acceptability of violence; (c) perceptions of attitudes towards sexual entitlement in a relationship and the acceptability of violence in the community; and (d) ideas around masculinity and control in a relationship [189].

Conservative attitudes and acceptance of traditional gender roles – such as that a woman should obey her husband, a man should have the final say in family matters, and that a woman cannot refuse to have sex with her husband – are not only widely held by men but also by a number of women in South Africa [103], [200]. Certain sexual behaviours are also said to be indicative of masculine ideals on gender relations and masculinity [110]; these are discussed further in section 2.4.2 below.

3.4.4 Relationship Level Risk Factors: Violence Victimisation and Perpetration

The following section discusses the risk factors for VAW perpetration and victimisation at the relationship level. There is a strong relationship between male controlling behaviour and gender inequitable attitudes, sexual risk-taking behaviour, HIV and IPV. Poor communication and high conflict, certain disparities between partners and cohabitation are additional relationship level risk factors.

3.4.4.1 Male Controlling Behaviour and Gender Inequity in Relationships

Men who have gender inequitable attitudes and hegemonic ideals of masculinity are more likely to display controlling and abusive behaviour in their relationships. In one study, female

ATTITUDE/BELIEF	EXAMPLE	RAPE	PHYSICAL IPV	SEXUAL IPV	STUDIES
Boy child preference	-		✓		[190]
Hostile attitude towards women	When it really comes to it a lot of women are deceitful	✓			[110]
Adversarial views about women	Women are taking jobs away from men when they work	✓			[110]
Acceptability of the use of violence and justifying hitting women	-		✓	✓	[193], [243]
Acceptance of rape myths	In some instances of rape, a woman wants to have sex	✓			[110], [166]
Gender inequitable attitudes	There are times when a woman deserves to be beaten	✓	✓	✓	[110], [193], [243]

Table 13. Associations between Gender Attitudes and Beliefs and Different Types of VAW Perpetration in South African Literature.

38 See section 3.4.6.1 for a discussion of social and cultural values and norms.

participants repeatedly described their lack of power within their relationships [195]. Perceptions around ownership and objectification of female partners and the idea that women are the 'property' of their male partner are linked to notions of male superiority, power and control [194], [195]. Controlling male partners may demand to know what their female partners are doing at all times, use physical punishment when their control is challenged and threaten abuse to maintain control [189], [194]. Male controlling behaviour is embedded in implicit ideas about womanhood, masculine superiority and the perception that women should unconditionally respect men. Violence is justified as an exercise of the patriarchal right to control and punish a female partner if she violates expected norms.

In a longitudinal study investigating the association between relationship factors and IPV during pregnancy and postpartum, relationship power was the only relationship factor associated with the trajectory of IPV over time [238]. Relationship power was measured using the modified Sexual Relationship Power Scale, which assessed each woman's perceived control over decision-making, her own behaviour and her partner's behaviour. Women who had experienced pre-pregnancy IPV, but who had more power within the relationship, experienced lower levels of physical and psychological IPV during pregnancy and up to nine months postpartum. This suggests that higher relationship power is a protective factor against IPV during pregnancy or, conversely, women with little control in their relationships are at greater risk of IPV during pregnancy and the postpartum period, particularly if they have experienced IPV before their pregnancy.

3.4.4.2 Sexual Risk-Taking Behaviour

Various types of sexual risk-taking behaviour increase the risk for VAW. Men who engage in sexual risk-taking behaviour may be more likely to perpetrate IPV and non-IP sexual violence while women who engage in sexual risk-taking behaviour may be more likely to be victims of IPV. Such behaviours are also said to be gender inequitable and indicative of male views regarding gender equity and control in relationships [110].

Male Sexual Risk Behaviour

A number of male risky sexual behaviours are associated with the perpetration of IPV and non-IP sexual violence. The key risk factors are presented in Figure 11.

In a study with pregnant couples in rural Mpumalanga, men with multiple sexual partners, who were aware of their partner's HIV negative status, and who perpetrated minor IPV were more likely to have had unprotected sex with their partner [338]. On the other hand, men in the Stepping Stones study who consistently used condoms, held to less conservative gender

attitudes and were less likely to have multiple sexual partners (>2) and to perpetrate physical IPV [339].

Men who inconsistently used condoms were most likely to perpetrate IPV and engage in sexual risk behaviour. Men who never used condoms, held conservative gender attitudes but were less likely to perpetrate IPV or engage in sexual risk behaviours, than inconsistent users. This is indicative of the relationship between sexual risk behaviours, IPV and inequitable gender attitudes.

Qualitative findings also highlight the association between male sexual risk-taking behaviour, such as infidelity, and IPV perpetration [340]. In a study of abused women in Johannesburg, male infidelity and male opposition to condom use was frequently mentioned by victims [195]. Participants described being fearful of requesting safe sexual practices as this placed them at risk for sexual and physical IPV. While noting an association between their partner's infidelity, IPV and the risk of contracting HIV/AIDS, participants said that many women in their communities believed that it was not necessary to use condoms in long-term relationships. The majority of participants themselves, however, did not believe that women were safe from contracting AIDS in long-term relationships. Participants also felt that demanding condom use was an empowering action, as they upheld their right to safe sexual practices.

Male sexual risk-taking behaviour is significantly associated with the perpetration of physical and sexual IPV and non-IP sexual violence. Men who engage in such behaviour may also be at a higher risk of HIV, placing their partners at risk of contracting the disease through, for example, lack of condom use.

Female Sexual Risk Behaviour

Engagement in sexual risk-taking behaviour is an associated risk factor for female IPV victimisation, particularly in contexts of poverty and substance use. The following female sexual risk-taking behaviours are associated with IPV victimisation: (a) having had multiple sexual partners (>5), (b) having had casual sexual partners, and (c) transactional sex [186], [209]. These factors are also associated with male control in the relationship. While, never using a condom is not associated with IPV, it is associated with higher levels of male control in the relationship [209].

Transactional sexual relationships are relatively common, particularly in township settings. In a Soweto-based study, 21% of female participants reported having engaged in transactional sex [186]. Women in transactional sexual relationships are often younger and of a poorer socio-economic background than their male partners, which places them at risk of being



coerced into unsafe sexual practices and of IPV victimisation [247]. Engagement in transactional sex is associated with broad IPV victimisation (i.e. having experienced both physical and sexual IPV or having experienced multiple incidents of either physical or sexual IPV) as well as problematic substance use, poverty (living in substandard housing), and living in an urban area [186]. Engagement in transactional sex and other risky sexual behaviours may place women at risk for HIV.

HIV and HIV-Risk Behaviour

IPV, high-risk sexual behaviour, gender inequity and HIV intersect to create vulnerability for women. A number of studies reported a link between HIV and IPV. The strongest findings to support a causal association between IPV, relationship power inequity, and HIV were based on longitudinal data from the Stepping Stones study [341]. Relationship power inequity and physical or sexual IPV were significant risk factors for incident HIV infection in this study. Women aged 15 – 26 years in the rural Eastern Cape who reported low relationship power equity and more than one IPV incident at baseline were significantly more likely to acquire HIV during the 2-year period between baseline and follow-up than women who reported medium or high relationship power equity and only one or no IPV incidents respectively. Based on the population attributable fractions, 13.9% of new HIV infections could be prevented by addressing low gender equity in relationships. In addition, 11.9% of new HIV infections could be prevented

if physical and sexual IPV was effectively addressed. Non-IPV rape was not associated with incident HIV infection in this study, however. This latter finding is not surprising considering that single acts of sexual violence, such as rape, have a smaller risk of resulting in HIV than repeated, sustained acts, such as chronic IPV.

Another key study found that, after adjustment for women's own high-risk behaviour³⁹, pregnant women at an antenatal clinic in Soweto were significantly more likely to be HIV positive if they reported a history of mid to high frequency physical and sexual IPV or a high level of perceived male dominance and control in their relationship [209]. While experiencing physical IPV alone or in combination with sexual IPV was associated with an increased risk of HIV infection, experiencing sexual IPV alone was not associated with increased risk of infection. The finding that male dominance and control, but not IPV, was associated with never using a condom suggests that this measure of gender inequality in a relationship acts as a barrier to adopting safe sexual practices and is a better indicator of HIV risk than overt violence [342].

All of the other risky behaviours assessed in this study⁴⁰ were associated with IPV and/or male control as well as with HIV status, although they did not account for the relationship between IPV and HIV. This suggests that there are other factors at play or that there is a risk of direct infection from an abusive or controlling male partner (i.e. there is an

³⁹ High-risk behaviours included multiple sexual partners, alcohol and drug use and transactional sex.

increased risk that a male partner who perpetrates IPV is HIV positive) [209], [342]. The relationship between male relationship control, IPV and HIV is supported by evidence from qualitative studies [195], other Sub-Saharan African countries [343], [344], and is frequently mentioned in the international literature [345], [346].

Studies focusing on male perpetration further support the above findings. A significant association was reported between HIV-risk behaviours and the perpetration of physical and sexual IPV [196] and non-IP sexual violence [166]. Such risk behaviours included having a greater number of sexual partners, transactional sex, having a casual sexual partner, problematic drug and alcohol use, and non-IP sexual violence. In the baseline of the Stepping Stones study, more frequent IPV was associated with more severe HIV-risk behaviours, with men who reported only one incident of IPV not at a greater risk for engaging in such behaviours than men who did not perpetrate IPV. Although HIV status was not investigated in these studies on perpetration, one study that did test HIV status found a direct association between HIV and physical IPV perpetration [20] whereas another Cape Town-based study did not find an association between self-reported HIV status and sexual assault perpetration [166].

In contrast to the findings of a relationship between HIV and sexual assault, no difference was found in HIV status between men who had raped and men who had not raped in the former study [20]. However, these studies were cross-sectional in design and thus unable to identify the temporal sequence of events (i.e. whether HIV infection and risk-taking behaviours preceded abuse or vice versa).

The relationship between IPV and HIV is closely linked to gender equity and power in relationships. Where relationships are governed by gender-unequal norms and male control, women may be in a weaker position to negotiate condom use. Conversely, men who adhere to gender-inequitable masculinities that include HIV risk behaviours, such as having multiple partners, may also be more likely to perpetrate IPV. Rape, however, is not associated with a higher risk of HIV. Emerging findings which suggest the efficacy of interventions that integrate a focus on GBV, gender equity in relationships, and dominant constructions of masculinity with HIV prevention, are discussed in section 2.5.3 [196], [305], [347].

Poor Communication and Relationship Conflict

Frequent conflict within a relationship was mentioned as creating risk for IPV victimisation and perpetration [190], [193], [243]. In particular, conflict regarding sex and safe sexual practices [193], [243] and alcohol use [190] were found to be

significant predictors of IPV victimisation and perpetration. In a Cape Town study, sexual IPV perpetration was associated with conflict over refusal to have sex and when men perceived their authority to be threatened [193]. Comparatively, physical IPV perpetration was associated with conflict about sex and about the male partner's infidelity [243]. The authors argued that these represent broader ideas on gender relations, such as male sexual entitlement and male dominance. However, conflict over substance use, household financial issues, and family members were not significant predictors of sexual or physical IPV in this study.

Poor communication in primary, intimate relationships is associated with both IPV and non-IP sexual violence. While not a significant association, the three-province study found that there was less communication about family planning and HIV in abusive relationships [190]. An association was also found between suggesting condom use and experience of physical and economic IPV; however, the association was not in the direction expected [348]. Researchers had expected that women who suggested condom use were more likely to be abused by their partners. However, findings indicated that women who had experienced financial abuse from a current partner or physical abuse from previous partners were more likely to engage in communication around safe sexual practices. It was suggested that: (a) women who are currently experiencing financial abuse do not feel obliged to have sex on their partner's terms; and (b) women who have previously experienced physical IPV find it harder to trust men and thus are more likely to feel the need to suggest condom use.

In the Stepping Stones study, men with poor relationship communication skills were more likely to report having raped an IP or a non-IP [109]. In a linear regression analysis, poor communication skills were significantly associated with having raped an IP or non-IP. The authors interpreted this finding as an indication that men who perpetrate rape seek little emotional intimacy in their relationships and use rape as a demonstration of power and control.

In a longitudinal study of pregnant women in Durban, the presence of stressors⁴¹ within the relationship at pregnancy was associated with higher levels of psychological IPV [238]. However, IPV did not vary over time as a result of relationship stress and there was no association between physical IPV and relationship stress. These findings may be due to psychological IPV being more sensitive to the effects of relationship stress or that the effect of relationship stress on physical IPV is mediated by attitudes regarding the acceptability of the use of violence.

Qualitative research has also explored the relationship between poor communication and IPV. In Fox et al.'s study, victims of abuse reported being fearful of communicating with

40 The other risk behaviours assessed in this study were having five or more sexual partners, having casual sexual partners, transactional sex, and alcohol and drug use.

their partners as this might lead to abuse [195]. While the women in this study mentioned poor communication in general, communication around safe sexual practices was particularly difficult. Women reported that questioning their partner regarding his sexual activity or attempting to discuss condom use would result in their partner becoming defensive, making accusations of infidelity or becoming violent. This meant that women were unable to negotiate safe sexual behaviour, which placed them at an increased risk of contracting HIV.

3.4.4.3 Relationship Characteristics

Certain relationship characteristics can increase the risk for IPV. These include economic-, educational- and age-related factors as well as the status of the relationship.

Economic Dependence

There are conflicting findings as to whether female financial independence increases risk for or protects against IPV. Some studies have found it to be protective, while others have found that financial autonomy and empowerment can 'threaten' traditional masculine roles, which can lead to an increase in IPV [55], [323]. In the three-province study physical IPV was associated with either partner, rather than a third party, financially supporting the home but economic disparity between partners was not a significant predictor of physical IPV [190]. When the main source of household income is from a third party, particularly in cases when money is provided by a third party who is not a parent, general relationship conflict and conflict over finances is lower. It is suggested that tension over money and resources in poor households can lead to DV.

In a qualitative study in Cape Town, women described how they were often at greater risk for IPV when their earnings were higher than or equal to their male partner [323]. This was particularly the case when the female was the primary breadwinner. Male participants described their female partner's economic independence as causing them to feel powerless, inferior and emasculated. IPV was used as a means of disempowering their female partner in an attempt to regain dominance and control in the relationship.

Conversely, economic vulnerability can place women at risk of violence, with some studies indicating a higher risk of abuse amongst women who are economically dependent on their partner [191], [348]. Matthews et al. found that unemployed victims had higher median BACs when killed by an IP [94]. It was suggested that this relationship was due to unemployed women often being more economically dependent on their partners, less capable of leaving abusive partners, and thus more likely to use alcohol to cope with the violence and fear.

Numerous qualitative studies have also found an association between female financial dependence and IPV [195], [247], [323], [327]. Male participants in Fox et al.'s study described how they would continue to abuse their girlfriends as they knew their girlfriends were economically dependent on them and would be less able to leave the relationship [195]. Some men described how they did not want their partner to work, as this would weaken their control in the relationship. Other men sought to maintain economic control over their partner, by clinging to traditional roles of being the provider and breadwinner [323], [327]. A number of female participants who were economically dependent on their partners described how their partners would not provide them with the finances necessary to meet their basic needs. When women are economically dependent on men, they are more restricted in their options for seeking help and support services if they fall victim to IPV.

The WHO identifies female economic empowerment and education as a risk factor for physical and sexual IPV up to a certain point [4]. Drawing on a study conducted in South Africa, findings suggested that up to a certain point greater economic and educational empowerment of women is a risk factor for sexual IPV, because women who have improved education and are more economically independent are more likely to challenge patriarchal norms [4], [11]. Male partners then use violence in an effort to regain control and dominance in the relationship. The WHO explains the relationship between female empowerment and physical IPV victimisation as representing an inverted U shape – greater empowerment is associated with greater risk up to a particular level, after which empowerment becomes protective [4]. It is not apparent, however, based on available South African studies whether this applies in the local context.

Age and Educational Disparities

There is limited evidence associating age and educational disparities between partners with risk for IPV. Physical IPV was found to be more common when there were educational differences between partners, with IPV victims more likely to be either less or more educated than their partners [243]. It is thought that it is not the existence of educational disparities between partners that is a risk factor for IPV but rather that the disparities exacerbate gender power inequality in relationships, which then creates risk. Conversely, in the national SASAS, both partners having a low level of education was found to be a significant risk factor for physical IPV [204]. It was argued that less educated partners employ poorer coping mechanisms in stressful and conflictual situations. Furthermore, having lower levels of education is associated with lower SES status, as less educated couples have fewer employment opportunities, which increases financial stress.

41 Stressors included factors such as financial stress, first-time parenthood, legal issues and the perception that one's partner was unfaithful.

A number of studies found that when age discrepancies existed between couples, women were at a greater risk of experiencing IPV. SASAS findings indicated that women who are younger than their male partners are at significantly greater risk of physical IPV [204]. Jewkes et al. found that women who had a partner five or more years older were at greater risk of physical, sexual and financial IPV [348]. Age differences in a relationship are associated with unequal power dynamics and gender inequality, which increases the risk of IPV. When there is a significant age difference between partners, female partners are less likely to initiate discussions concerning HIV preventative practice, which in turn places them at greater risk for contracting HIV/AIDS [193]. Conversely, the three-province study did not find age disparities to be a significant predictor of DV [190].

Cohabitation versus Marriage

SASAS findings indicate that cohabiting couples are at greater risk of IPV [204]. Male partners are more likely to have abused their partners over the past ten years if they are unmarried and cohabiting than if the partner is a wife or a non-live-in girlfriend [193]. Cohabitation, however, was not found to be a significant predictor of abuse in a multiple regression model using a number of demographic, behavioural and relationship variables [190]. A small qualitative study found single pregnant women to be at greater risk for DV compared to married women [191]. The significant findings from SASAS are reflective of USA studies, which have found that IPV is significantly higher amongst cohabiting couples compared to married couples. It is not clear what factors could underlie this association [349].

Marriage can also be protective against engagement in transactional sex; which is a risk factor for IPV. Women who are married are less likely to engage in transactional sex compared to (a) women who are in dating relationships, (b) those living with a partner and (c) those who are single [186].

3.4.5 Community Level Risk and Protective Factors

Weak community sanctions against violence and community pressure to remain silent about abuse may contribute to sustaining high levels of VAW. Certain areas within communities can also be particularly dangerous for women, such as public or open spaces and alcohol-serving venues. Furthermore, women are also at risk of violence in institutional settings such as prisons. There is evidence that community level interventions that promote gender equity along with other factors may be protective against VAW.

3.4.5.1 Locations within Communities and Violence in Institutions

The only dataset that provides information on VAW across all provinces is SAPS data. SAPS data, however, indicates rates of VAW significantly lower than those identified by surveys. This is likely owing to the high rate of under-reporting of incidents of VAW to SAPS. Despite this, SAPS data and survey data both identify that prevalence rates for different forms of VAW differ between provinces. While the reasons for these differences have not been sufficiently investigated or discussed, they suggest differences in the presence and absence of factors that increase the risk for VAW. Inter-provincial comparison studies would be helpful in determining the reasons underlying these differing prevalence rates [248]. Research should also be conducted to investigate the factors associated with differing rates of VAW between communities in the same province.

A small number of studies found an association between location and rape. Public or open spaces and the victim's or the perpetrator's home appeared to be the most common sites for sexual violence, including sexual assault and rape [22], [326], [350]. In addition, public and private spaces (where victims are taken against their will) are common locations for the sexual assault of lesbians [219]. Being alone after dark also increased their risk for assault. Evidence from Gauteng shows that most rapes occurred when a woman was walking – alone or accompanied (41.7%), while a smaller percentage occurred when a victim was offered a lift or to be accompanied when walking (10.2%) or during a house break-in (11.5%) [22]. More women are raped in locations outside the home than children; this is possibly connected to the finding that more women are raped by strangers while children are more frequently victimised by family or acquaintances.

Qualitative research identified alcohol-serving venues in townships as sites of increased risk for VAW [244]. These male-dominated, sexually charged environments can reinforce negative attitudes towards women and community norms of male power and control. In larger venues VAW may go unnoticed or there may be weaker sanctions against it, where owners may tolerate and even perpetrate VAW. Conversely, venues may also provide a place of protection and escape from VAW in the home or community, where social pressure and accountability are ensured through patrons and owners enforcing discipline and offering protection. Women reported feeling safe and 'a sense of community' at smaller venues [244].

However, even if the venue itself provides a measure of safety, the finding that a large proportion of sexual violence takes place when women are alone in public spaces highlights how women are still at risk of sexual assault when they leave the

venue. Women described being equally at risk of victimisation by making their way home alone or by accepting an offer by a male patron to accompany them home [244]. Similarly, mini-bus taxis were mentioned as an unsafe means of returning home, particularly in cases where a woman is dropped off last. The potential risk women face – in public spaces, drinking venues, when walking in the community or when using public transport – highlights how violence limits women's freedom of movement. There is some work on how safety can be improved through urban upgrading (see e.g. Violence Prevention through Urban Upgrading), although additional research is needed on how to improve the safety of public spaces for women.

There is a lack of research examining violence and abuse in the workplace and within institutional settings, such as tertiary institutions [248]. There is, however, some research on the experience of violence by women in prisons. In South Africa, women constitute approximately 3% of the incarcerated population [351]. Haffejee et al. conducted a study with 348 incarcerated women in Gauteng. In this study, when asked about experience of violence over the past 12 months: (a) 47% of participants reported emotional abuse; (b) 34% reported physical violence; (c) 11% reported economic violence; and (d) 3% reported sexual violence [351]. Fellow prisoners mainly perpetrated physical violence, while prison warders were found to be the primary perpetrators of economic abuse. Although participants reported experiencing much less violence in prison compared to outside, the finding that a third of participants were subject to physical violence over the past year is disturbingly high. These findings highlight a high prevalence of women-on-women violence amongst incarcerated females, which requires further exploration. In addition, this study indicates that significantly more attention needs to be given to ensuring the safety and wellbeing of incarcerated women in South Africa. Finally, more quantitative research needs to be conducted on the risk and protective factors for VAW in other institutional settings such as mental and tertiary institutions, as well as the risk and protective factors for VAW in the workplace.

3.4.5.2 Community Silence versus Community Sanctions against VAW

Patriarchal norms and violent masculinities are entrenched within many South African communities⁴² [168]. Community tolerance and acceptance of VAW contribute to its high prevalence and the poor response to it [4]. Globally, there is a much lower prevalence of IPV in communities which: (a) have low tolerance for, and strong sanctions against, IPV; and (b) where women are able to access places of safety (e.g. shelters or family homes) [4]. Sanctions may include legislative measures and interventions and “moral pressure for neighbours to intervene” in cases of suspected IPV [4, p. 99].

The view that what happens in the home must be kept private and is no business of the wider community or government increases the risk of DV (i.e. IPV) [54]. Women can be pressurised into remaining silent about incidents of IPV in communities where it is frowned upon to speak openly about relationship difficulties and where couples are expected to deal with their problems in private; this is particularly the case with physical or sexual IPV [164], [195]. In some communities IPV is associated with a woman having ‘transgressed’ and thus deserving ‘punishment’. Norms around shame and the secrecy of the private sphere contribute to the under-reporting of IPV and enable violence to continue unchecked [164], [195].

3.4.5.3 Promotion of Gender Equitable Attitudes

Addressing gender inequitable attitudes and practices, through interventions involving both men and women, can be effective in reducing VAW and associated risk factors [103]. Contextually relevant support groups and awareness-raising interventions with men concerning concepts of masculinity and gender equity can also be effective [218]. In order to prevent GBV, it is essential to address social norms on gender and masculinity that support violence at the systemic and structural level [352].

A DV behavioural intervention developed by the Soul City Institute for Health and Development Communication (‘Soul City’) and the National Network on Violence Against Women targeted change at all levels of the socio-ecological model [353]. Soul City made use of radio, television dramas, pamphlets and posters, community events, and a DV helpline to raise awareness and encourage a shift in attitudes and behaviour regarding DV. The intervention included a national campaign to exert pressure on the government and police into implementing the DVA by raising awareness and support through the media, by engaging politicians in community meetings and by hosting public parliamentary hearings. Research, including a national survey and a national qualitative impact assessment, was then conducted to assess the intervention's effectiveness. The intervention's successes included: (a) greater awareness and attitudinal changes amongst respondents concerning DV; and (b) a 22% increase in the proportion of respondents who believed that their communities did not perceive DV to be a private affair [353]. Further, it was argued that Soul City's intervention played a significant role in ensuring the implementation of the DVA in 1999. Qualitative findings suggested that the intervention contributed to a greater sense of agency amongst women in facilitating decision-making and community action. In summary, Soul City's use of mass media and edutainment as a mechanism for social change was found to be particularly effective.

⁴² These concepts and constructs are discussed in more detail in section 3.4.6 below.

A number of integrated interventions that have shown potential for changing gender attitudes to reduce IPV and associated risk behaviours are discussed in more detail in Table 14. The intervention outcomes generally indicate efficacy in altering gender-inequitable attitudes and VAW. Interventions that integrate a focus on GBV and gender equity with HIV prevention may be particularly effective [196], [305], [347]. Including alcohol use as a component in the intervention may also increase the intervention's success. Interventions that target men as the agents of change show promise and need particular focus [166]. More research is needed to further explore the connection between HIV and IPV and to evaluate such interventions.

3.4.6 Societal Level Risk and Protective Factors

Gender-inequitable cultural and social values, patriarchal norms, violent masculinities and notions of male sexual entitlement increase the risk for VAW. Legislation pertaining to women's rights offers a measure of protection, but is hampered by a disconnect between policy and implementation.

3.4.6.1 Cultural Norms and Values

It has been argued that "at the societal level, identified risk factors [for VAW] ... include notions of male ownership

INTERVENTION	ABOUT	OUTCOMES	COMMENTS
Integrated GBV and HIV risk reduction intervention	A five session integrated intervention grounded in Social Learning Theory and focusing on behaviour change self-efficacy designed to reduce gender-based violence (GBV) and HIV risk behaviours with a comparison intervention of a single 3-hour alcohol and HIV risk reduction session.	A quasi-experimental study assessing the effectiveness of the two interventions found that men who received the GBV/HIV integrated intervention showed short-term decrease in the acceptance of VAW but long-term decrease in losing their temper with a woman and hitting or pushing a sex partner [354]. There was little long-term improvement in their HIV protective behaviours, such as talking with partners about condom use, alcohol use before sex and number of sex partners. Men reported greater <i>intention</i> to engage in HIV risk reduction behaviours. The alcohol/HIV prevention intervention had a greater effect on reducing risky sexual behaviours.	Future interventions with a focus on all three areas (alcohol use, HIV, and GBV) could be more effective.
Sonke Gender Justice's 'One Man Can' (OMC) campaign	Campaign, workshops, and action kits containing resources and information on how to act against DV and sexual violence to support men and boys to take action to end domestic and sexual violence, to reduce the spread and impact of HIV/AIDS, and to promote healthy, equitable relationships.	An impact evaluation conducted in three provinces found that engagement in the campaign was related to increased knowledge on GBV and HIV and behaviour changes including HIV testing and reporting of GBV to the police, NGOs or other structures [355].	The evaluation was unable to determine whether engagement in the campaign led to long-term attitudinal and behavioural changes, suggesting the need for long-term follow-ups to determine the efficacy of such behavioural intervention programmes.
Intervention with Microfinance for AIDS and Gender Equity (IMAGE)	A combined intervention consisting of group-based microfinance and a gender and HIV training curriculum.	A cluster randomised control trial to assess the effectiveness of the intervention was conducted among women in rural Limpopo [181], [356], [357]. The intervention was protective against physical and sexual IPV victimisation and male controlling behaviour. Over a two-year period there was a 55% decrease in prevalence of IPV amongst the participants and an increase in HIV communication and empowerment compared to the women in the control group but no difference in unprotected sex or HIV incidence.	Results suggest the utility of integrating targeted public health interventions with economic development initiatives.
Stepping Stones	An HIV prevention programme utilising participatory learning with both men and women.	The intervention was protective against physical and sexual IPV perpetration amongst men [341], [358]. There was no significant effect on HIV incidence amongst intervention participants but slightly less men in the intervention group reported IPV perpetration at the 12-month follow up and significantly less men reported IPV perpetration at the two-year follow up. Less transactional sex was reported in the intervention group at the 12-month follow up. There were no significant differences in behaviour or HIV incidence among women.	These results show that interventions that address both men and women can have an effect on risk behaviours.

Table 14. Descriptions and Outcomes of Five Integrated Interventions and Campaigns Targeting GBV and HIV.

of women; ideas of masculinity linked to aggression and dominance; rigid gender roles; acceptance of interpersonal violence; and physical chastisement” [190, p. 1604]. The degree of tolerance of violence in South African society is fuelled by social and cultural norms and values. While individually held gender inequitable attitudes and beliefs seem to differentiate men who have perpetrated VAW from those who have not at the individual level, such attitudes and beliefs reflect societal level acceptance and support of patriarchy, traditional gender roles and violent masculine ideals. When certain social and cultural constructions are widely accepted in communities and broader society, they create a climate that enables and sustains VAW [193], [195], [209].

3.4.6.2 Patriarchal Norms

South African society is frequently described as patriarchal. Patriarchal norms, whereby male authority and power over women is deeply embedded within the society, contribute to all forms of VAW [103], [110], [164], [189], [359]. When such norms prevail, men are raised with the notion that they are superior to and can control women, and that women must be submissive [359]. Further, violent actions by men may be accepted by women; as many women are raised to submit to male power and control in order to protect the traditional family structure [54]. Forms of VAW associated with patriarchal norms include sexual harassment at work and school; rape; physical, economic, sexual and emotional IPV; and femicide [103]. In societies that adhere to such values, it is more likely that IPV and other forms of VAW will be justified or accepted [4].

In communities where patriarchal norms dominate, male perpetration of IPV is perceived as legitimate punishment. Punishment and anger are two of the most common reasons given by men for the rape of a girlfriend. Punishment is also given as a motive for non-IP rape and gang rape [110]. This ‘punishment’ is often used in response to perceived ‘transgressions’ on the part of a female IP, such as infidelity or disrespect [164], [360]. Violent punishment for female transgression is perceived as a demonstration of control and discipline, but it is also sometimes viewed as an indication of love and of valuing the relationship [164]. These views are embedded in a social discourse around intrinsic masculine superiority – the idea that men need to protect their relationships and their girlfriends, who are unable to think independently. Thus, beatings are seen as ‘guidance’. While IPV is justified as a legitimate exercise of patriarchal rights and a defence of male dignity, it is sometimes contrasted with the perception that mature men are able to control themselves and do not have to resort to violence.

3.4.6.3 Hegemonic and Violent Masculinities

Feminist scholars have highlighted the role of hegemonic masculinities in supporting gender inequality and VAW [163]. In South Africa, masculine ideals include sexual prowess (having many sexual partners), physical strength, hierarchical power and male control of women [11], [329], [361], [362]. Femininity, on the other hand, is associated with submission, subordination and nurturing [323]. Some of these understandings of masculinity and femininity are supported by certain religious ideals which emphasise the sanctity of marriage, forgiveness and a man’s authority (vs. a woman’s subordination) within the home [323], [340]. Men may use violence in response to a perceived loss of masculinity, such as when traditional gender roles and power are threatened by women’s employment or by educational disparities [323], [340]. VAW is perceived as legitimate when it is used to gain control or to punish when control is challenged [164], [329].

In post-Apartheid South Africa, the perpetration of VAW is associated with a history of violent race- and class-based masculinities [163], [362]. Involvement in various forms of violent activities during Apartheid provided many men with a sense of identity, power and control. Masculinities associated with being part of the struggle, involvement in private security work, militarism and/or vigilante violence shaped the perception among many South African men that violence is intrinsically linked to masculinity.

IPV is sometimes used to defend male dignity and power in circumstances of economic deprivation [164], [327]. Social norms associating male success with economic success encourage men who are economically deprived to gain respect through alternative means; including sexual dominance and power in IRs. Transitional South Africa presents new and evolving masculinities, along with the old [218]. Many South African men have faced marginalisation, poverty and unemployment post-1994, which, together with a backlash against gender equality, have resulted in violent masculinities that contribute to VAW. Often VAW is in response to feelings of powerlessness as a result of not being able to attain ‘successful’ masculinity as breadwinners for the family [327]. The view that women have greater power, are favoured by government and have gained disproportionately in the new South Africa contributes to feelings among some men that their power and control and the patriarchal order is being challenged [218]. As a result, they may seek to reassert their power in the private sphere through perpetration of physical and sexual violence.

Contributing to this feeling of insecurity and powerlessness is the connection between perpetration of VAW and abuse

during childhood, as discussed in section 2.3.2.1 above [20], [109], [123], [189], [243]. Engagement in violent behaviour in adulthood, including membership in gangs and perpetration of various forms of VAW, can act to enable men to regain a sense of power and control lost through childhood abuse.

3.4.6.4 Male Sexual Entitlement and the Male Sex Drive Discourse

In patriarchal societies, such as South Africa, certain assumptions around sex are central to constructions of masculinity. Discourses around male sexual drive, male sexual entitlement and sexual indebtedness are used to legitimise and excuse IPV and non-IP rape and are thus viewed as risk factors for both types of VAW [22], [193], [340], [359]. For instance, it is a widely held belief in some South African communities that men are driven by an uncontrollable biological urge for sex and that men who are sexually aroused need to satisfy their urges [340], [359], [360], [363]. Thus, following the 'male sexual drive' discourse, if a man rapes in order to satisfy this urge, he will not be blamed [8].

Boonzaier et al. point to the double standard within the 'male sexual drive' discourse. In in-depth interviews with couples men commonly questioned their partner's fidelity while they had been, or were currently being, unfaithful themselves [340]. This gendered double standard with regards to infidelity in relationships appeared a number of times in the qualitative literature, with male partners perpetrating IPV against their female partner if she accused them of infidelity [244]. While having multiple sexual partners was seen as an indication of successful masculinity and male sexual drive was used to justify marital infidelity, women were expected to conform to traditional, culturally constructed standards of femininity and female sexual behaviour [340]. Additional research is needed to understand the relationship between marital infidelity and IPV, as it appears common for men who perpetrate IPV to also be unfaithful [340].

Associated with the perception of male sexual entitlement is the notion of 'marital sexual duty', where women are perceived as not being allowed to refuse sex within a marriage [323], [340]. The view that men have the right to sexually control their female partners, that women must comply when their partners demand sex and that women's bodies are objects to be controlled by men appeared a number of times in the literature [323], [327], [340], [359]. Marital rape/sexual IPV is thus legitimised and women are denied choice and agency in their sexual relationships [323].

While quantitative studies investigating such factors are rare, there is some evidence of the role of male sexual entitlement

in rape and sexual IPV perpetration in South Africa. When asked about the motivations for committing IP, non-IP or gang rape, the most common response in a sample of men in a cross-sectional survey on rape perpetration, related to sexual entitlement [110]. 45% of the men in this study who had perpetrated rape indicated that they did not feel guilty. Conflict over refusal of sex and perceived challenges to male control/authority in the relationship were the only types of conflict significantly associated with sexual IPV in a cross-sectional study conducted in Cape Town [193].

A number of qualitative studies explored the association between discourses around male sexual entitlement, sexual drive and VAW in South African communities. Rejection of male sexual propositions can place women at risk for sexual IPV due to ideas around male ownership of women and sexual entitlement [219], [330]. Ethnographic research in an Eastern Cape township revealed how 'forced sex' in sexual relationships was common, ranging from verbal persuasion to physical violence [330]. In many cases, 'forced sex' was viewed as legitimate if it occurred in established relationships, as sex was seen as an obligation and sexual coercion or persuasion was differentiated from rape.

Norms around male sexual drive and male sexual entitlement have also been found to govern transactional sexual relationships [330]. In shebeens⁴³, sex is sometimes used as a currency in return for alcohol. If a woman does not provide sex in return for alcohol, she is seen to have stolen from the man, and his actions are seen to be justified if he consequently enforces his 'right' to sex. It has been suggested that transactional sexual relationships are rooted in the dominant ideals of successful masculinity – the control of women, the male sexual drive discourse and the dismissal of female sexual drive. These ideals may be used to legitimise such exploitative sexual relationships and instances of violence within these relationships [110], [247], [364].

3.4.7 Summary and Conclusion

Violence against women is a critical issue facing South Africa [365]. Post-Apartheid South Africa has a strong legislative framework, which comprehensively outlines the protection and promotion of the rights of women. Unfortunately, for many women their right to freedom and security is but a right on paper as they continue to face high rates of violence in their daily lives. Factors at the individual, relationship, community, and societal level intersect to increase or decrease the likelihood of female victimisation or male perpetration. Although South Africa lacks reliable national data from which prevalence rates can be estimated and longitudinal data from which risk and protective factors can be comprehensibly

⁴³ A shebeen is an unlicensed alcohol venue.

drawn, the analysis of the available literature on risk and protective factors for VAW in South Africa was able to identify several key factors and relationships (see Figure 12).

At the individual level, age, substance use and previous experiences all contribute to women's victimisation and men's perpetration of VAW. For instance, although women of all ages are at risk of violence, younger women may be particularly vulnerable to sexual violence.

Various socio-economic indicators are associated with both victimisation and perpetration. Contexts of poverty and poor education, where resources are scarce and unemployment and substance use is widespread, also contribute to the high levels of VAW.

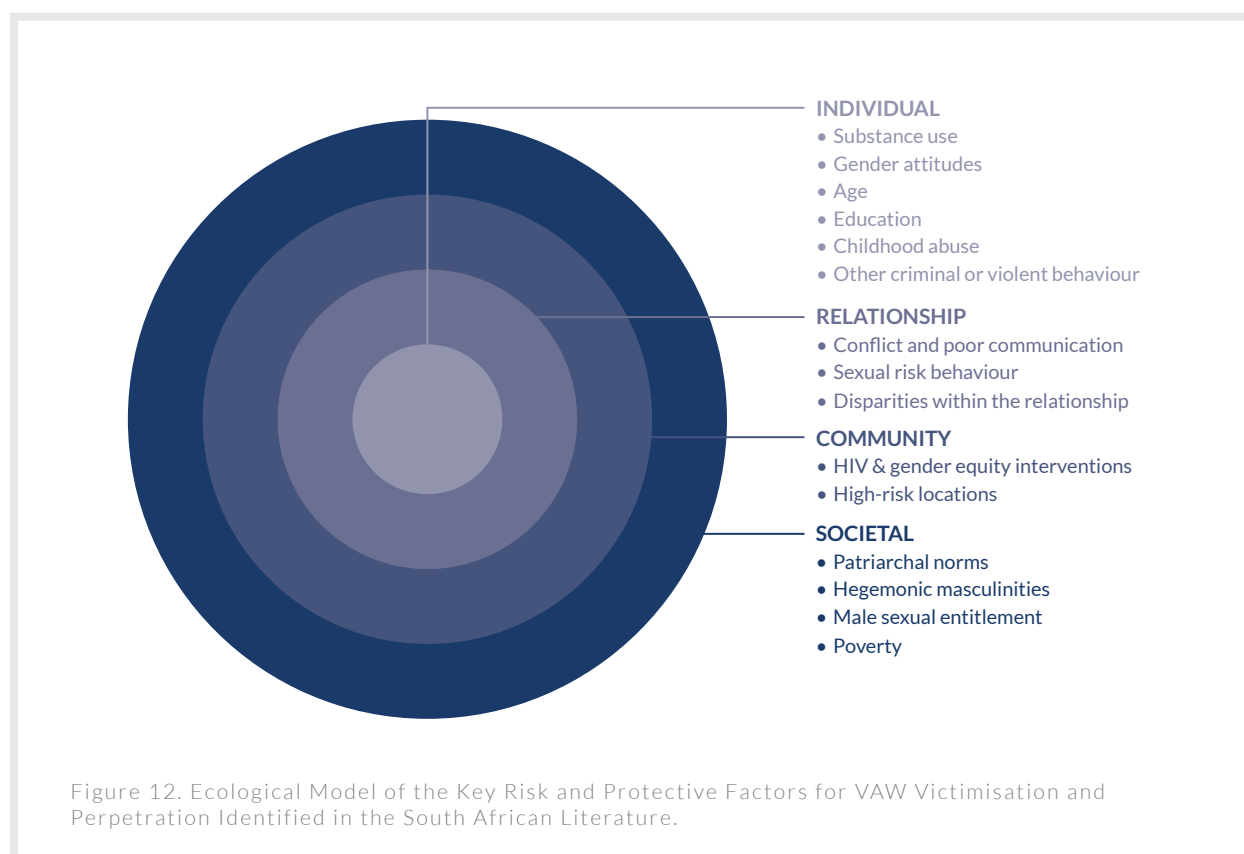
VAW takes places within a broader pattern of violent behaviour and experiences. Perhaps most importantly, there is a significant relationship between childhood experiences and witnessing of violence and later female victimisation or male perpetration of VAW. This suggests that a focus on protecting children from abuse and responding to the effects of past traumas is essential in order to break the intergenerational transmission of violence.

In addition, men who perpetrate IPV and sexual violence are likely to have been involved in other anti-social behaviour,

particularly violent behaviour. Men who are involved with gangs, who have committed other crimes, such as robbery, own an illegal gun or other weapons, have a history of bullying at school, and have been involved in fights at work or in the community may be more likely to also perpetrate VAW. Men who perpetrate one form of VAW often do so more than once and may also be more likely to perpetrate other forms of VAW. The finding that male perpetrators use violence in other spheres of their lives suggests the normalisation of violence as a legitimate means of dealing with conflict and expressing masculinity.

Male dominance and control in relationships speaks to both individual attitudes and beliefs regarding gender roles and broader societal level values and norms that support gender inequity. This reflects the complex interplay between individually held attitudes and community and societal values. While on the one hand gender inequitable, societal and cultural values can become internalised to increase the likelihood for VAW, when individual men hold to misogynistic and gender inequitable attitudes, they in turn contribute to a societal climate of gender inequity.

It is important to acknowledge that VAW in the home takes place within a cultural and social environment that supports patriarchal understandings of masculinity, gender inequitable attitudes and practices, and hierarchical gender positions. Not only are such behaviours within a relationship are associated



with the perpetration of IPV, but controlling and abusive men are also more likely to engage in sexual risk behaviours, which are linked to increased HIV risk among female partners. IPV takes place within a context of fear and high levels of relationship conflict. Abusive relationships are often marked by poor communication, particularly around sex and safe sexual practices.

South Africa is a violent society, with a history of violence being used as a means to resolve conflict. The violence experienced and perpetrated by men under Apartheid has played a role in shaping violent masculinities. The collective trauma experienced under Apartheid and the perception that injustice and past inequities have not been adequately addressed have contributed to high levels of frustration and anger among many South African men. Traditional gender norms as well as the challenging of these norms appear to be risk factors for VAW. Traditional views associate masculinity with power, control and ownership of women, and allow men to punish their partners when 'needed'. Further, prevalent attitudes of male sexual entitlement, male sexual prowess and the inability of men to control their sexual desires are used to justify sexual violence against women. These factors are exacerbated by the high levels of alcohol and drug abuse in South Africa.

Many South Africans lack sufficient respect for the rule of law [366]. This is partly a consequence of the Apartheid era where the laws and law enforcement were often unjust and discriminatory. Now, despite the positive legislative changes, there is still a general cynicism towards the law because many leaders and law enforcers do not abide by the law themselves. In addition, the police and the criminal justice system have not effectively and efficiently addressed VAW [8], [189], [360], [366]. This has resulted in (a) a lack of deterrence for the perpetration of VAW [22], [232]; (b) the creation of a society which lacks respect for the inherent dignity and value of human life [232]; and (c) a culture of fear which places the responsibility on women to protect themselves from violence rather than putting the responsibility on men to refrain from perpetrating VAW.

There are significant gaps in the South African literature on VAW. This limits our understanding of the dynamics related to victimisation and perpetration. Of the larger studies that have examined VAW on a provincial or national scale, few have used regression or modelling techniques to analyse the resulting data. In addition, there is a significant lack of longitudinal research, which is essential for identifying the temporal relationship between risk and protective factors and experiences of violence. Cross-sectional data, on which most of our knowledge about risk and protective factors is based,

only allows the identification of a relationship between factors at one point in time.

Key areas for future research on VAW in South Africa include research into: (a) the risk and protective factors for violence against certain groups of vulnerable women, including elderly women, LB women, women with disabilities, refugee women and sex workers; (b) emotional/psychological and economic IPV; and (c) the impact of drug use and socio-economic factors on victimisation and perpetration. There is a particular dearth of research on the factors that may act to protect women from victimisation and men from perpetrating VAW. Despite this, there is an emerging body of literature on the potential effectiveness of interventions that address gender attitudes in combination with HIV, substance use and/or microfinance at the community level. Such interventions, which target men, have shown promise in reducing violent and other high-risk behaviour, but more research is needed to investigate their effectiveness.

3.5 STRUCTURAL EQUATIONS MODELLING: VAW

The data vetting process indicated that the most appropriate and available data sets for SEM was the Gender Links Gender Based Violence Prevalence and Attitudes Household Survey.

3.5.1 The Gender Links Surveys

The Gender Based Violence Prevalence and Attitudes Household Survey (GBVS) was motivated by a number of important national and regional considerations. It was designed and undertaken by Gender Links in collaboration with SADC Gender Unit, the African Centre for Women at the Economic Commission for Africa and a range of research institutes, NGOs, government agencies and other entities. The objective of the GBVS was to develop a core set of prevalence indicators that will provide for baseline data at inception, and subsequently, robust data for monitoring on-going trends and patterns.

Two surveys were conducted, one for adult women and one for adult men. The women's survey examined violence victimisation and various determinants and risk factors. The men's survey examined violence perpetration and various determinants and risk factors. Both surveys are employed for modelling purposes.

3.5.1.1 GBVS Sampling Issues

The GBVS sampling frame was developed using official data from Statistics South Africa. Both the women's and men's surveys employed a two-stage probability-proportionate-to-size (PPS) stratified design to survey respondents aged 18 years and older in four provinces in South Africa: Gauteng, Limpopo, KwaZulu-Natal and Western Cape. The first stage entailed random sampling of primary sampling units (PSUs) in each of the provinces, and the second stage entailed selection of households within these PSUs.

Respondent inclusion was based on them being: 18 years and older; a regular household member; cognitively competent; and providing informed consent. The survey was administered in a number of different official languages depending on geographical location and respondent characteristics and preferences. Once the survey was completed, the data was reweighted using official statistics to ensure a representative sample of adult women and men in the four provinces.

The lack of a national probability sample may, at face value, be considered an impediment to use of the data for modelling purposes. However, it is argued that the data is nevertheless of great utility for the following reasons:

- The purpose of this research is first and foremost to test the integrity of the explanatory models regarding the risk factors/correlates and determinants of GBV. This provides empirical confirmation of the models developed out of the critical review.
- For modelling purposes, the principal requirement is for a dataset with high internal validity – that is, robust conceptualisation and measurement of key constructs. The GBV surveys easily meet this criterion.
- Once these models have been established and properly verified, they can then be subject to further tests to assess the degree of generalisability to the broader national population. At that stage the national representivity of the sample become critical.

3.5.1.2 GBVS Design Issues

The GBVS are cross-sectional surveys. Accordingly, they carry with them all the associated limitations and risks of such a research design:

- All measures are recorded at a single (contact) point in time – this means that it is difficult to precisely specify the temporality of different behaviours and attitudes, i.e., what are antecedent and what are outcomes.
- The relationships amongst variables may be overestimated – a common challenge with cross sectional surveys is the inflation of the size of inter-relationships amongst variables, meaning that relationships may show even where they are very small or non-significant.
- Overall, the GBVS cross-sectional samples, while arguably less powerful than a panel study in terms of establishing the temporality of antecedents and outcomes, are still very useful for understanding the theoretical relationships amongst key variables.
- However, such results must be seen within the context of the limitations of the cross-sectional research design.

3.5.1.3 GBVS Measurement/Field Issues

The GBVS employed a range of measures to assess various aspects of violence and abuse and the likely determinants or correlates thereof:

- The majority of these are multi-item scales and measures.
- The use of multiple items for scale measurement is optimal as it permits proper coverage of the underlying latent construct and allows greater flexibility for development of composite variables.
- Most of the measures employed in the GBVS have been tested and proven robust in a range of different countries and social, political, cultural and linguistic contexts.
- The items contained in the GBVS measurement scales have thus benefitted from proper scale development and validation both in terms of conceptual formulation and operationalisation of variables.
- Overall, the measurement of key constructs and variables is robust and well validated.

3.5.2 Key Variables: Violence Victimisation

The key variables for violence victimisation drawn from the Gender Links data and used for SEM are listed in Figure 13 on the next page and described in more detail in the subsection below.

BACKGROUND VARIABLES	INDIVIDUAL VARIABLES	RELATIONSHIP VARIABLES	VIOLENCE VICTIMISATION
EDUCATION	DAGGA USE / ABUSE	MALE CONTROL OF RELATIONSHIP	VICTIM: EMOTIONAL IP VIOLENCE
AGE	ALCOHOL ABUSE	ECONOMIC DEPENDENCY	VICTIM: PHYSICAL IP VIOLENCE
HOUSEHOLD / INDIVIDUAL POVERTY	MULTIPLE SEXUAL PARTNERS	TRANSACTIONAL RELATIONSHIPS	VICTIM: ECONOMIC IP VIOLENCE
CHILDHOOD ABUSE	PARTNER'S INFIDELITY		VICTIM: SEXUAL IP VIOLENCE
CHILDHOOD EXP. TO DOMESTIC VIOLENCE	PARTNER ALCOHOL ABUSE		SEXUAL VIOLENCE (NON-IP)

Figure 13: GBVS Key Variables (Violence Victimization).

3.5.2.1 Background/Base Variables: Violence Victimization

HOUSEHOLD/INDIVIDUAL POVERTY	A composite measure of the extent to which the household goes without food combined with the degree of access by the respondent to emergency money.
AGE	The current age of the respondent.
EDUCATION	The highest level of education attained by the respondent.
CHILDHOOD EXPOSURE TO DOMESTIC VIOLENCE	The respondent's exposure to domestic violence in their childhood home before they reached 18 years of age.
CHILDHOOD ABUSE	The frequency with which the respondent had suffered emotional, physical and sexual abuse before they had reached 18 years of age. This construct was measured by way of three separate scales – for physical, emotional and sexual abuse. However, the very high correspondence between the three inhibited their use separately, and the overall single construct was instead employed.

3.5.2.2 Individual Variables: Violence Victimization

ALCOHOL ABUSE	The extent of long-term use and abuse of alcohol by the respondent, weighted for binge drinking.
DAGGA USE	The extent of use of dagga by the respondent in the past 12 months.
PARTNER ALCOHOL ABUSE	The extent of long-term use and abuse of alcohol by the respondent's most recent or current partner, weighted for binge drinking.
MULTIPLE PARTNERS	The number of sexual partners of the respondent in the past year, weighted by the number of sexual partners throughout their lives.
PARTNER INFIDELITY	The respondent's assessment of the likely infidelity of their current or most recent partner.

3.5.2.3 Relationship Variables: Violence Victimisation

MALE CONTROL OF RELATIONSHIP	The extent to which the male partner exercised control over the behaviour, movement and activities of the woman. This variable covered aspects of condom negotiation during sex, economic activity, freedom of association and belief.
ECONOMIC DEPENDENCY	The extent of economic dependence by the respondent on the male partner. This variable covered all behaviours by a woman to initiate and remain in relationships in order to ensure the economic survival of herself and her children.
TRANSACTIONAL RELATIONSHIPS	The extent to which the respondent had engaged in casual relationships as a means to securing economic and financial security

3.5.2.4 Outcome Variables: Violence Victimisation

EMOTIONAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, been subjected to emotional abuse and violence by their intimate partner at the time.
PHYSICAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, been subjected to physical abuse and violence by their intimate partner at the time.
SEXUAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, been subjected to sexual abuse and violence by their intimate partner at the time.
ECONOMIC IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, been subjected to economic abuse and violence by their intimate partner at the time.
SEXUAL VIOLENCE (NON-IP)	The frequency with which the respondent had, at any point in their lives, been subjected to sexual violence by someone other than their intimate partner at the time.

3.5.3 SEM Models: Violence Victimisation

3.5.3.1 Physical Intimate Partner Violence

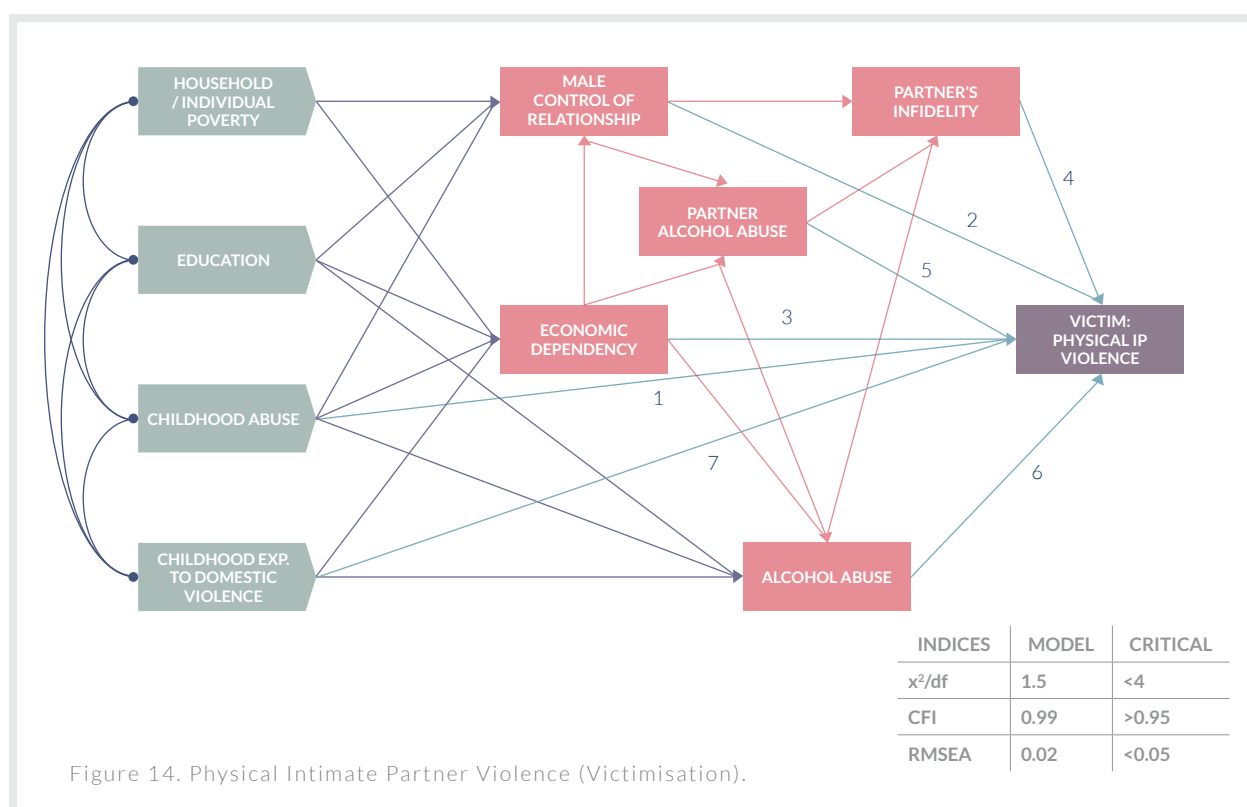
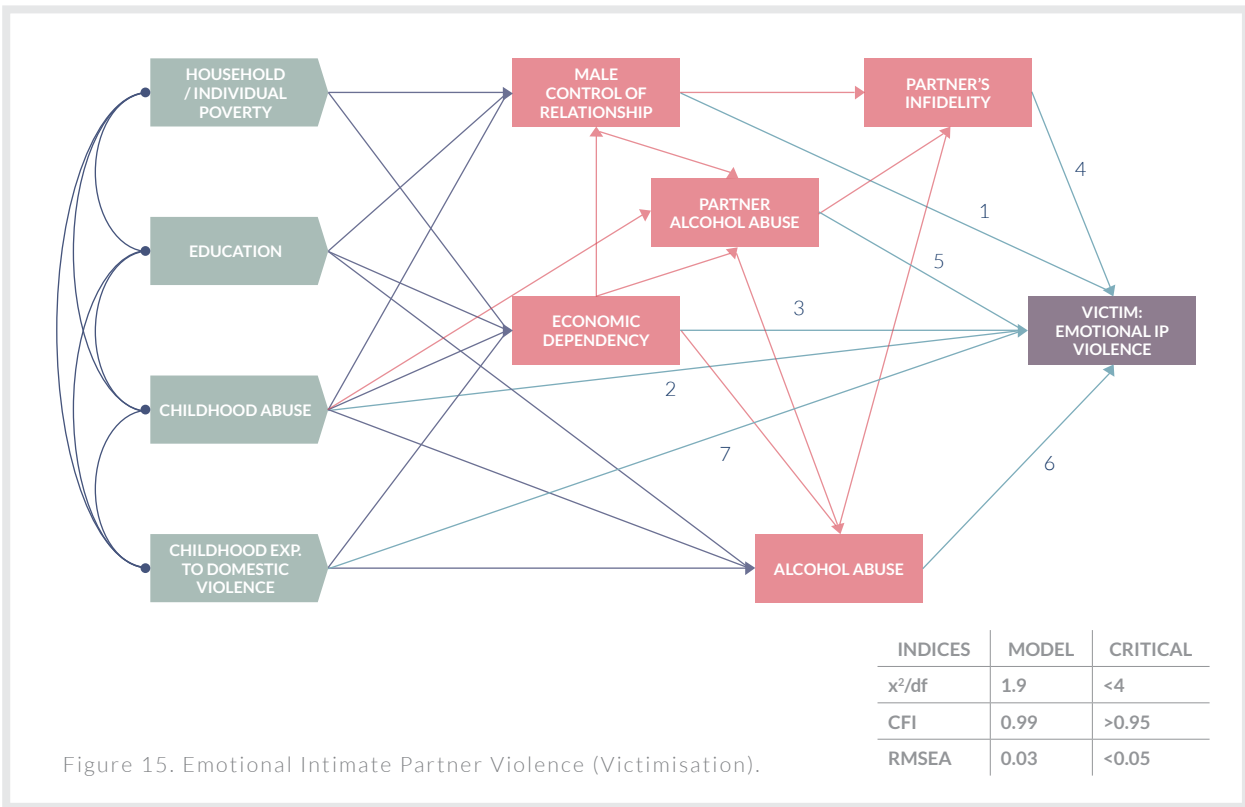
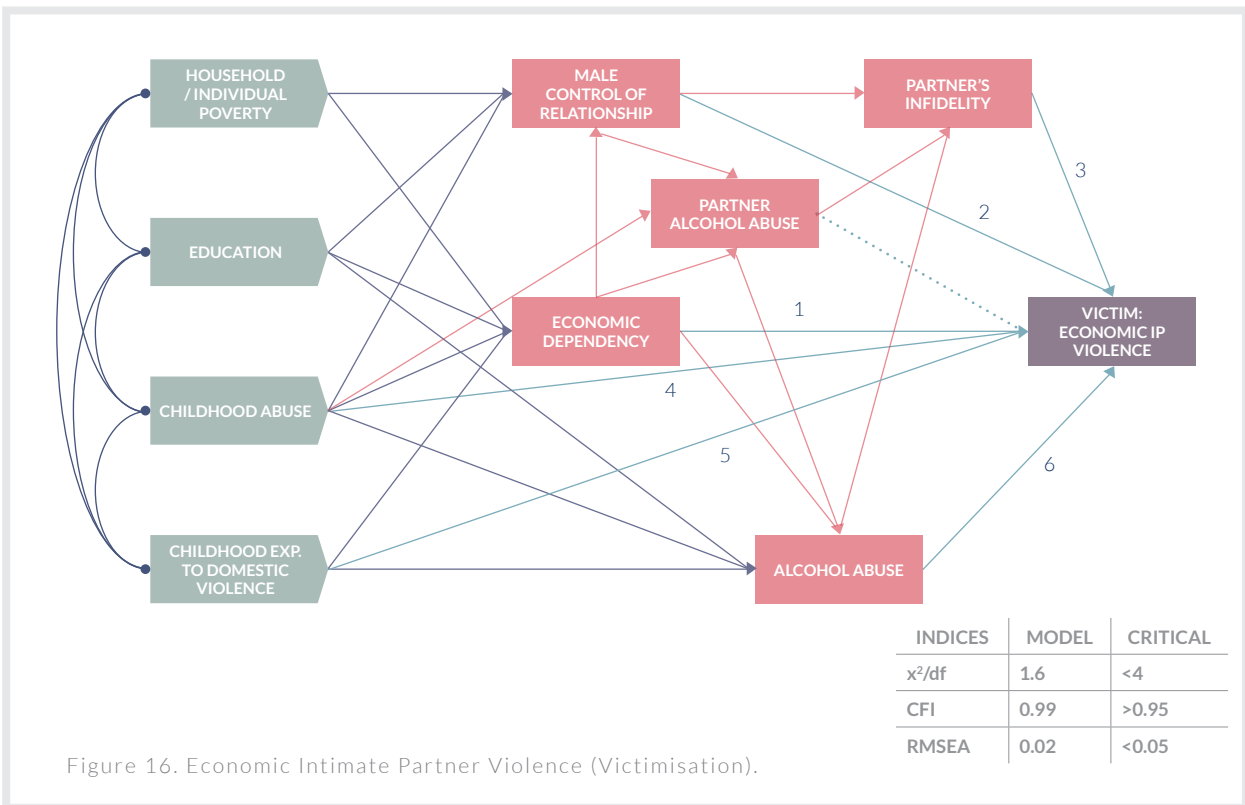


Figure 14. Physical Intimate Partner Violence (Victimisation).

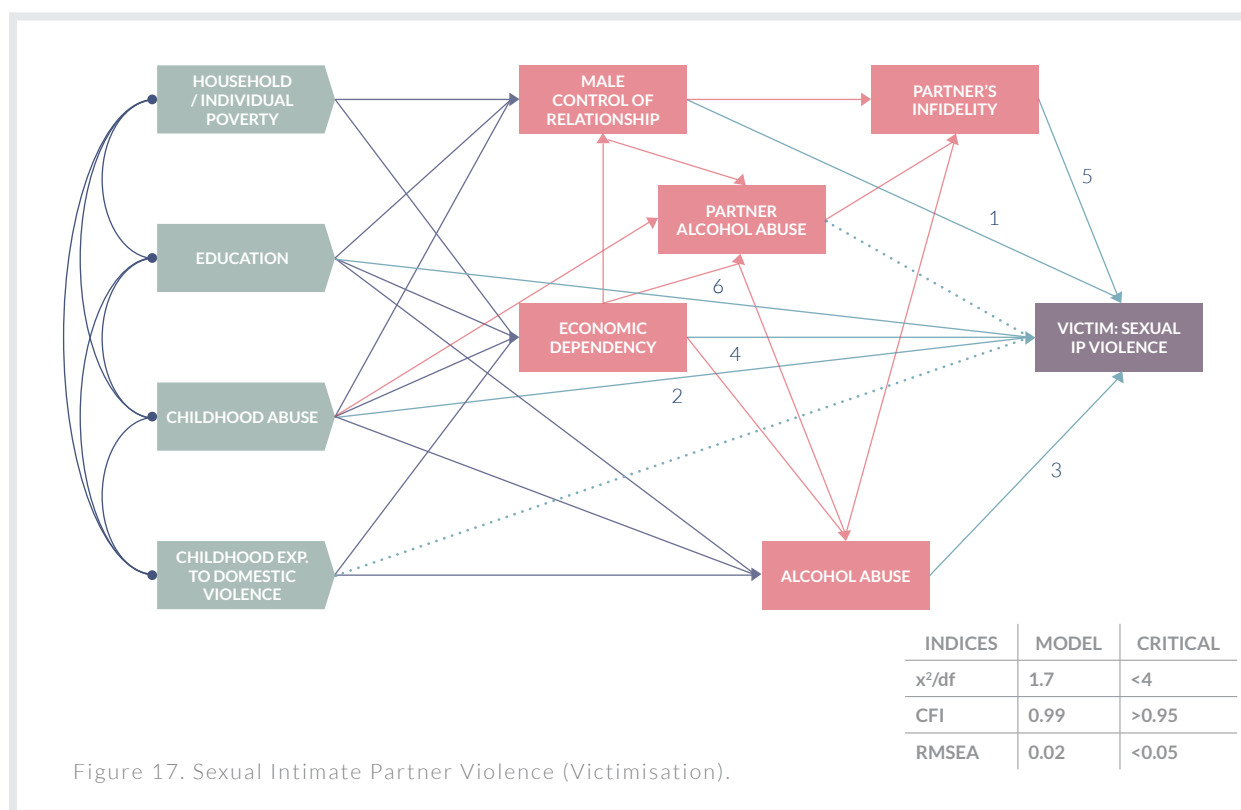
3.5.3.2 Emotional Intimate Partner Violence



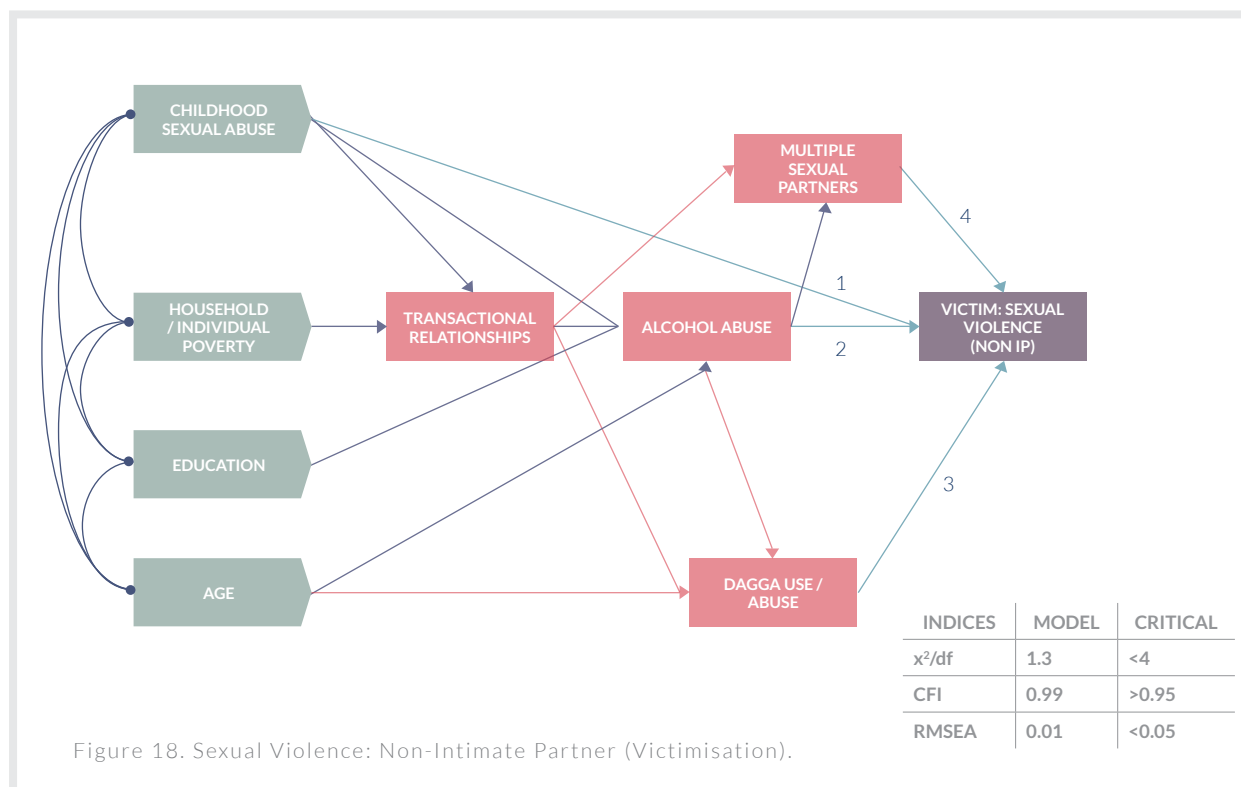
3.5.3.3 Economic Intimate Partner Violence



3.5.3.4 Sexual Intimate Partner Violence



3.5.3.5 Sexual Violence (Non-Intimate Partner)



3.5.3.6 Key SEM Findings: Violence Victimization

Risk/Protective Factors: Base Variables

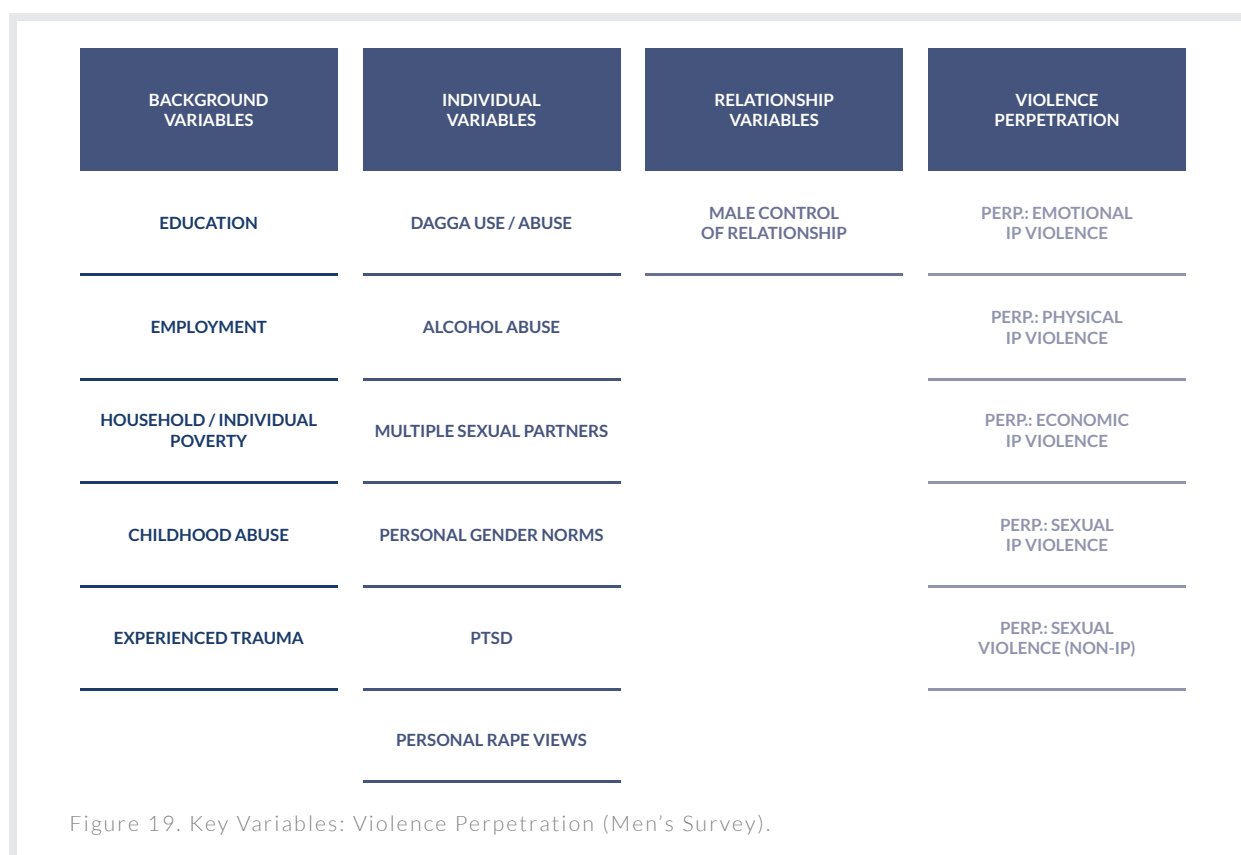
- **Individual/Household Poverty:** Individual and household poverty feature significantly as a base indirect determinant for victimisation. Women from poorer backgrounds are at much greater risk for all types of violence, both IP and non-IP. Higher levels of poverty amongst women are significant determinants of greater economic dependency and diminished control in their current or most recent relationship. There is a strong association between poverty and exposure to domestic violence during childhood and childhood abuse. The association between education and poverty is also in the expected direction.
- **Education:** The educational levels of respondents was significantly indirectly related to their risk of violence victimisation, with lower levels of education being associated with increased risk of violence victimisation (through intermediate factors). Education is a significant direct determinant of greater economic dependency on male partners and a diminished control in the relationship. It is also a significant determinant of increased alcohol abuse.
- **Age:** Age was a significant indirect determinant of risk for victimisation in term of sexual violence, with a direct effect in terms of increased use of alcohol and dagga by younger women, both of which increased risk of suffering sexual violence.
- **Childhood Abuse:** Emotional, physical and sexual abuse suffered by the woman as a child was a significant base determinant of violence victimisation. The effect for such abuse was both indirect and direct. In many instances of victimisation, childhood abuse was the most significant risk factor. In terms of the indirect effects of childhood abuse:
 - *Abuse during childhood places women at higher risk for economic dependency.*
 - *Abuse during childhood places women at higher risk for diminished control in relationships.*
 - *Abuse during childhood was a significant predictor of their alcohol abuse.*
 - *Abuse during childhood was a significant predictor of association with partners who abused alcohol.*
 - *Abuse during childhood was a direct determinant of engagement in transactional relationships.*

Risk/Protective Factors: Intermediate Variables

- **Economic Dependency:** Economic dependency by women on their partners left them vulnerable to all forms of IP violence:
 - *The effect was direct in all forms of violence victimisation except sexual violence.*
 - *The effect was indirect in terms of an increased probability of alcohol abuse, which in turn increased the probability of violence victimisation.*
- **Transactional Relationships:** There is an indirect risk of sexual violence victimisation as a result of increased propensity for transactional relationships. Such relationships lead to:
 - *Multiple partners; and*
 - *Increased alcohol and dagga abuse, both of which in turn increase the risk of suffering sexual violence.*
- **Alcohol Use and Abuse:** women who abuse alcohol are at greater risk for all forms of violence victimisation. The effect is both direct and indirect (through the determination of multiple sexual partners in the case of sexual violence).
- **Partner Alcohol Abuse:** The abuse of alcohol by the partner of women is a significant determinant, direct and indirect, of violence victimisation. The effect is indirect through the perceived infidelity of the partner. The partner's alcohol abuse is significantly directly determined by their control in the relationship and the extent to which the women are economically dependent on them.
- **Partner Infidelity:** Perceived infidelity by their male partners is a significant determinant of increased risk for violence victimisation. Such infidelity is predicted by the control the male has in the relationship as well as the abuse of alcohol by the woman - women who abuse alcohol are more likely to be in relationships with partners who are more likely to be unfaithful.

3.5.4 Key Variables: Violence Perpetration (Men's Survey)

The violence perpetration SEM draw on some common variables with the victimisation models, as well as unique variables. The unique variables will be described in some detail in the pages that follow.



3.5.4.1 Background/Base Variables: Violence Perpetration

HOUSEHOLD/INDIVIDUAL POVERTY	A composite measure of the extent to which the household goes without food combined with the degree of access by the respondent to emergency money.
AGE	The current age of the respondent.
EDUCATION	The highest level of education attained by the respondent.
CHILDHOOD EXPOSURE TO DOMESTIC VIOLENCE	The respondent's exposure to domestic violence in their childhood home before they reached 18 years of age.
CHILDHOOD ABUSE	The frequency with which the respondent had suffered emotional, physical and sexual abuse before they had reached 18 years of age. This construct was measured by way of three separate scales – for physical, emotional and sexual abuse. However, the very high correspondence between the three inhibited their use separately, and the overall single construct was instead employed.

3.5.4.2 Individual Variables: Violence Perpetration

ALCOHOL ABUSE	The extent of long-term use and abuse of alcohol by the respondent, weighted for binge drinking.
DAGGA USE	The extent of use of dagga by the respondent in the past 12 months.
PARTNER ALCOHOL ABUSE	The extent of long-term use and abuse of alcohol by the respondent's most recent or current partner, weighted for binge drinking.
MULTIPLE PARTNERS	The number of sexual partners of the respondent in the past year, weighted by the number of sexual partners throughout their lives.
MALE CONTROL OF RELATIONSHIP	The extent to which the respondent exercised control over the behaviour, movement and activities of their partner. This variable covered aspects of condom negotiation during sex, economic activity, freedom of association and belief.

3.5.4.3 Relationship Variables: Violence Perpetration

MALE CONTROL OF RELATIONSHIP	The extent to which the male partner exercised control over the behaviour, movement and activities of the woman. This variable covered aspects of condom negotiation during sex, economic activity, freedom of association and belief.
ECONOMIC DEPENDENCY	The extent of economic dependence by the respondent on the male partner. This variable covered all behaviours by a woman to initiate and remain in relationships in order to ensure the economic survival of herself and her children.
TRANSACTIONAL RELATIONSHIPS	The extent to which the respondent had engaged in casual relationships as a means to securing economic and financial security.

3.5.4.4 Outcome Variables: Violence Perpetration

EMOTIONAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, perpetrated emotional abuse and violence on their intimate partner at the time.
PHYSICAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, perpetrated physical abuse and violence on their intimate partner at the time.
SEXUAL IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, perpetrated sexual abuse and violence on their intimate partner at the time.
ECONOMIC IP VIOLENCE	The frequency with which the respondent had, at any point in their lives, perpetrated economic abuse and violence on their intimate partner at the time.
SEXUAL VIOLENCE (NON-IP)	The frequency with which the respondent had at any point in their lives, subjected a woman, other than their partner at the time, to sexual violence.

3.5.5 SEM Models: Violence Perpetration

3.5.5.1 Physical Intimate Partner Violence

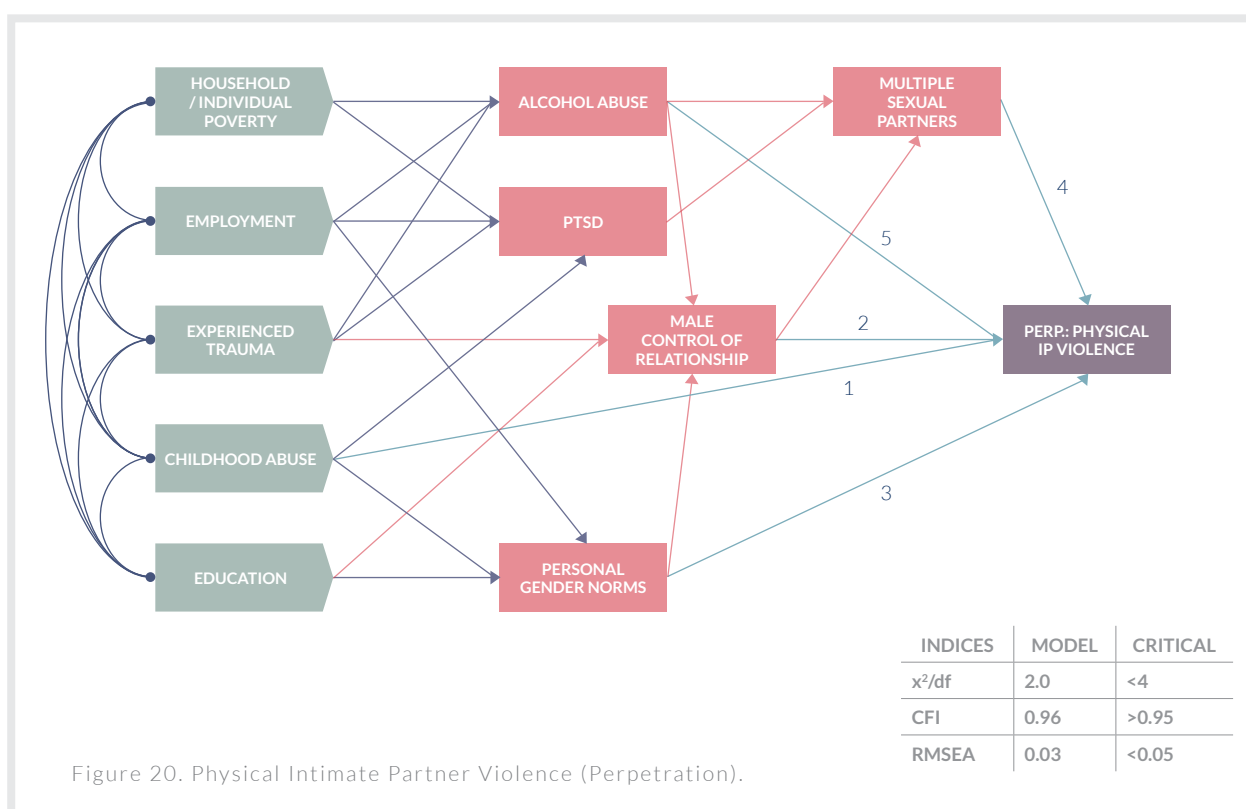
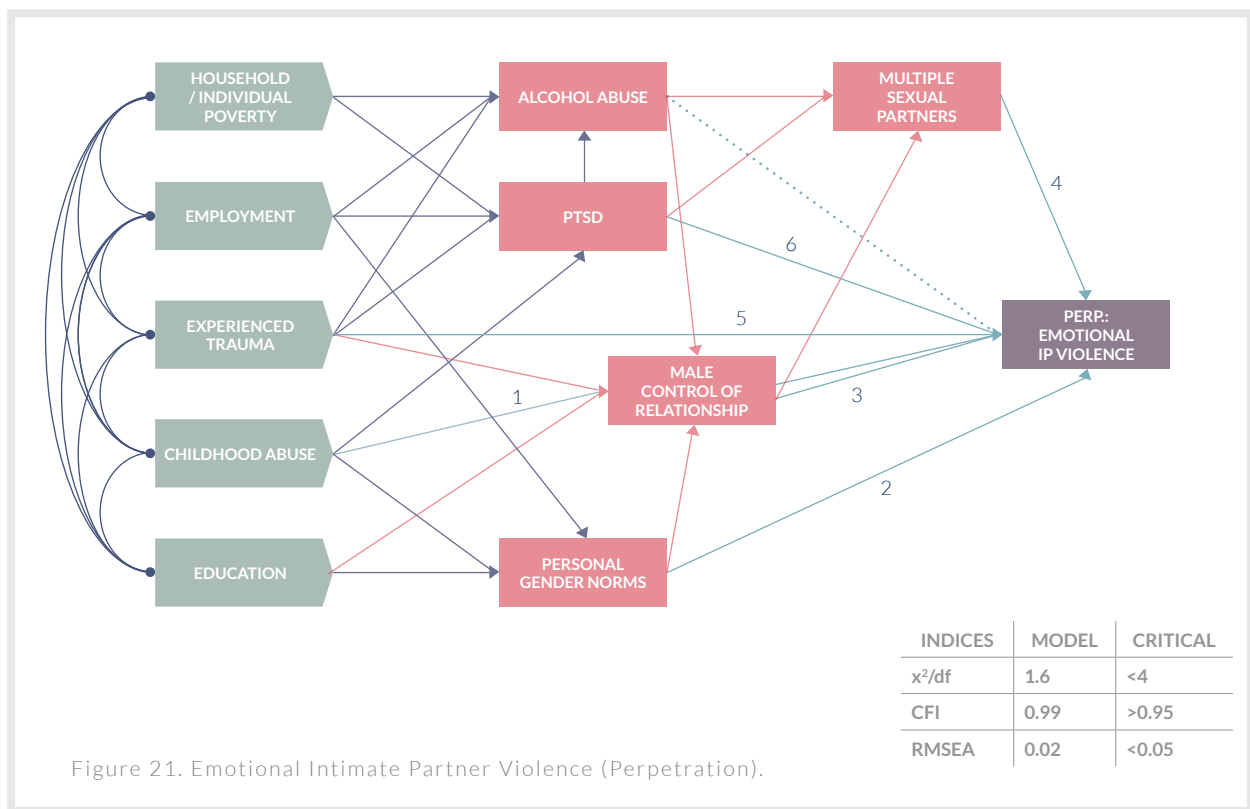
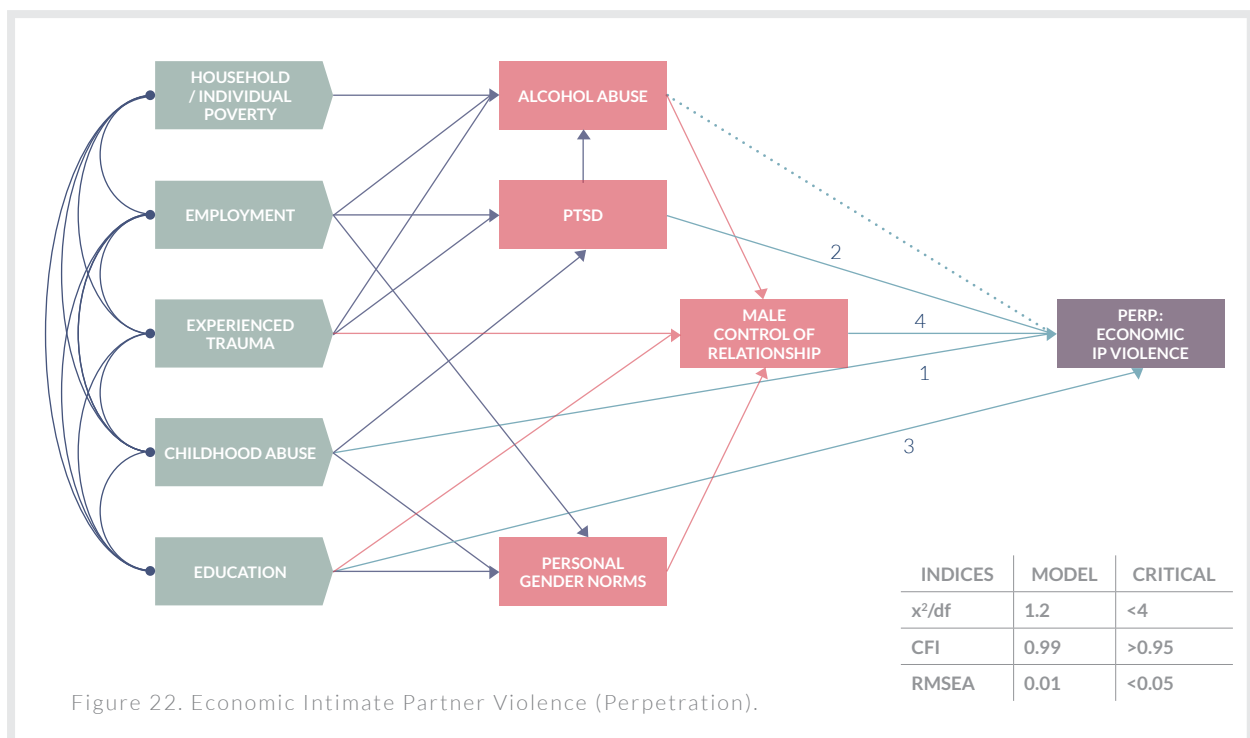


Figure 20. Physical Intimate Partner Violence (Perpetration).

3.5.5.2 Emotional Intimate Partner Violence



3.5.5.3 Economic Intimate Partner Violence



3.5.5.4 Sexual Intimate Partner Violence

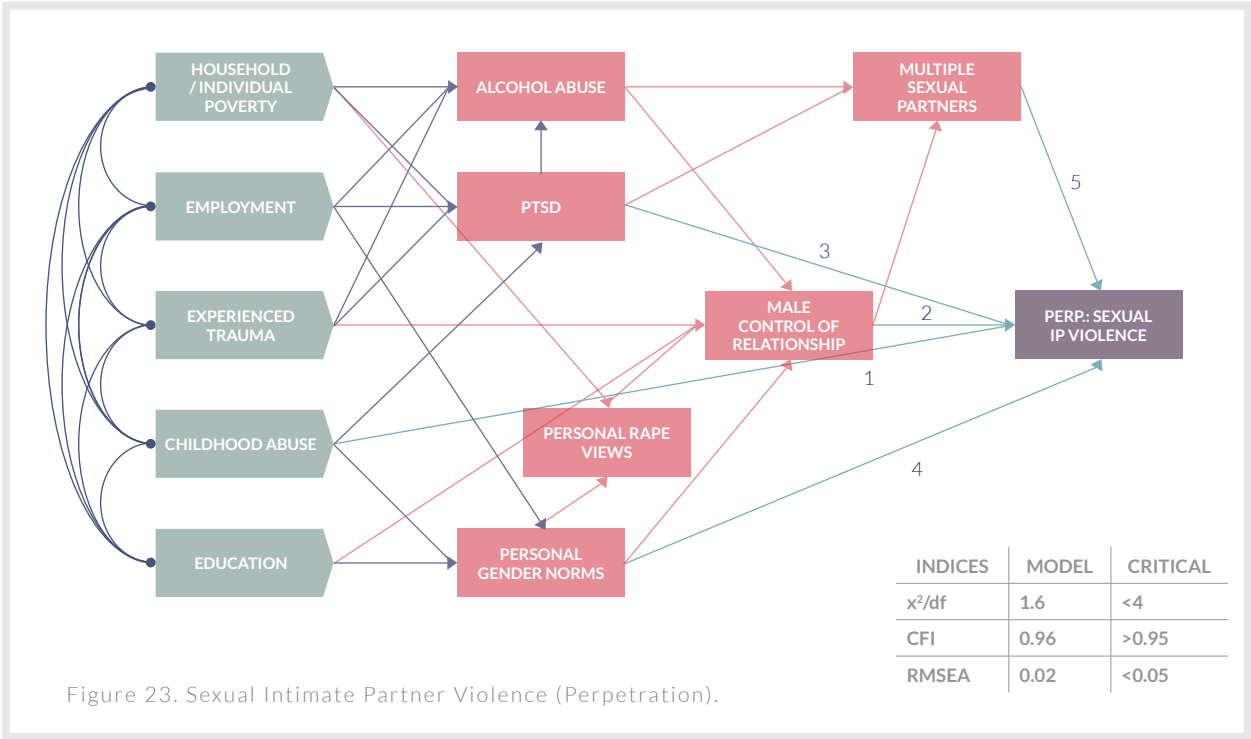


Figure 23. Sexual Intimate Partner Violence (Perpetration).

3.5.5.5 Sexual Violence (Non-Intimate Partner)

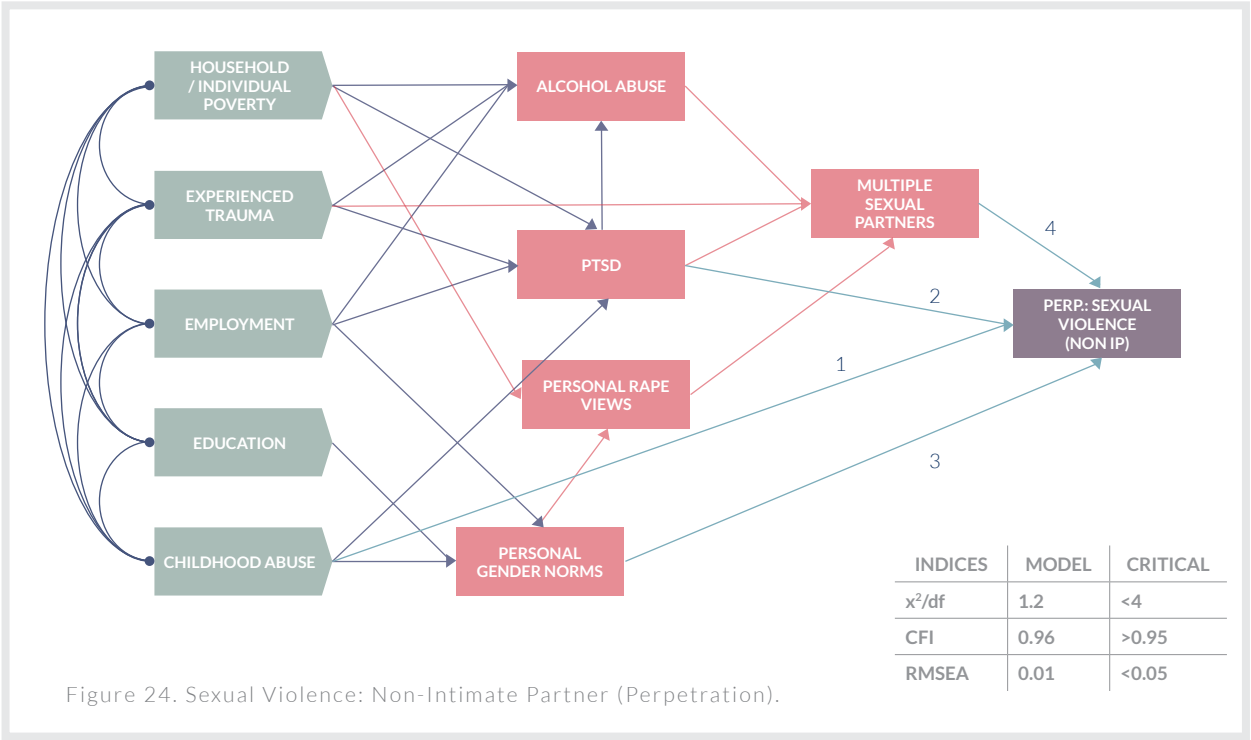


Figure 24. Sexual Violence: Non-Intimate Partner (Perpetration).

3.5.5.6 Key SEM Findings: Violence Perpetration

Risk/Protective Factors: Base/Background Variables

- **Individual/Household Poverty:** Individual and household poverty feature significantly as a base indirect determinant for perpetration. Men from poorer backgrounds are more likely to perpetrate all forms of intimate partner violence. They are also more likely to have been exposed to trauma or suffered abuse during childhood. Poverty is also strongly associated with employment status and education in the expected direction. There is a direct relationship between increased poverty and negative personal rape views.
- **Education:** The educational level of respondents was significantly indirectly related to their risk of violence perpetration, with lower levels of education being associated with increased risk of perpetration of all forms of violence. Lower education is a significant direct determinant of greater male control in the relationship and inequitable personal gender norms.
- **Employment:** Employment was a significant indirect determinant of perpetration. The direct effects for employment were on symptomatology of PTSD, with unemployed men more likely to report such symptoms and greater perpetration of violence.
- **Childhood Abuse:** Emotional, physical and sexual abuse suffered by the man as a child was a significant base determinant of violence perpetration. The effect for such abuse was both indirect and direct. In many instances, childhood abuse was the most significant risk factor for violence perpetration. In terms of the indirect effects of childhood abuse:
 - *Childhood abuse was a direct determinant of increased symptomatology of PTSD, which then impacted on increased propensity for violence perpetration; and*
 - *Childhood abuse was a significant predictor of personal gender norms, in that men who suffered such abuse were less likely to ascribe to gender equality and parity.*
- **Experience of Trauma:** The experience of trauma was a significant indirect determinant of violence perpetration. Higher levels of trauma were significantly directly associated with:
 - *Increased alcohol abuse;*
 - *Greater control in the relationship; and*
 - *Perpetration of emotional IP violence*

Risk/Protective Factors: Intermediate Variables

- **Male Control in Relationship:** The extent of control of the relationship by the male partner was both a significant indirect and direct determinant of violence perpetration. In terms of the indirect determination:

- *Greater control in the relationship was a significant determinant of increased abuse of alcohol, which in turn increased probability of violence perpetration; and*
- *Greater control was a significant determinant of increased infidelity, which in turn increased probability of violence perpetration.*
- **Personal Gender Norms:** Personal norms about inequitable gender relationships were a significant direct and indirect predictor of increased violence perpetration. The direct effect was on almost all forms of IP violence, while the indirect effect was in terms of the greater degree of control imposed on the relationship.
- **Personal Rape Views:** These negative views were a significant indirect determinant of increased perpetration of sexual violence, through the direct effect on more multiple sexual partners.
- **Alcohol Use and Abuse:** Alcohol abuse is a significant direct determinant of almost all forms of violence perpetration, with increased abuse predicting increased propensity for such perpetration. It is also significant indirectly in terms of the effect on increased multiple sexual partners, which in turn increases the propensity for perpetration.
- **Multiple Sexual Partners:** The increased number of concurrent sexual partners by males has a direct impact on the increased probability of violence perpetration. Such behaviour is in turn determined by the degree of control exercised in the relationship: men who impose their control are more likely to have multiple sexual partners and perpetrate all forms of IP violence.

3.5.6 Summary of Key Findings: Victimisation and Perpetration

3.5.6.1 Childhood/Background Factors:

- **Demographics:** Demographic background variables, especially those reflecting poverty and disadvantage, play a central role in indicating increased risk for victimisation and propensity for perpetration. This echoes the findings of the VAC modelling.
- **Childhood Abuse:** This variable is highly indicated for both victimisation and perpetration. It reflects a strong inter-generational effect that perpetuates the cycle of violence from parent to offspring. Family dynamics and parenting are also reflected in this, and this result corresponds to that found in the VAC models.

3.5.6.2 Relationship Characteristics and Dynamics

- **Male Control of Relationship:** The prominence of this variable reflects the strong role of relationship dynamics in both violence victimisation and perpetration. Women

who cede power to their partners place themselves at greater risk of victimisation, while men who capture this power create a platform for violence perpetration.

- **Economic Dependency:** Just as with male control of relationship, this variable reflects the centrality of relationship dynamics for both victimisation and perpetration. Women's economic dependency on their partners leaves them significantly more vulnerable to all forms of IP abuse and victimisation.
- **Transactional Relationships:** Engagement in such relationships is a high risk factor for suffering sexual violence.

3.5.6.3 Personal Characteristics and Behaviours

- **Personal Gender Norms:** For men, their personal views about gender relations are key to how they conduct themselves and their relationships, and this effect is very pronounced in most forms of violence perpetration.
- **Alcohol and Drug Abuse:** Substance abuse derives from/is facilitated by the dynamics of the relationship, and increases risk of victimisation and propensity for perpetration.
- **Trauma and Post Trauma:** Trauma and the post-trauma symptomatology are significant in explaining men's greater propensity for perpetration of all types of violence.



04

BEST PRACTICES FOR THE PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN

This section summarises accepted best practices for preventing and addressing violence against women and children that emerge from both local and international contexts. Additionally, it identifies many of the barriers to implementing best practices with a view towards finding interventions to address violence against women and children that may be effective and workable in South Africa.

4.1 ABOUT THIS SECTION

This section summarises accepted best practices for preventing and addressing VAC and VAW that emerge from both local and international contexts. Additionally, it will identify many of the barriers to implementing best practices with a view towards finding VAC and VAW interventions that may be effective and workable in South Africa.

Describing any intervention as a best practice is to make a very strong claim: international best practices suggest transferability and replicability, but evidence cautions against disregarding context-specific characteristics and dynamics. Hence, the examples provided in this section are not definitive, nor are they applicable to all contexts at all times, even within South Africa. They are instead examples of currently applied practices and interventions which evidence suggests are working well or have demonstrated applicability in South Africa. The language of “promising” or “good” practices are used when these initiatives provides evidence of potential scalability; and use “best” practices generally to refer to internationally recognised models for best practices.

This brief discusses successful strategies for violence prevention at three levels, namely primary, secondary and tertiary:

- Primary Prevention seeks to prevent violence exposure prior to its occurrence.
- Secondary Prevention is used in high-risk situations, or immediately after VAC or VAW has occurred (referred to as early intervention in South African literature and related policy).
- Tertiary Prevention addresses the long-term consequences of violence [367].

4.2 VIOLENCE AGAINST CHILDREN

4.2.1 Introduction

Effective prevention of VAC requires that we understand the scale of the problem, where it occurs, and the risk and protective factors. Children’s age and developmental status are an essential consideration, as vulnerabilities vary across child development [368]:

- Infants and young children are particularly dependent on the care of adults and older children, and are most at risk for victimisation at home.

- In middle childhood (around 7 to 11 years), exposure to harsh discipline remains prevalent, and sexual abuse emerges as a risk (sexual violence to infants remains rare).
- In adolescence, children are less dependent on parental supervision, and spend more time outside the home, at school, and engaged in activities in their communities, exposing them to risks in other settings. Sexual maturity following puberty opens up new challenges for both boys and girls.

4.2.2 Preventing Violence in the Home

The nature of risks and protective possibilities in the family are key to planning interventions. Many South African families are likely to be rendered vulnerable by a mix of poverty, conflict and substance abuse. The Department of Social Development has programmes in place to address the needs of these families affected by substance abuse and other challenges.

A key message from the South African research is that these interventions should *not be divorced from more intensive targeted interventions* to protect children. Children in these households are very likely to have already been victims of violence, are highly vulnerable, and without intervention are likely to require statutory intervention.

As is recognised in the Children’s Act, preventive interventions have to commence early to reduce the numbers of children at risk. They may be universal or targeted:

- **Universal preventive interventions** target the general population and seek to reduce the risk of harm occurring to children in the first place. Policies and laws are included as are strategies to provide parents with knowledge of child development, to improve parents’ relationships with their children, and impart positive discipline skills.
- **Targeted interventions** address the needs of particular populations known to be at risk for maltreatment. Most commonly these are vulnerable caregivers (and often their families), who are challenged by problems that place their children at risk for maltreatment.

Unfortunately, only a limited number of prevention programmes focusing on the family home, including those for sexual abuse [369], have been shown to be effective [5]. In part this is due to the limited number of rigorous studies that have been conducted – particularly in South Africa – but also because of the complex and multifaceted causes of maltreatment, which make effective prevention a significant challenge, particularly in multi-problem families. Those that have shown potential for these populations are commonly long-term and high-cost and require professional staff [370]. However, a number of interventions have been successful in improving qualities known to protect children and reduce

risks of harm. Improving relationships between parents and children is key, as is early intervention where children are known to be at risk from toxic family environments.

Children who have been victims of maltreatment and abuse are more likely to become victims of future abuse or perpetrators of further violence. Thus, it is critical to support prevention programmes that foster nurturing and non-violent caregiving among parents. For example, parent programmes encourage healthy and stable relationships between caregivers and children [371]. Research from the World Health Organization has shown that these programmes have the potential to prevent child maltreatment, reduce childhood aggression [371].

4.2.3 Violence Prevention in Communities

Evidence from South Africa and other countries suggest that it is a common error to locate the source of interpersonal and gang violence in the young people themselves. This is certainly part of the problem to be addressed. However, equally important is the constellation of factors that make violence and criminal behaviour more likely in some communities rather than others, and which provide few opportunities for positive growth and development.

However, making dangerous communities safer is a considerable challenge, particularly where housing stock and infrastructure is degraded, social cohesion is fractured, gangs and organised crime exerts control and where policing is weak or ineffective. Solutions require long-term investment and significant political will. A mind shift is necessary from an overemphasis on individual youth and criminal justice solutions that leave the social and physical ecology intact, to integrated city strategies (that include effective policing, infrastructure development, school improvement and youth employment schemes). When applied to Diadema in Brazil, the homicide rate dropped by 80% [372].

A promising South African example that has shown promise in reducing homicides in an area of Cape Town is *Violence Prevention through Urban Upgrading*. The programme involves the re-design of township areas to promote safety and create positive spaces for child and youth activities such as sports [373]. The CSIR Safe Community of Opportunity model provides a comprehensive approach to improving community safety [374].

The key is to increase community safety for children by addressing the systemic and multi-determinant nature of the problem. This takes time, political will, capability and investment. As a minimum, based on promising practice, and informed by the research literature and interviews with

South African children [111], local governments would be well advised to:

- Use a *population-based approach* that takes account of the likely scale of risk to budget for and progressively role out services informed by the best evidence available.
- Collect data on the intervention community and use it to understand possible sources of violence exposure, community resources, and to track change over time. Crimes that present risks to children and adolescents can be geocoded and mapped to identify hotspots that can be studied to understand both structural and personal correlates to inform intervention.
- Undertake research to establish the needs of the most high-risk groups for perpetration and exposure to violence in the community (normally adolescents and young adults). This will inform interventions appropriate to their situations and capacities.
- Provide safe and positive spaces for children and youth to engage in constructive activity after school and in the holidays.
- Consult children and youth: Rather than imposing activities on the target population, consultations with different age groups are necessary to inform what is provided.
- Use locally available facilities where feasible. Community halls, school facilities and those of faith-based organisations provide potential sites for programmes.
- Secure the safety of playgrounds, libraries and other areas used by children (such as open areas on housing estates).
- Prevent drug dealing and enforce alcohol regulations.

4.2.4 Violence Prevention in Schools

The evidence base for the prevention of violence in schools is fairly extensive. However, evaluations are limited in South Africa [375]. It is important to distinguish between efforts to prevent criminal and gang violence spilling over into schools through improving security, and the prevention of corporal punishment and other forms of school-based victimisation such as bullying. Public health approaches that take the whole school into account and have a clear understanding of the dynamics of the problem are likely to have most success. Effective schools in violence-prone neighbourhoods can impact positively on the resilience of children [176].

Recommendations for improving school safety and preventing violence in schools have already been provided to government [376], [377]. Educators have reportedly received training on positive discipline to assist them to cease corporal punishment

and improve classroom management. It is not clear how well this was delivered, monitored and evaluated. However, it is clear that the impact of has been very limited; and high rates of corporal punishment and violence to children in school continue. Although not without challenges, particularly in communities affected by violence, progress is possible.

The Department of Basic Education has a well-informed and comprehensive *School Safety Framework* [378]. If effectively implemented by Provincial governments, victimisation of children at schools can be reduced. However, it is important to note that such a strategy can only be properly implemented in well-run schools, and hence provincial governments need to support school leadership in this regard with the support of the school governing body. Teacher Unions have significant potential to influence the effectiveness of school management, teaching and prevention of corporal punishment and other forms of violence. They should be engaged as partners in school violence prevention.

Particular attention needs to be paid to sexual abuse by educators as this remains a significant problem, and as learners are subject the authority of educators, their ability to report is significantly constrained. School leadership must enable reporting by learners if progress is to be made. In addition, as significant numbers of children experience the trauma associated with violence in the home, school and community, provision of counsellors is *strongly* recommended.

Guidelines of programmes for prevention in schools based on evidence from research studies and promising practice are provided in Table 15.

4.3 VIOLENCE AGAINST WOMEN

4.3.1 Introduction

Research has indicated that VAW can be prevented, or at least its trajectory positively altered [371]. While violence prevention strategies prioritise the primary prevention of VAW – where violence is prevented before it manifests – to date, the vast majority of resources and interventions have been directed at secondary and tertiary prevention programmes [379], which generally treat the symptoms, rather than the underlying causes, of violence.

However, in recent years, international efforts have increasingly focused on primary prevention through the slow and incremental accrual of evidence highlighting methods, approaches and practices that may prevent violence before it manifests [379]. Hence, many of the programmes designed for the prevention of VAW also have direct relevance for the prevention of VAW, such as early childhood education and

schools-based programming. It has also been pursued with the understanding that primary prevention cannot be effective where there is minimal commitment to secondary and tertiary prevention and that the three levels of prevention are both complementary and interdependent. There are several reasons for this.

The first relates to the complex cycle of abuse and victimisation, where victims of abuse or of other “violence exposure” experiences become perpetrators of abuse themselves. Epidemiological and empirical conclusions surrounding this victim-to-perpetrator cycle are extensive but contradictory, largely as a result of how “abuse” is defined (i.e. indirect violence/exposure to direct victimisation), the age-of-onset and length of time of victimisation/exposure, the relationship of the victims and perpetrators (family, community, peers), victim recall and perceptions of “degree of harm suffered”, the levels resilience of affected victims, just to mention a few. However, there is a generally accepted theory that victimisation *may* lead to perpetration and that prevention of this is critical before the onset of both internalised *and* externalised abusive or destructive behaviours.

Secondly, if victims receive relevant services and adequate care:

1. They are more willing and able to proceed with the criminal justice process, subsequently reducing impunity, increasing deterrence and preventing further violence;
2. Further victimisation can be curbed in the context of widespread intimate partner violence; and
3. They can become important advocates for change in the wider system, drawing on their experiences to improve structures and policies, and improve prevention through public education [380].

In the South African context, victim services are generally closely linked, where secondary prevention measures can often flow into tertiary prevention measures. For example, immediately after a sexual assault a victim might report to a one-stop centre, where she/he will receive immediate crisis or containment counselling, along with other medico-legal or clinical services. Counselling may well continue over the long term, or the counsellor may make a referral to another, more service-relevant organisation, initiating tertiary intervention.

At the same time, criminal justice proceedings may require that an accused sexual offender be referred for a psychological assessment (if, for instance, they are considered a dangerous offender, have discernible or possible mental health issues, or be a “risk” to the victim should the victim reside in the same household). Psychological assessments, counselling, the employment of “protective measures” as well as other harm-reduction methods can therefore occur at the secondary or tertiary levels. Some might consider crisis counselling,

KEY AREAS OF INTERVENTION	VAC PREVENTIVE INTERVENTIONS
1. IMPROVEMENT IN SCHOOL SAFETY	<p>Key evidence-informed whole school guidelines developed by Gevers and Flisher (2012)[375] are quoted below: "DBE should monitor adherence to minimum safety standards and efforts at preventing and responding to school violence.</p> <ul style="list-style-type: none"> • School policies and procedures, including a detailed code of conduct, promoting non-violence and setting out appropriate responses and consequences for violence in accordance with the Department of Basic Education's minimum standards of safety need to be implemented and clearly communicated to all those within the school community. • School staff need to be taught and supported in effective and appropriate classroom management and be held accountable for violence within the schools by enforcing school non-violence policies with appropriate means and any staff who perpetrate violence in the school need to be swiftly and decisively disciplined. • Security infrastructure at schools needs to be updated, maintained and monitored to keep the school premises safe and secure. • Through collaboration with the SAPS, Department of Social Development and local government as well as school and community initiatives, the environment surrounding schools should be cleared of drugs, alcohol and weapons. • Safe transit to and from schools needs to be established so that learners and educators have access to reliable, safe and affordable transport between their homes and the school. • Children and youths experiencing violence in the home or community need to be identified and provided with appropriate support services, including counselling. • Planned, co-ordinated and consistent extramural activities should be organised to involve learners in positive leisure activities after formal school hours. • Get youths' input when designing such programmes and be sure to make them available throughout the year and accessible to all. • Research efforts need to be increased so that programmes are effectively monitored and evaluated to inform programme improvement and generalisability to other schools." <p>RESOURCES Department of Basic Education <i>School Safety Framework</i> http://www.education.gov.za/Programmes/SafetyinEducation/tabid/1048/Default.aspx Burton P. (2008). Dealing with school violence in South Africa (Issue Paper No.4, 1–15). Cape Town: Centre for Justice and Crime Prevention. Centers for Disease Control Preventing Violence in schools http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/prevention.html UNESCO, Stopping Violence in Schools: A Guide for Teachers. http://unesdoc.unesco.org/images/0018/001841/184162E.pdf</p>
2. PREVENTION OF BULLYING	<p>Programme elements that reduce bullying include:</p> <ul style="list-style-type: none"> • Clear anti-bullying policy understood by learners and overseen by educators (consistent monitoring and intervention as necessary). • Playground and classroom supervision. • Firm discipline with perpetrators. • Parent meetings (both victim and perpetrator). • Formal engagement of peers in tackling bullying including peer mediation, peer mentoring and encouraging bystander intervention have not proven to be effective. <p>RESOURCES: Farrington DP, Ttofi MM. (2009). School-based programs to reduce bullying and victimization. <i>Campbell Systematic Reviews</i>: 6, 10.4073/csr.2009.6 Bullying Prevention Institute: http://www.bullyingpreventioninstitute.org/ Olweus Bullying Prevention Institute: http://www.bullyingpreventioninstitute.org/LinkClick.aspx?fileticket=5BnCPJGFPhc%3D&tabid=72 Cyberbullying: http://www.violencepreventionworks.org/public/cyber_bullying.page</p>
3. PREVENTION OF GENDER-BASED VIOLENCE	<p>Some programmes to be considered:</p> <ul style="list-style-type: none"> • Stepping Stones HIV and Gender-based violence prevention: The programme is designed to prevent HIV infection and better communication and more equitable gender relations between partners. Randomised Trial has shown effectiveness in reducing sexual risk-taking and violence perpetration by youth (see the VAW best practice section below for more details): http://www.mrc.ac.za/gender/stepping.htm • Men Care (Global Fatherhood Campaign) Sonke Gender Justice (promising but no trial data – see the VAW best practice section below for more details): http://www.genderjustice.org.za/community-education-mobilisation/mencare • Promundo (promising but no trial data): http://www.promundo.org.br/en/activities/programs/ • Respect for U is an intimate partner violence (IPV) prevention programme aimed at young adolescents. The 17-lesson programme was originally designed for implementation in Grade 8 Life Orientation classes. The programme addresses associations between intimate partner violence, ideologies of male superiority, a culture of violence, and alcohol and drug use. The goals are to increase social support for girls, change norms that support boys' right to control girls and insist on sex, increase understanding of substance use in the context of relationships, and improve communication to prevent the use of violence in relationships. Outcome evaluation is in progress: http://www.mrc.ac.za/gender/respect4u.htm

Table 15. Possible Practices to Reduce the Risks of Violence in Schools.

combined with longer term support of younger victims, as a form of primary prevention (interrupting the victim-to-perpetrator cycle).

These prevention and intervention measures, however, need to be supported by a progressive legal and/or policy framework that: (a) actively promotes violence prevention through the absolute proscription of all forms of violence and the creation of, or support for, early prevention programmes; (b) ensures the consistent provision of victim support services provided by the current laws on sexual offences, domestic violence and child maltreatment, amongst other laws promising care and support to victims; and (c) supports the *appropriate* use of offender-based programmes as a violence prevention measure.

Any attempt to develop a coordinated and effective South African strategy must work across all levels of prevention. This, in itself, constitutes an internationally recognised good practice [381].

4.3.2 General Characteristics of Good VAW Prevention Strategies

4.3.2.1 Multi-level Strategies and Services

VAW prevention needs to work across various institutional and social levels. In this regard, two elements are significant:

- Government departments across the national, provincial and local levels must provide for strategic planning for VAW prevention in their annual national plans of action, VAW budgeting and integrated service meetings. Additionally, government and civil society stakeholders and service providers must coordinate efforts in order to make a substantial difference to the effectiveness of interventions and services. Intra- as well as inter-departmental and inter-sectoral strategic planning and coordination can ensure that programmes are not replicated unnecessarily, and that they include all relevant elements. In turn, collaborative work will enhance the capacity of government and civil society and build new networks that can sustainably address VAW [382].
- The socio-ecological model is widely accepted as a best practice in violence prevention. To prevent and respond to violence against women, the socio-ecological approach requires that stakeholders address violence at the individual, relationship, community and societal levels. For example, prevention at an individual level would include programmes that attempt to change individual attitudes and behaviours regarding VAW. Prevention of VAW at a relationship level includes strategies to influence interactions between a dating couple or the behaviour of boys and men in peer groups. Community prevention strategies comprise efforts to

influence behaviour and attitudes at a wider community level or mobilise community action to fight VAW and support survivors (see box VAW Best Practice 1). Prevention efforts at a societal level address structural issues such as economic inequality and poverty as well as inequitable gender norms. To prevent and respond appropriately to violence, the socio-ecological approach suggests engagement with violence prevention activities at multiple levels, at the same time. Additionally, because VAW has many interconnected risk factors at multiple levels, VAW prevention must link with other social justice efforts including transforming gender attitudes, substance abuse, education, HIV/AIDS and access to psychosocial services for victims of child abuse [381].

4.3.2.2 Integration vs. Specialisation

There is on-going discussion among policy-makers, scholars and service providers about the utility of an integrated approach as opposed to a specialised approach to VAW prevention. The United Nations Division for the Advancement of Women (UNDAW) identifies three aspects to this issue:

- Should efforts cover a range of forms of violence or focus on one?
- Should governments be encouraged to develop violence against women strategies and policies or should the issue be mainstreamed across all policy areas?
- Should services be specialised, e.g. dedicated police units and sexual violence courts [380]?

UNDAW [371] argues that this should not be an either/or strategy. UNDAW advocates for both a holistic approach to addressing all VAW as well as a specialised strategy to prevent and redress specific forms of violence against women. In other words, violence against women ought to be mainstreamed into policy agendas across the board, but where specialised services can improve the experiences of women and prevent violence, they should be implemented at a local level, in way that recognises local needs, local contexts and local resources.

The nature of services (or interventions) should therefore be adjusted to the social needs and structural realities of the population being served/treated/supported as well as consider the existence and service mandates of complementary primary, secondary or tertiary services being offered in the area. 'Specialised services' should therefore principally fill an existing gap in services or amplify existing service provision through the introduction of specialised skills.

4.3.3 Primary Prevention Practices

Primary prevention is defined as decreasing the incidence of a problem. Primary prevention is aimed at addressing VAW before it occurs, in order to prevent initial perpetration or victimisation. Prevention efforts may also take the form of

targeted action aimed at behavioural issues and risk producing environments [367]. Primary prevention needs to account for:

- Multiple social factors including norms, practices, beliefs about gender;
- Equality and women's and men's role and status in society;
- Complex risk factors for VAW, including various other socio-economic determinants;
- Individual, relationship, community and societal level (ecological model) engagement and participation; and
- The need to change social norms and values and shift the onus for combating VAW from groups of individuals and individual organisations to all people in South Africa [386].

Popular strategies in primary prevention of VAW tend to include parent and caretaker programmes, school-based programmes, sex and relationship education for children and youth (see the section on VAC best practice above), interventions for the economic empowerment of women and interventions that work specifically with men and boys.

4.3.3.1 Comprehensive Youth Sex and Relationship Education

Evidence also shows that children who receive early, consistent and positive messaging about sex, gender and sexuality are more likely to be confident about themselves and their bodies, to treat others with respect, and to avoid (or identify) risky sexual practices, abuse or dating violence [387]. Further, studies have shown that age-appropriate education on these topics has the effect of delaying sexual debut and activity, reducing the number of sexual partners, increasing the use of contraception and/or reducing unplanned pregnancy and sexually transmitted infection (STI) rates, and decreasing exposure to dating violence [388].

The World Health Organization reviewed evaluations of 47 programmes in different countries [389]. In 15 studies, sex and HIV/AIDS education neither increased nor decreased sexual activity and rates of pregnancy and STI [389]. However, in 17 studies, HIV and/or sex education delayed sexual activity, reduced the number of sexual partners, increased the use of contraception and/or reduced unplanned pregnancy and STI rates [389].

VAW BEST PRACTICE 1

Raising Voices developed the SASA! (Start, Awareness, Support, Action) Activist Kit

SASA!'s Activist Kit was designed using the ecological model to violence prevention in order to identify, train and mobilise community leaders and activists to address VAW and HIV in their own communities [383]. Local men and women are trained by SASA! to facilitate attitude and behaviour change, through various activities, in order to decrease the social acceptability of VAW, and hence VAW itself [384].

An evaluation of SASA! using a randomised control trial was performed in Uganda between 2007 and 2012. It was found that men and women involved in SASA! were more likely to have attitudinal changes, including that the social acceptance of perpetration of IPV by a man was significantly lower among participants [385]. Additionally, participants widely accepted women's rights to refuse sex [385].

Involvement in SASA! also influenced participants' behaviour. Men in the intervention groups were significantly less likely to have reported multiple sexual partners. Women participants reported approximately 50% less physical IPV in the previous year, although there was no substantial difference between the control and intervention groups for sexual IPV [385].

In addition to the original 10 countries, following the positive results of the study, SASA has now been introduced in 15 additional countries [385].

Schools are the most effective locales for such programmes, as a vigorous school-based curriculum has the potential to have a wide and sustained reach. Gender-based violence frequently occurs in educational settings, with young girls especially being exposed to sexual harassment, intimidation, assault and rape, bullying, verbal and psychological abuse based on their gender at the hands of fellow (male) students, teachers and principals. This is particularly true in South Africa [390]. As such, school-based interventions are vital for changing inequitable gender norms and behaviours before they become engrained in children [371]. Additionally, primary prevention in schools can create a zero-tolerance environment for perpetrators, including for educators.

Research on the impact of school-based programmes is beginning to show a promising impact on reducing levels of VAW. However, these studies have been primarily performed in developed countries and contexts, such as North America and Northern Europe. Additionally, empirical studies have mostly focused on the short-term outcomes of school based programmes, ignoring their long-term impact [371].

4.3.3.2 Economic Interventions for Women

Women's economic empowerment is central to reducing their vulnerability to violence, and is a powerful primary prevention strategy. One programme (that has been evaluated for impact)

VAW BEST PRACTICE 2

Safe Dates

Safe Dates is an American school-based primary prevention programme that includes girls and boys 13 – 15 years old. The programme utilises a variety of teaching tools including ten sessions of educational curriculum, a poster contest, theatre production, support services as well as training for service providers in communities aimed at changing attitudes and behaviours regarding VAW.

A randomised control trial of Safe Dates participants performed one month after its culmination found reduced sexual violence perpetration, reduced psychological abuse, more equitable gender norms and increased knowledge of tertiary services for survivors of violence among participants compared to the control group [391]. Additionally, four years after the programme ended, participants in Safe Dates reported significantly less perpetration of sexual violence as well as physical violence compared to the control group [392].

An adaptation of Safe Dates is now being evaluated for school based settings in South Africa.

VAW BEST PRACTICE 3

Microfinance for AIDS and Gender Equity (IMAGE)

IMAGE, initiated in rural South Africa, provides economically disadvantaged women with microfinance and training on gender, poverty and HIV. Empirical evaluations testing the efficacy of IMAGE have shown that IPV among participants in the programme was reduced by 55% in two years [383]. By comparison, women who received microfinance without gender and HIV training did not see a reduction in IPV. Moreover, younger IMAGE participants increased their use of voluntary HIV testing services and counselling. The evaluation of IMAGE has suggested that intervention strategies that simultaneously address factors that facilitate VAW such as poverty, HIV and gender imbalances can alter behaviours and reduce violence [393]. Consequently, IMAGE has both been scaled up at a relatively low cost throughout South Africa and been introduced in other countries [383].

shows that interventions that provide sustained economic empowerment training and gender programming for women and their partners has reduced IPV [393]. The identification of factors that seem to enable abusive environments combined with the dual approach of working with vulnerable women and their partners appears to have a notable preventive effect on potential future violence.

In addition, research [394], [395] shows that female victims of gender-based violence in South Africa invariably lack access to housing, and that their ability to access and keep secure housing is inevitably shaped by their (lack of) access to economic resources as well as IPV-sensitive as well as responsive State housing policies. Under such circumstances, economic interventions aimed at women can constitute effective secondary prevention, allowing women to exit dangerous situations, or violence when it first occurs, and to prevent re-victimisation.

It is surprising, then, that policy and interventions addressing the economic determinants of VAW are limited in South Africa [396]. However, evidence suggests that economic interventions such as microfinance and economic empowerment, along with the provision of long-term housing, would significantly assist abused women, and increase their resilience against re-victimisation [396], and this is an important area for future policy development.

Microfinance and economic empowerment intervention programmes have been introduced in a variety of settings in South Africa and across the continent. While these programmes have received significant attention, their efficacy in reducing VAW and achieving other outcomes remain unclear, but promising [393]. Emerging evidence [382], [393] indicates that combining economic empowerment/microfinance with gender programming results in more reductions of IPV and VAW than economic programming alone.

4.3.3.3 Working with Men and Boys

Engaging men and boys is a relatively new field in VAW prevention that has received significant attention in recent years. Due to the emerging nature of this work, and the limited evaluations in the field, it is difficult to speak definitively about best practices in working with men and boys in preventing VAW. Research suggests that there is substantial evidence of effectiveness of interventions to improve boys' and young men's attitudes about gender norms, and VAW, but the evidence of effectiveness related to behaviours is less straightforward.

In a systematic review of evaluated interventions, only one out of eight studies demonstrated a significant impact on behaviour [397]. Sixteen studies measured outcomes related to non-sexual forms of violence, or both sexual and non-sexual violence, but only nine of these studies were classified as

methodologically strong or moderate, with only seven that were significant [397].

From the evidence available, the following principles for interventions with men and boys appear successful:

- Linking boys and men's programmes to women's empowerment and the prevention of violence against women.
- Targeting intervention with boys and men at risk of becoming perpetrators of VAW.
- Acknowledging and responding to the pervasive issues (poverty and unemployment, frustration and substance abuse) that boys and men experience [383], [398], [399].

In attempting to engage men and boys in preventing VAW, research shows that it is critical to address their own experiences and exposures to violence. Engaging boys and men about their experiences of violence should have an effect of reducing the risk that they will perpetrate violence, since boys who have experienced violence are more likely to commit violence themselves. One meta-analysis reviewed 21 programmes that provided psychological interventions for child and adolescent survivors of child maltreatment [371]. The results of the analysis suggest that psychological treatment for survivors resulted in improvements in 71% of the children in treatment, compared to the control group. In a randomised trial of one of the 21 programmes, researchers found a reduction in both victimisation and perpetration of physical and emotional abuse [371].

Discussing violence prevention and men's violence against women with men and boys can be challenging. Men and boys who have not engaged in violent behaviour may feel unfairly targeted and can become antagonistic to violence prevention strategies that they view as accusatory. Therefore, it is essential that primary prevention strategies find ways to engage men and boys in a way that enables them to become active participants in preventing VAW. One way to do so is to illustrate how women's empowerment and gender equality will benefit both men and women. This can be done by utilising men's role models and general sense of "justice, fairness and equality" (amongst men) [400]. At the same time, it is essential that programmes engaging men and boys involve women as teachers and community mobilisers, in order to shift gender norms and normalise women's empowerment. Displaying female leadership is paramount in changing the attitudes that enable VAW.

4.3.4 Secondary Prevention

Secondary prevention is defined as lowering the prevalence of a problem in the population [367]. It usually refers to either prevention in high risk situations where violence has not yet

occurred, but seems imminent, or interventions that happen immediately after the violence has occurred to deal with the short term consequences, e.g. treatment or counselling, or both.

Good practices in secondary prevention should:

- Be victim centred and speak to the best interests of victims [380].
- Be inter-sectoral and address the multi-dimensional consequences of violence and resultant needs [380].
- Empower victims of violence to rebuild their lives [380].
- Allow victims to make decisions on their own behalf and respect their choices [381].
- Be cognisant of, and address the needs of vulnerable and high risk groups. Women with certain risk factors are potentially more at risk of experiencing violence. Women who: abuse substances; have been exposed to or experienced violence; fall within a lower socio-economic bracket; are migrants; have little education or legal literacy; hold progressive views towards gender roles; have an alternative gender identity and sexual orientation; or have a disability or chronic illness may be at a higher risk of being victimised by gender based violence. Therefore it is critical for policy-makers and practitioners to pay special attention to women who fall within these high-risk groups when planning and implementing secondary prevention efforts.
- Reduce the stigma associated with experiencing violence [383]. Conservative gender norms and taboos about female sexuality and the normalisation of VAW have contributed to widespread stigma, guilt and anxiety among victims of violence. The result is that many women do not report violence or access services. This is compounded by the prejudice and mismanagement of police, judiciary, health care workers and social service providers [380]. Hence, it is crucial to have well-trained and sensitive staff engaging with victims [396].
- Identify individuals most at risk for perpetrating violence so as to intervene in high risk situations, and/or limit violence early on [383]. Individuals who: have had a traumatic or violent childhood; abuse substances; are involved in other forms of criminal behaviour; exhibit psychopathic traits and/or anti-social behaviour; age; have a low educational attainment or socio-economic status; or hold gender inequitable attitudes are at greater risk for committing violence. Thus, prevention efforts must identify individuals and sub-groups who are most likely to perpetrate violence.
- Train women as professional and support staff to enable same-sex services where this is the victims' preference [383].

4.3.4.1 Domestic Violence Screening in Health Care Settings

In South Africa, DV victims seek treatment for injuries at health care facilities before they seek help anywhere else, putting health care practitioners in a unique position to screen for and manage DV [401]. For instance, it has been found that between 62.5% and 91% of DV victims seek treatment at a health care facility, and that between 71.4% and 93.3% disclosed the abuser's identity to a health care professional, while only 15% to 20.4% reported to the SAPS [207]. In rural areas, health care facilities may be the most accessible place to report abuse or seek help. These findings not only demonstrate that the health sector is the preferred avenue of help-seeking for DV victims, but highlight the urgency of including health-related responses in the DVA.

In addition to the obvious need to provide health care to victims of DV, screening in the health care sector is also vital to the effective handling of DV by the justice sector. Should a victim want to obtain a protection order or lay criminal charges against a perpetrator, or should child custody become an issue, health care professionals' medico-legal documentation of DV and expert testimony can be vital evidence for the prosecution [402]. If properly (but anonymously) documented, screening will also provide a better picture of the actual prevalence of DV in the country and victims' health needs, providing a sound base for policy-makers to work from.

The World Health Organization and the Federation for International Gynaecologists and Obstetricians' frameworks for positive interventions recommend that health care staff universally screen (all female patients, in all settings) for DV and provide treatment and referrals [403]. In England, the Department of Health now advises "routine enquiry" about DV of some or all women patients, which is congruent with Canadian and United States policies [404]. Due to the proactive approach taken in these countries, stigma and fear seems to have been reduced, with patients being increasingly open to dealing with DV [405].

4.3.4.2 Bystander Interventions

Scholars and practitioners have identified bystander intervention as a promising secondary violence prevention practice. As most people are unlikely to help others in certain situations, including VAW situations, bystander interventions try to equip individuals to intervene when appropriate. A bystander is anyone who observes a situation that looks like someone could use some help. They must then decide if they are comfortable intervening. Bystander intervention

VAW BEST PRACTICE 4

Sonke's One Man Can Campaign

One Man Can discusses the large issue of men's violence against women, while also reinforcing what men can do to prevent violence against women from occurring. One Man Can is currently being implemented in South Africa and several countries throughout the continent. Sonke's One Man Can programme seeks to promote gender equality, end violence against women and respond to the HIV/AIDS crisis [399]. The campaign has effectively built and strengthened networks between the UN, the South African Government, faith-based organisations and other local NGOs [383]. An impact evaluation has found that participants of Sonke's One Man Can project have reported "positive behavioural changes in terms of HIV testing, awareness and reporting of violence, and condom use" [383].

programmes teach men and women to overcome the tendency to passively observe and instead offer help and immediate assistance to someone who may be in danger. Bystander intervention programmes have been found to be effective in university and college campuses [406]. They can be an effective technique for discouraging and preventing imminent violence, and for reducing the social acceptability of violence and changing wider social norms around gender.

While bystander intervention has been noted as a promising practice in violence prevention, the diffusion of responsibility, ambiguous situations, victim blame and the possibility of being embarrassed by intervening remain fundamental obstacles to bystander intervention [406]. These variables play out differently in different contexts dependent on prevailing social and gendered norms. For this reason more empirical testing of intervention strategies is needed in different contexts [408].

4.3.4.3 Specialised Services for Victims of VAW

Because many women are hesitant to seek help, it is critical that services are offered in an accessible, sensitive and effective way. Specialised services include one-stop centres for victims reporting and treatment, specialised investigative units, and specialised courts for addressing VAW. They provide a range of services to rape victims, including acute or emergency medical care, medico-legal (or "forensic") examinations of victims, the provision of post-exposure prophylaxis (or "PEP") for the prevention of HIV, pregnancy and other sexually transmitted infections, crisis and longer terms counselling and, in some part, support and preparation of rape victims if their cases proceed to trial.

Specialised victims services, including one-stop centres, may be able to increase reporting of violence, because of increased confidence in the system and the services available. Increased

reporting of VAW should be interpreted as indicating the efficacy of the service and service provider, and not as an indictment of policing as increased crime reporting has traditionally been viewed. Specialised victim services are often underfunded, which places the value of their work at risk [408]. Services that provide women and girls with support – to disclose sexual violence or leave violent and abusive relationships, navigate the criminal justice system and to recover and rebuild their lives – receive relatively little funding, especially in relation to the number of women affected by VAW, and its cost to victims and wider society [409].

While Thuthuzela Care Centres (TCCs) are doing great work in selected locations throughout South Africa, there are simply not enough TCCs in the country. With the pandemic of sexual violence in the country, just over 50 care centres cannot adequately reach enough survivors of sexual assaults. Moreover, many of these care centres are not fully functional and adequately staffed with specialised forensic nurses, counsellors or legal representatives. Although the one-stop centre model can work extremely well in some contexts, its implementation has proven problematic in rural settings. In order to justify a dedicated centre, the centre needs to serve a considerable population, and see a large volume of victims. However, in rural areas where populations are more diffuse, this can mean travelling long distances to TCCs.

Whilst TCCs address the immediate and complex needs of victims of sexual assault, there is currently no national one-stop service for victims of domestic violence. At present the Department of Social Development (DSD) is piloting such a model in the Western Cape, a Khuseleka One-Stop Centre for all victims of gender-based violence, which would house the multiple services that a victim of domestic violence may need. Among these would be trauma counselling, health care, psychosocial support, shelter services, SAPS and legal services [410].

In South Africa and in other contexts, victims of VAW do not always seek help from specialised services, and it is vital that all first responders in all settings are sensitive and survivor-friendly, as these agencies serve as gateways to specialised victim services and to the health care and criminal justice systems in general. So while specialisation is important to ensure victims receive the most appropriate services efficiently, it is also important to emphasise and integrate a victim-focused, gender-sensitive ethic throughout relevant public systems.

4.3.4.4 The Role of SAPS

In the attempt to access support and protection, survivors of violence often first report to the South African Police Service (SAPS). As the SAPS are vital first responders and gatekeepers to others services for victims of violence, it is essential that they provide effective and consistent services. However, SAPS officials, part of a wider patriarchal social context, sometimes possess attitudes that form barriers to serving victims of VAW with sensitivity [396]. As first responders, their knowledge, competence, sensitivity and efficiency are paramount to secondary, as well as tertiary intervention. Monitoring SAPS service provision to victims of VAW, however, is challenging.

Oversight of services provided by SAPS in relation to VAW is performed by various departments within SAPS as well as structures outside of the organisation, often leading to a lack of consistency in the lodging of complaints as well as their resolution. For example, the Independent Police Investigative Directorate (IPID) investigates only criminal offences committed by members of SAPS, including VAW. For complaints regarding service delivery (failure to investigate and other forms of professional misconduct), complainants must go to the Police Inspectorate of SAPS Provincial Commissioners [411].

For Domestic Violence Act non-compliance – victims must lodge their complaint with the Civilian Secretariat of Police (CSP), a role previously held by the Independent Complaints Directorate (ICD) [396]. Bringing this oversight function “in-house” has been problematic. For example, in the first year of its new role the CSP received only 22 complaints from three provinces, a 77% decline in the number (94) recorded by the ICD in its final 12-month reporting period [396].

In response to the jurisdictional challenges of addressing complainants, not to mention questionable accountability measures, the CSP has recently drafted an instrument to be used for monitoring SAPS compliance and implementation of the Domestic Violence Act. It is a small but encouraging step. However, restructuring the oversight mechanisms, including functions currently held by the Police Inspectorate and CSP, to strengthen IPID may be a vital next step. Further, the introduction of a Public Complaint Director to liaise with the public and improve transparency and cooperation between the public, police and IPID should also be considered.

4.3.4.5 Access to Services for Vulnerable Groups

VAW prevention and services must be accessible for all women, including minority and vulnerable groups. Women who: abuse substances; are migrants; engage in sex work and transactional sex; have a non-normative gender identity and/or sexual orientation; or have a disability are at an increased risk for being victimised by violence. Given that certain risk factors increase a woman's likelihood of being a victim of violence, there is a need for VAW prevention and service provision for these at-risk individuals. The effort to make existing services inclusive requires the identification of the barriers faced by the various groups of vulnerable and underserved individuals.

VAW BEST PRACTICE 5

The Mentors in Violence Prevention Project

The Mentors in Violence Prevention Project trains male American athletes and other student leaders in campus settings to interrupt sexist behaviour that they may notice among their peers [398]. Athletes are identified to intervene both due to their perceived leadership roles, as well as their disproportionate involvement in sexual violence on campus [407]. Bystanders are taught intervention techniques such as turning lights on at a party, turning off music, pulling potential perpetrators away from women and other innovative techniques. Research has shown that following bystander intervention training, 38% of male participants have intervened in a sexual assault compared to the 12 percent of the research group that had not been involved in the campaign [407]. When trained bystanders intervene in potential sexual assaults and sexist behaviour, they contribute to building a male peer culture that is more gender equitable and less violent [398].

Some examples of barriers for vulnerable groups include:

- Inaccessible or delayed services due to language barriers. Because language needs vary, there must be accommodation provided for in victim services. Examples of accommodations are: language modification or simplification in the case of people with intellectual disabilities, sign language interpretation for clients who are deaf, or foreign language interpretation and translation for clients who are immigrants, refugees, asylum seekers and human trafficking victims. Indeed, language barriers also prevent the effective dissemination of knowledge about the existence of services for victims of violence. Therefore users of diverse languages and individuals needing communication-centred accommodation should be targeted for both services and awareness-raising [312], [412].
- Immigrant, asylum seeking and refugee women are also less likely to report violence due to language barriers and fear of deportation and further abuse [407]. These women must be recognised through legislation and protected through South Africa's legal code. No woman, neither citizen nor undocumented migrant, in South Africa should be refused legal justice or victim services.
- A recent evaluation of the Western Cape victim empowerment services highlighted the fact that there are very few shelters that can accommodate transgender victims or are even known to be LGBTI-friendly. Although such shelters may exist, these shelters do not have a prominent public profile, and it is thus unclear how accessible they are to potential residents [410].
- This evaluation also identified a need for combined shelter and rehabilitation facilities for drug users. Women struggling with substance abuse issues are excluded from shelters, yet evidence demonstrates that VAW and substance use are often concurrent [410].

4.3.5 Tertiary Prevention

Tertiary prevention focuses on long-term interventions after the initial violence has occurred. It is defined as decreasing the negative effects associated with, and preventing the recurrence of, VAW. These include various individual interventions such as counselling and criminal justice services, as well as legal and policy reform. Tertiary prevention also includes interventions with sex offenders, such as sex offender treatment programmes, although these are not within the ambit of this brief. In the past, most efforts to prevent VAW were limited to this area. This section will focus on tertiary prevention in terms of victim services and legal and policy reform.

4.3.5.1 Strengthening the Legal and Policy Framework

The South African government has made significant commitments to protecting victims of violence through the development of progressive national laws. Some have argued [413] that the area of violence against women, in particular, has witnessed profound legislative and policy changes in recent years and these changes have to some extent improved the provision of state services to victims of crime. While having a strong legal framework for VAW is considered a best practice, this has not, however, resulted in rigorous implementation of these laws, or the provision of comprehensive and consistent quality of victim services and criminal justice processes. Key legislation regarding VAW includes:

- Domestic Violence Act No. 116 of 1998 provides for clarification in granting a protection order in cases of domestic abuse. Section 2 states that “any member of

VAW BEST PRACTICE 6

Thuthuzela Care Centres

South Africa has followed international best practices in establishing one-stop centres for post-violence exposure service provision [383]. Thuthuzela Care Centres (TCCs), located in just over 50 areas throughout South Africa where reports of rape are extraordinarily high, have integrated victim-oriented services in one-stop centres for survivors of sexual violence in South Africa. These services include a medical and forensic examination, an opportunity to bathe, crisis counselling, an option to provide a statement to an investigating officer and a safe ride home. By integrating criminal justice systems, health, and psychosocial service provisions, TCCs have increased the quality and efficacy of care for survivors of sexual violence in South Africa. By providing victim-centred services and reducing the administrative burden, TCCs reduce secondary trauma [382], [383].

the South African Police Service must, at the scene of an incident of domestic violence or as soon thereafter as is reasonably possible or when the incident of domestic violence is reported; render such assistance to the complainant as may be required in the circumstances, including assisting or making arrangements for the complainant to find a suitable shelter and to obtain medical treatment.”

- The Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (hereafter referred to as the SOA) expanded the number of sexual offences and gives clarity to many definitions. The SOA repealed the common law offence of rape and substituting it with a new extended statutory offence of rape, applicable to all forms of sexual penetration without consent, regardless of gender. The SOA also created new offences, such as sexual assault, certain compelled acts of penetration or violation, the exposure or display of child pornography and the engaging of sexual services of an adult and new sexual offences against children and persons who are mentally disabled. It also:
 - *Establishes a duty to report sexual offences committed with or against children or persons who are mentally disabled;*
 - *Provides the South African Police Service with new investigative tools when investigating sexual offences or other offences involving the HIV status of the perpetrator;*

- *Provides the courts with extra-territorial jurisdiction when hearing matters relating to sexual offences;*
- *Provides certain services to certain victims of sexual offences to minimise secondary traumatisation (PEP and the right to have an accused tested for HIV);*
- *Creates a National Register for Sex Offenders;*
- *Makes provision (in section 62) for a national policy framework to guide the implementation of the legislation that must be created within one year. Gazetted in 2012, the final NPF is disappointing in its lack of attention to detail in relation to the operationalisation of process or procedure according to the SOA. As the implementation framework of the SOA, the NPF has promising ‘implementation ideas’ but does little to articulate the methods in which these ideas out to be implemented, in practice.*
- Protection from Harassment Act 17 of 2011 provides protection from all forms of harassment (including online) and enables victims to apply for protection orders.

It must be noted that criminal justice as a tertiary prevention strategy has some fundamental limitations. All too often, criminal justice is perpetrator centred, focusing on punishing and prosecuting offenders. While prosecution is indeed necessary, this process can be traumatic for victims of violence and is all too often unsuccessful [381]. Hence, it is vital that these laws also facilitate a safe and accessible environment

VAW BEST PRACTICE 7

The Sexual Abuse Victim Empowerment (SAVE) Programme*

SAVE is a psycho-legal programme run by Cape Mental Health aimed at people (mostly women and children) with intellectual disabilities who are complainants in sexual violence cases [413].

The programme, which was introduced in Cape Town in 1991, provides clients with counselling, assessment and court preparation services (if the case goes to trial). Follow-up services are also provided to victims and their families. In addition to working with a social worker, clients also see a psychologist as part of the SAVE programme. The psychologist will compile a psycho-legal report, which is of particular importance to the prosecution.

The SAVE programme has demonstrated its success in facilitating access to justice for complainants with intellectual disabilities by assisting to find safe accommodation as well as alerting service providers to their needs [413].

* Please note that SAVE has proven effective in the local, South African context, and is therefore considered a ‘best practice’ for the purposes of illustrating successful inclusive victim empowerment. It is not, however, an international standard best practice.

wherein victims can report, and receive good quality and timeous services, allowing them to participate in criminal justice processes, and continue with their lives as productive citizens. Therefore, for tertiary prevention to be most effective, it must work in concert with the health sector, social services and the housing sector to provide an empowering and rehabilitating environment for victims of violence.

Further, legislation is often vague about the actual details of victim services. Research has identified that where legislation does not clearly delineate how departments are supposed to coordinate or render services, the result is inaction, or poor delivery of services to victims [414]. The lack of a legal and policy framework to guide and coordinate victim services is a critical shortcoming that creates confusion and inadequate service provision [410]. There is a need for clear instructions and regulations, and policy to ensure that VAW services are rendered in the manner that they were intended by the legislation. It is also important to note, though, that legal frameworks alone are not enough to enable service providers to meet the needs of victims; these must be backed up with sufficient resources and capacity to allow for full implementation.

4.3.5.2 Long-term Victim Services

Whilst the SOA mandates immediate health care interventions for victims of sexual assault, it does not address the longer-term needs of victims, including long-term counselling. In fact, counselling is not legislated in South Africa at all, and there are no existing policy guidelines for the kinds of counselling. Additionally, legislation does not guide the length of counselling that victims should receive. As a result, counselling varies among and between NGO and Department of Social Development service providers, with victims receiving variable and often inadequate counselling.

For example, an evaluation of the Western Cape's Victim Empowerment Programme highlighted the lack of long-term counselling services as a serious impediment to victim-healing [410]. Indeed, in an international study, 75% of victims of assault, robbery and rape who were interviewed two-and-a-half years after the incident reported that they continued to be affected by the crime [414]. Victims of sexual offences in particular experience distress for months, or even years, after the incident, and are at increased risk of long-term psychological problems, including depression, anxiety, dissociation and Post-Traumatic Stress Disorder (PTSD) [415], [416].

Currently, a shortcoming in victim services is that there are a limited number of places of safety and emergency shelters available for victims of VAW. Moreover, there is limited long-term housing for victims who cannot return to their former residences and cannot rely on family members. Because of economic dependence on abusive partners, women exiting an emergency shelter may have to return to cohabitating with

the perpetrator or live on the streets. Transitional housing has proven extremely useful in tiding women over until they have found work, are financially independent and are able to pay rent at market prices [410]. However, such transitional housing is extremely scarce, and remains an important potential area of cooperation between DSD and the housing sector [410].

Given that VAW impacts millions of women living in South Africa, it is critically important to provide long-term services to victims of violence in order to prevent future violence from recurring and to promote justice, rehabilitation and healing for victims and their families.

4.3.5.3 Coordinated Service Provision and Information Management

Information management is one of the most basic but most effective ways of improving services. Effective information management prevents cases from “falling between the cracks”, keeps victims and perpetrators informed of legal processes (which they are legally entitled to), allows tracking of delays in services or systems of justice and provides a means of tracking victims and offenders as they cascade through the health, social development and criminal justice systems. The potential of systematic information collection and management could have a profound impact on how all-level prevention programmes are designed and how they are measured.

Currently there is no way for service providers or victims to track cases across government departments. Given the number of role-players involved in providing services to VAW victims, including health care, police and investigation services, counselling and court preparation (which spans state and NGO agencies) and court services, this has serious consequences for the flow of information to service providers, as well as to victims.

From the perspectives of service providers, the burden falls on individual social workers, investigating officers and others to make the necessary calls, and take the necessary steps to determine whether a victim has received the necessary information on services. In order to identify problems and render required follow-up services, social workers need to be able to track cases through the system once a client has left their office [410].

On the other hand, it is not surprising that there is a tremendous fall-out in information for victims of VAW, specifically in regard to criminal justice processes, court dates and medical treatment. This means that victims sometimes are unaware of the next steps in the process, do not know where to seek services, do not follow criminal justice procedures timeously and ultimately “drop out” of the system [417]. In this regard, a system or procedure for tracking a case/victim through the system is vital to delivering adequate victim services.



05

KEY RECOMMENDATION

A population-based, public health approach focuses on interventions targeting whole populations and aims at reducing prevalence rates of violence against children and women.

5.1 MOTIVATION

The extensive review of existing research on VAC and VAW in South Africa, and the predictive modelling presented in the previous sections of this report, emphasises the multidimensional, interconnectedness and considerable overlap of the determinants of violence against both women and children. Hence, in order to effectively prevent such violence it is essential for government to respond in a coherent and comprehensive inter-departmental manner that actively and constructively cooperates with, and supports, appropriate non-governmental stakeholders. This complex state of affairs presents a considerable challenge to the South African government, as it would to most governments, due to an entrenched institutional culture and departmental-based budgeting that discourages far-reaching interdepartmental action.

In the recent past the South African government has nonetheless devised effective solutions to multidimensional national crises, principally on public health issues. Key examples include polio, measles, malaria and HIV/Aids. In the case of polio, measles and malaria the actions of South African government, in collaboration with others, has contributed to the virtual eradication of these diseases within South African territory. In the case of HIV/Aids, a concerted multi-sectoral approach that included civil society dramatically improved life expectancy of many South Africans living with HIV/Aids, and significantly reduced the transition of the virus from mother-to-child.

Violence is considerably more complex than a disease or a virus. Previous attempts to devise comprehensive violence reduction strategies, such as national government's 1996 National Crime Prevention Strategy, have largely failed to achieve notable positive outcomes largely due to enormity of resources and cooperation required. As indicated in the best practices section ad hoc evidence-based interventions have yielded some promising outcomes, but mainly on a small scale. In effect, government would have to be fundamentally re-engineered in order for it to comprehensively implement strategies and programmes to prevent and reduce all forms of violence in South Africa.

There are, however, important learnings for violence prevention from the logic and processes that were devised and followed in relation to the prevention and/or eradication actions in relation to polio, malaria and HIV/Aids. Critically, the responses had clear and realisable priorities and objectives, as well as drew on existing government processes, resources and

strengths. Hence, a similar logic could be followed in relation to violence if any meaningful violence prevention outcomes are to be achieved.

The research presented in this report underlines the high prevalence of VAC throughout South Africa. Not only is this a critical issue for children and their families, but VAC has also been found to be a principal risk factor for both VAW perpetration and victimisation. However, the child protection system in South Africa is overwhelmed by a high case load, and thus a preventative strategy to addressing VAC could possibly be more effective and a better use of scarce resources [418]. Hence, a strong focus on preventing VAC, particularly through early intervention, may be the most appropriate course of action for the South African government to have a significant impact on reducing and preventing violence in the long term.

5.2 A PROPOSED POPULATION-BASED EARLY INTERVENTION PUBLIC HEALTH APPROACH TO ERADICATING VAC

A population-based, public health approach focuses on interventions targeting whole populations and aims at reducing prevalence rates of VAC. The suggestion should ideally make use of a four-pronged strategy:

1. Early intervention and prevention of VAC;
2. More research on the prevalence of VAC, through analysis of data generated through universal screening for VAC;
3. Intervention programmes at scale [419];
4. Improved information and surveillance systems concerning CM⁴⁴.

In essence the proposed approach would aim to address VAC through early screening of parents and children. Parents identified as at risk of perpetrating VAC and children displaying signs of maltreatment will then be identified and referred for appropriate interventions and support. In addition, high-risk children and parents will be carefully monitored.

5.2.1 Screening of Parents during Pregnancy

All pregnant mothers accessing antenatal care should be screened for certain vulnerabilities, such as mental health

⁴⁴ "Increased investment in improving information about child maltreatment, including the development and maintenance of information systems tracking measures of child abuse in the health, social care, police, education, and justice sectors." [419, p. 114]

problems and lack of social support. Such vulnerabilities can place mothers at increased risk of abusing or neglecting their children. As outlined in the Early Childhood Development (ECD) Policy, at risk mothers should then receive parenting support through regular home visits made by Maternal and Child Community Workers (MCCWs) and if necessary should be referred to the ECD Parent Support Programmes. Indigent mothers and caregivers can also be referred to SASSA for CSGs and CDGs.

This screening data could then be fed into the surveillance system. It is essential to record and monitor the data from this screening, in order to follow up with these parents; identify if there are certain areas where there is a greater prevalence of vulnerable mothers; as well as to monitor and evaluate the effectiveness of the interventions to which vulnerable parents are referred.

5.2.2 VAC Screening (Routine and Targeted)

The South African government uses the WHO's *Expanded Program on Immunisation and Vaccine Preventable Disease Surveillance* (EPI) as well as the *Reach Every Community* (REC) strategy in its approach to eradicating vaccine preventable diseases [420]. The EPI is a universal approach, while the REC strategy targets high-risk areas and areas which do not receive as thorough coverage during routine vaccination. Similarly, the proposed VAC eradication strategy will include routine, universal screening for VAC and then mass screening campaigns targeting high-risk communities (REC strategy). The REC strategy has identified how marginalised communities often face an increased burden of disease and consequently such communities are specifically chosen for targeted immunisation interventions [421].

Similarly, we have noted that marginalised and poorer communities may also display higher prevalence rates of VAC; and so can also potentially be targeted for specific VAC screening interventions. The surveillance data from the universal VAC screening will enable the identification of high-risk communities which can then be targeted in the REC strategy (e.g. the data will be used to conduct field-mapping) [422].

Social mobilisation and educational awareness-raising sessions could also be included for parents [423]. For infectious diseases, it is suggested that the government holds mass campaigns every three to five years. VAC campaigns could be held more regularly owing to the high prevalence rates

[422]. Mass campaigns are also useful in addressing mobile population groups, whose children are at greater risk of having missed out on routine screening [422].

5.2.3 Universal VAC Screening Directive

The following is recommended:

- The South African government could issue a directive which will require all children to undergo routine screening for VAC every time they visit health facilities to receive vaccinations. This universal approach is not only important because of the high VAC prevalence rates, but because VAC occurs upon a continuum and thus it is essential to screen all children, not just those belonging to high-risk groups [419].
- The National Delivery Framework for VAC screening could possibly fall under the "National Programme of Action for Children: Framework". This framework calls for immunisation as well as for health screening of all Grade 0s and Grade Rs [424].
- The Inter-Ministerial Core Group (Seven nominated ministries represented are Health, Education, Welfare, Water Affairs and Forestry, Finance, Justice and Minister without Portfolio (RDP)) is responsible for the oversight and implementation of this framework. The Department of Health (DOH) is primarily responsible for oversight and implementation of immunisation strategies and it is suggested that the DOH could be primarily responsible for the VAC screening [425].
- The VAC DOH could be responsible for oversight of the screening and the Department of Social Development (DSD) should be responsible for the referred cases. The role of the Department of Basic Education (DBE) could include amending the Admission Policy for Ordinary Public Schools to include a proof of VAC screening requirement, for enrolling in a public school (as is required with immunisation) [426].
- Each province could have a VAC control committee (like an infection control committee) to oversee the implementation of national and provincial policies concerning VAC; to monitor the VAC screening, VAC campaigns and the VAC surveillance system [427].
- The VAC screening tool could be a simple, standardised one page screening form which is simple and quick to administer, but also effective in screening for VAC.
- Both routine and campaign screening should be indicated on the Road to Health Chart (RTHC).
- While targeted interventions are very important, it is essential that a focus on RECs does not take away from the efficient and effective role of universal screening [428].

5.2.4 Training of Child Care Workers

The following are recommended:

- The development of national guidelines for training health care workers (HCWs) on VAC screening.
- The establishment of oversight mechanisms to ensure that HCWs are screening correctly and that the information is being fed into a central VAC management database in a timely manner.
- HCW workers are required to visit crèches, nurseries, EDCs, ECLCs to immunise children - the same could be undertaken for the screening of VAC among children in these settings.
- Confidentiality should be ensured during the screening process and with regards to screening findings.
- Childcare workers including: teachers, early childhood practitioners (ECPs), Community-Based Child and Youth Care Workers (CWCYs), Doctors, Nurses, Community Health Workers (CHWs), Allied Health Professionals (AHPs), community nurses, Maternal and Child Community Workers (MCCWs), Imams, pastors, Sunday school workers, NGO workers working with children etc. should be trained to identify indicators and patterns of VAW. Further, they should be trained on how and where to refer children affected by violence. Suspected cases of VAC must be referred to the DSD and, where necessary, the DOH.
- Community Policing Forums and neighbourhood watch organisations could also meet with the Police to discuss how they can be involved in preventing and reporting cases of VAC in the community.

5.2.5 VAC Surveillance System

Every health centre is required to have a surveillance system where they record immunisation data of their patients [429]. A surveillance system should also be developed for VAC. While the VAC screening data could be entered into the DHIS, it would be ideal if it could be fed into a separate VAC surveillance system, which is accessible and can be used by other governmental departments, such as the DBE, DSD, DOP, DJCD and NPA.

A central surveillance system with information from health facilities, educational facilities, police services, courts etc. would enable better information-sharing and data-

management in victim services. Such a system would also allow for better monitoring of VAC cases.

Proof of VAC screening could be made a requirement for registering for enrolment in South African public schools [378].

5.2.6 Home-based Interventions and Referrals

Article 143 (2) (b) of the Children's Amendment Act identifies the need for provision of prevention and early intervention programmes "to families where there are children identified as being vulnerable to or at risk of harm or removal into alternative care." The purpose of these programmes is detailed in Article 144. Article 144 (1) outlines interventions which could improve parenting skills and train parents in non-violent parenting methods [370]. The VAC screening could assist in identifying children and parents in need of these programmes.

Pregnant mothers who are identified as vulnerable during the VAC parenting screening could be included within the ECD programme "Family and Home-Based Support for Pregnant Women and Children under 2 Years of Age". As part of this programme, Mother and Child Community Workers (MCCWs) (a) visit vulnerable pregnant mothers and caregivers and mothers with infants below 9 months, on a regular basis; (b) support and train child minders of 0-2year olds; and (c) register qualifying pregnant mothers for the CSG and vulnerable caregivers for the CDGs [430].

Vulnerable parents can also be referred for involvement in the ECD Parent Support Programme. This programme provides parents with information and support concerning development and non-violent discipline. It aims at empowering parents through (a) promoting positive parenting and avoiding harsh discipline; (b) providing training on child safety and protective practices; (c) encouraging parent-child bonding; (d) referral of vulnerable parents (parents who are violent, abuse substances or display symptoms indicative of mental health disorders) [430].

5.2.7 Limitations/ Challenges

One of the challenges of this proposed strategy is that VAC screening could possibly be a deterrent for parents to vaccinate their children. This challenge could partly be addressed through how the screening is presented/ marketed to parents and caregivers.

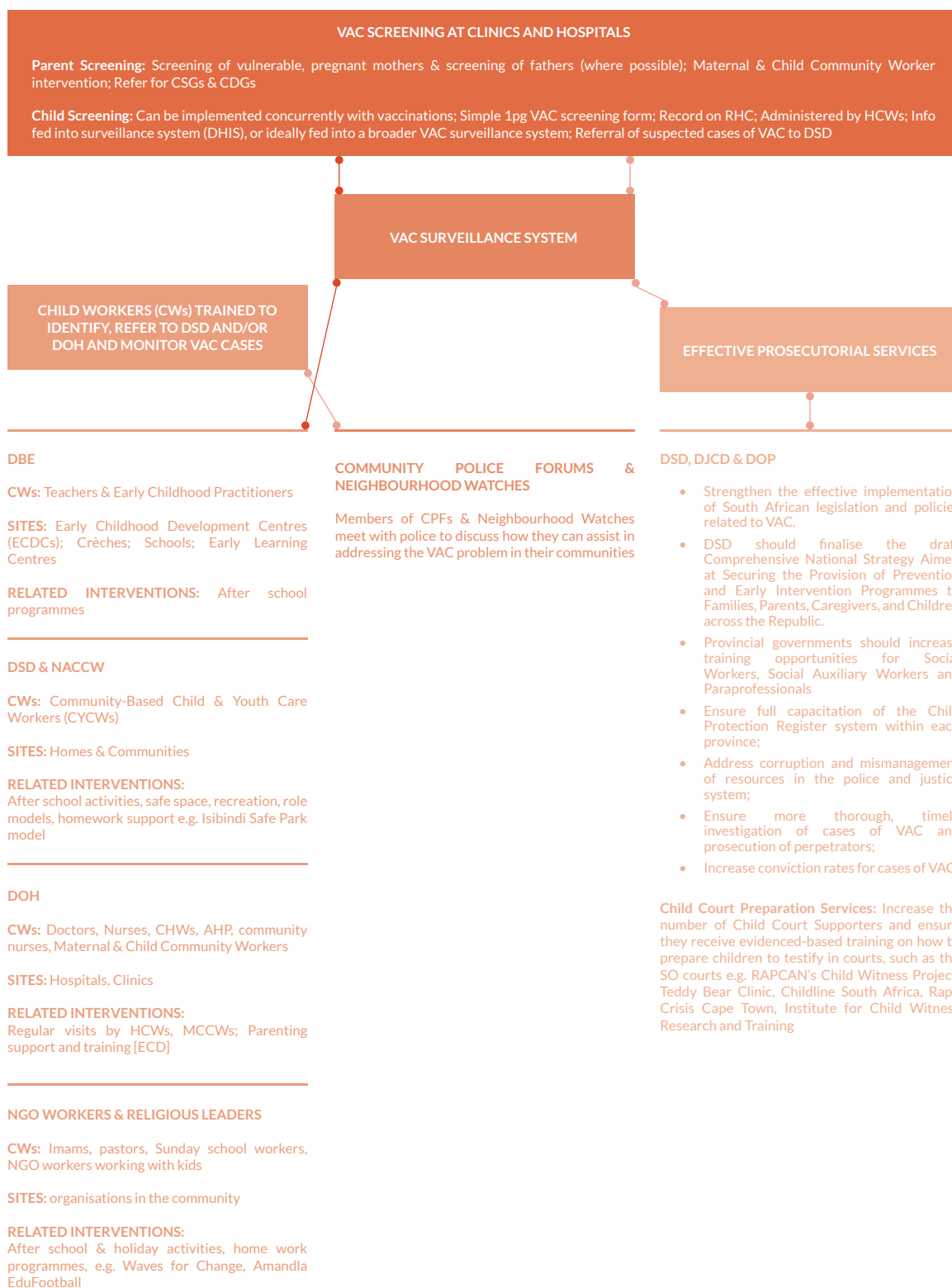


Figure 25. Population-based Early Intervention Public Health Approach to Eradicating VAC.

KEY

CSG	Child Support Grant	CW	Child Worker	CHW	Community Health Worker
CDG	Care Dependency Grant	DOH	Dept. of Health	AHP	Allied Health Professional
VAC	Violence against children	DBE	Dept. of Basic Education	MCCW	Mother and Child Community Worker
RHC	Road to Health Chart	ECDC	Early Childhood Development Centre	CFP	Community Police Forum
HCW	Health Care Worker	ELC	Early Learning Centre	SO	Sexual Offences
DHIS	District Health Information System	CYCW	Child and Youth Care Worker	DJCD	Dept. of Justice and Constitutional Development
DSD	Department of Social Development	NACCW	National Association of Child Care Workers	DOP	Dept. of Police

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